Center for a New American Security

NOVEMBER 2010

POLICY BRIEF

America's Duty
The Imperative of a New Approach to Warrior and Veteran Care

By Nancy Berglass

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the Veterans of earlier wars were treated and appreciated by their nation."

- President George Washington

America's failure to prepare for and adequately address the impact of war upon service members and veterans is one of the most significant challenges of the post-September 11 era. Nearly a decade into two wars, the strain on the all-volunteer force is manifesting itself in troubling ways. Rates of depression, brain injury and suicide among warriors and veterans are high and increasing. Military use of psychiatric medications has increased 76 percent since the beginning of Operation Enduring Freedom (OEF), with 17 percent of the current active duty force on anti-depressants.[1] From 2005 to 2009 alone, service members took their own lives at an average rate of one every 36 hours.[2] Reliable scientific studies report that post-traumatic stress disorder (PTSD)[3] and traumatic brain injury (TBI) afflict up to 35 percent of all troops.[4]

Addressing the deployment-related needs of those who have served is not only the moral thing to do, it is also strategically wise for the nation. The strength and viability of an all-volunteer force is undermined when the health and well-being of its members and veterans is so precarious.

Though the implications for national security, public health and social welfare are serious, the U.S. government's response has been inadequate. Infrastructure, training and funding at the state and local levels, on which the burden of reintegrating millions of veterans and military families falls, do not suffice. Addressing these challenges is no small task, especially under the worst economic conditions in recent history. Yet, if we are willing to embrace innovation and long-needed reform in military and government policy, the challenge is surmountable.

A new paradigm for warrior wellness will require a dramatic reprioritization in the allocation of federal funds and fundamental changes to the relationship between the Department of Defense (DOD) and Department of Veterans Affairs (VA).[5] It will also

require a groundbreaking inclusion of private-sector stakeholders – nonprofit organizations chief among them – in the cause of warrior wellness. DOD and VA, of course, bear primary responsibility for the care of those who have borne the battle, but warriors[6] come home to communities, not to federal agencies, and so it is at this crossroads of national obligation and social welfare that a new understanding of military wellness must take root. It is there that engagement with well-vetted nongovernmental partners should be among the most important strategies for ensuring the sustainability of an all-volunteer force, the successful social reintegration of our nation's newest veterans and the ongoing care of those who fought before them. Not doing so will bequeath to this generation of service members many of the same indignities and burdens of combat-related mental illness, homelessness, addiction and poverty that remain unaddressed for thousands who fought in Vietnam.

Given the inadequacy of government efforts to address the needs of today's service members to date, particularly the daunting issues of mental health and suicide, it is essential that DOD and the VA engage private-sector players and leverage their value and impact. This is not a distant aspiration. The U.S. government can draw upon an emerging network of nongovernmental organizations to form a model of public-private partnerships that will greatly enhance the care and services provided to those who have served the nation.

Modern Warfare Requires Modern Warrior Care

Since 2001, America's wars have been characterized by repeated deployments, widespread exposure to blast-related head injuries, and protracted large-scale call-ups of the National Guard and Reservists. Of the roughly 2.2 million Americans who have deployed since the Sept. 11 attacks, over 800,000 have been required to serve multiple tours.[7] Of these, one quarter has gone to the fight three times or more. A 2009 study published by the *American Journal of Public Health* documents that those who deploy more than once are at a 300 percent increased risk for severe mental health outcomes.[8] At the same time, current brain scan images of young Operation Iraqi Freedom (OIF) soldiers bear a frightening resemblance to those of much older boxers who have weathered decades of blows to the head.[9] The RAND Corporation's landmark 2008 "Invisible Wounds of War"[10] report documents that between 14 and 19 percent of OEF/OIF veterans experience debilitating effects of post-traumatic stress, the unpredictable effects of traumatic brain injury and/or the unrelenting impact of combat-related depression. A Stanford University study places the percentage closer to 35 percent.[11]

For the 43 percent of today's fighting force that is comprised of Reserve and Guard members, the extended separations from family, work and the civilian community life to which they are accustomed have taken a toll as well. While several studies indicate similar rates of post-traumatic stress and depression among both active duty and reserve component service members during the initial stages of deployment,[12] a Walter Reed Army Institute of Research study indicates that many mental health concerns among reserve component Reservists after the first 12-month period are attributable to "variables related to readjustment to civilian life or access to health care."[13] Additionally, without access to many of the family-support resources available to active duty service members and their families, the spouses, parents, caregivers and children of Reserve and Guard members demonstrate higher levels of "child disengagement and more challenges with financial well-being" than their active duty counterparts.[14] Children from reserve component families experience greater difficulty readjusting to parents after deployment and report consistent problems stemming

from interactions with civilian peers and teachers, who typically have limited understanding of the deployment experience.[15]

As remains true for thousands of Vietnam-era veterans, increasing numbers of OIF and OEF veterans exhibit troubling levels of substance abuse. A 2007 study published in *Military Medicine* indicates that up to one-third of troops returning from OEF/OIF reported struggles with "problematic drinking."[16] A 2009 Veterans Health Administration paper identifies 27,000 cases of "excessive or improper drug use" and 16,200 new diagnoses of Alcohol Dependence Syndrome among OEF/OIF veterans seen at VA hospitals.[17] In the recent *Health Promotion/Risk Reduction/Suicide Prevention 2010 Report*, Army Vice Chief of Staff General Peter Chiarelli noted with concern that Army personnel committed 16,997 drug- and alcohol-related offenses in FY2009, a possible sign of declining discipline.[18] The same report found that 72 percent of the Army's 64,022 felony and death investigations between FY2001 and FY2009 were drug-related.[19] Perhaps most troublingly, the Army found that the number of felony drug investigations grew between 18 and 26 percent from FY2004 to FY2009 (a number made less clear due to "gaps in siloed reporting"), and significant numbers of Army personnel found possessing or using illegal drugs are not referred to the Army Substance Abuse Program (6,297 in FY2009).[20]

Rates of unemployment and poverty, along with divorce and family violence, among troops, veterans and military families are of significant concern as well.[21] At least 130,000 and as many as 250,000 U.S. veterans are homeless each night; 89 percent were discharged honorably and over 7,000 are veterans of Iraq or Afghanistan.[22] Together these outcomes are what Defense Secretary Robert Gates recently referred to as "the dilemmas and consequences that go with having so few fighting our wars for so long."[23]

These figures are not an indictment of DOD or VA. Under the leadership of ADM Mike Mullen, Chairman of the Joint Chiefs of Staff, and the less-visible, yet thoughtful stewardship of Secretary Gates and VA Secretary Eric Shinseki, both departments have publicly acknowledged shortcomings and established ambitious internal programs to address them. DOD and VA have made important advances in mitigating some of these problems. DOD's exceptional work in battlefield medicine and VA's successful suicide hotline program, for example, are among many notable achievements. Yet neither agency has moved to identify problems and implement solutions comprehensively or effectively enough.

At least 130,000 and as many as 250,000 U.S. veterans are homeless each night; 89 percent were discharged honorably and over 7,000 are veterans of Iraq or Afghanistan.

By working largely within the confines of governmental structure, both DOD and VA fail to take advantage of private-sector resources. Both agencies could fulfill their missions more quickly, effectively and with a desperately needed personal touch by leveraging the exceptional promise of community partners to help them meet their charges. By partnering with capable private-sector providers in the communities to which warriors come home, both DOD and VA can enhance the management and delivery of warrior care, and sometimes meet the individual needs of warriors with unique circumstances. While the military and other federal agencies struggle to escape the confines of bureaucracy and turn good ideas into action, private-sector organizations are on the front lines at home. They provide service members, veterans and their families treatment

and services ranging from emergency financial and child-care assistance to adaptive housing and employment-readiness training. In this sense, the nongovernmental sector is already playing a major role in supporting America's national security. Community organizations, often more efficiently than federal agencies, are bridging the gaps between service to the nation and reintegration with family and community afterward. By engaging more openly with nonprofit providers while maintaining rigorous criteria for vetting and accountability, DOD and VA can select and engage with the best of the exceptional resources civilian society has to offer our service members and veterans.

Warrior and Veteran Care: The Current Landscape

While organizations serving service members and veterans cannot – and should not – take the place of the government, they can and must play an essential role in coordination with federal agencies. It will take a diverse and coordinated group of local and national stakeholders, including but also reaching beyond DOD and VA, to implement strategic and systemic solutions to the deployment-related challenges facing troops, veterans and their families in this era of persistent conflict.

There are three fundamental flaws in the provision of governmental services to troops and veterans, which ultimately undermine the nation's capacity to support those whose national service has left them with significant unmet needs.

First, the military's "we take care of our own" mentality can be counterproductive to providing for the needs of warriors, veterans and their families. Discrete programs and services are quite effective within their own small milieus (the Special Operations Forces, for example, are notably good at caring for members and their families), but there is no consistent case management for the individual warrior or military family; no overriding strategy for each service; no cohesive infrastructure for the system overall that recognizes, mitigates and addresses the complex, multifaceted effects of service in today's all-volunteer force. Our military does an exceptional job of preparing soldiers, Marines, sailors and airmen for the fight – boot camp makes warriors of recruits – but we do little to "de-boot," to support that warrior and his or her family as he or she comes out of the extraordinary experience of having served in combat. A prosthetic leg, some physical therapy and a bottle of meds do not equal a homecoming plan. The Army's Warrior Transition Unit (WTU) program shows great promise for those with visible wounds, but there are still numerous obstacles to making that program effective, including the daunting stigma for some warriors of even being in a WTU.

Second, the inflexible nature or even lack of meaningful coordination between DOD and VA bureaucracies hinder the effective and efficient provision of services. Providing a large infrastructure for care and benefits is something our federal agencies do well; meeting the individual needs of a vast and diverse population of warriors and veterans is not. From guidance on the new GI Bill to disability claim advocacy, several veterans' service organizations (VSOs) have entire programs and numerous staff devoted to helping veterans navigate the federal agencies that are supposed to serve them. That a field of nonprofit organizations exists primarily to interface between an agency and its constituents alone is a testament to the inefficacy of governmental operations. By their very nature, federal one-size-fits-all programs simply cannot apply equally to the unique circumstances facing, for example, an unmarried wounded Army Reservist from rural Iowa, as compared to a career Marine from San Diego who is returning home to three children. National-level bureaucracies are ill-equipped to tailor their services in ways that recognize how deployment affects individual

service members in very different ways. DOD and VA's failure to cooperate in tying together the "bookends" of military service via provision of consistent, dignified and adequate care and support systems before, during and after deployment undermines the post-conflict safety and security of those who risk their lives for our nation, and may ultimately weaken our force.

National-level bureaucracies are ill-equipped to tailor their services in ways that recognize how deployment affects individual service members in very different ways.

Third, a poorly understood and unevenly enforced system of laws and protocols severely limits the extent to which federal agencies may engage with nongovernmental partners. It is not uncommon to see serving senior officers at functions of congressionally-chartered military-service organizations (MSOs) or VSOs, such as the American Legion or Veterans of Foreign Wars. Those same leaders however, will assert that they are prohibited from even appearing to endorse lesser-known but sometimes more innovative and efficacious organizations or nonprofits. There are exceptions: the military medical establishment found a way to partner with the enormously talented reconstructive surgeons at UCLA's Operation Mend, for example, while other health organizations are also rebuilding and saving lives with neither support nor acknowledgment from federal agencies. There are no consistent, official criteria by which the excellence of potential nonprofit partners can be vetted. There are no consistent standards for excellence and no strategic plans by which community-based resources are assessed, accessed or held accountable while bridging the growing gaps between federal agencies and the needs of our veterans. Rather, antiquated policies automatically favor and award privileges to relatively few large, often well-endowed VSOs, which have venerable histories but somewhat less of a connection with the current generation of warriors and veterans.[24] Not all have demonstrated the capacity to deliver meaningful direct services that pertain specifically to this generation of service members and veterans. By the widely accepted vetting and due-diligence standards of organized philanthropy, few of these groups merit such exclusive access to government resources and recognition.

The Emerging Paradigm for Warrior and Veteran Care

In light of the challenges described, an effective paradigm for modern-era warrior care cannot depend entirely on government programs and services. Both DOD and VA have struggled throughout the course of two wars to meet many of the basic responsibilities associated with the needs of their charges. The nonprofit sector has stepped in to introduce new ideas and methods to address unresolved problems. Across the spectrum of military care, the nonprofit community is a quiet giant. In communities nationwide, nonprofit programs and services touch every aspect of a warrior's or military family's life, offering mental health counseling and crisis intervention, financial assistance, scholarships, workforce reintegration, transportation, housing and even advocacy within DOD and VA systems.[25] Some organizations are longtime players on the national stage, whose experience enabled rapid response to the earliest needs created by the wars in Iraq and Afghanistan. Many others were established as national and local responses to the current conflicts, upholding missions that pertain to the new and unique circumstances of today's wars. The 2009 report of the Iraq Afghanistan Deployment Impact Fund (of which

the author is director), which distributed close to 250 million dollars in grants to military- and veteran-support nonprofits nationwide, documents that its 53 grantees provided critical, sometimes life-saving deployment-related services to 2 million warriors, veterans and military family members, between 2006 and 2009 alone.[26] Thanks to the work of nonprofits, thousands of veterans have found themselves able to readjust and thrive after deployment to Iraq and Afghanistan. Few resources were available to aid their transition previously.

Nonprofit providers of services to troops, veterans and military families add value in at least four critical areas where government agencies are challenged:

Capacity and efficiency. Despite the best of intentions and efforts, DOD and VA are overwhelmed and inhibited by bureaucracy. There are excellent nonprofit providers in communities across the nation, however, whose local relationships and resources, as well as large numbers of "boots on the ground," can dramatically leverage the impact of what is possible from Washington.

Personalized care. With proper access to evidence-based care models, hometown organizations can address a range of individual needs in ways no bureaucracy can match. Kentucky-based USA Cares, for example, has used its networks to find local counselors in communities nationwide when veterans have threatened to hurt themselves and their families. Los Angeles-based New Directions has identified homeless veterans of the wars in Iraq, Afghanistan and Vietnam and provided them with services to address substance abuse, housing and unemployment challenges under one roof. The national Navy Marine Corps Relief Society has sent visiting nurses onto remote American Indian reservations to meet the needs of veterans in crisis there.

Trust. RAND's "Invisible Wounds of War" report revealed that large numbers of troops and veterans do not seek mental health care in the system because they fear either negative career consequences or ineffective treatment.[27] Both are indicators that some warriors mistrust or otherwise eschew the system under which they work. Community nonprofits that are independently operated can be a safe haven for those who may not otherwise seek help due to fear of repercussion. There are legitimate concerns when troops hide problems from their commanders; yet, most military leaders agree that it is better they seek help from community agencies than not at all.

Ability to engage the public. Nonprofit organizations put volunteer power to use quickly and efficiently. Were DOD and VA to establish partnerships with thoroughly vetted and accountable nonprofit organizations in the communities to which warriors return, the resulting networks could direct both volunteers and individual donors in ways that would harness America's goodwill, and transform warrior care in the process.

Nonprofits have proven essential to military wellness in the all-volunteer era, but operate almost entirely outside of any actual plan or strategy to address warriors' needs. Some receive funding support from the philanthropic community; almost none receive compensation from DOD or VA for the critical services they provide. Though their work is fundamental to military wellness, their current business models are not sustainable. A lack of cooperation or even acknowledgement from the very federal agencies whose constituents they serve keeps many good nonprofit providers marginalized, unable to reach the men and women whom, in some cases, they are uniquely capable of serving. The potential of the nonprofit sector to leverage warrior care will never be optimized until DOD and VA work together to formally engage local and other private-sector partners as part of an overall military wellness strategy.

Recommendations

The ongoing failure to attend to the deployment-related needs of those who have voluntarily served in America's armed forces in a time of protracted war can be overcome by a willingness to step outside of the confines of traditional government structures and bureaucratic constraints.

The following recommendations for the Obama administration, and DOD and VA in particular, would provide a first step toward implementing an improved infrastructure for warrior and veteran care.

1. The Obama administration should direct the design and implementation of a comprehensive "national homecoming plan" that will address the short-term and long-term deployment-related needs of troops and veterans, and attend to their successful reintegration with family, workforce, community and society. A homecoming plan that plays to the strengths of and forces efficiencies among the pertinent agencies and leverages their impact via strategic engagement with well-qualified private-sector partners would help ensure that warrior care is planned in advance. In this new paradigm, every veteran will have the access to health care, housing, education, employment and other opportunities and benefits they deserve after their service. Instituting such a plan requires first defining and implementing national standards for warrior care that begin with active duty and follow through to successful civilian reintegration. The task will be large and daunting. It is also critically important, long overdue and should be a priority for the Commander-in-Chief and Congress. President Obama and Congress must prioritize adequate funding for warrior care not only via standard line items for DOD and VA, but for the following innovations:

- ***A "Veterans Benefit Trust Fund"*** (as proposed by Linda Bilmes and Joseph Stiglitz to the House Committee on Veteran's Affairs) to ensure that veterans' health and disability entitlements are fully funded as obligations occur.[28]
- ***A "Military Service Endowment,"*** like its counterparts in the arts and sciences, would spur innovation, and strengthen the infrastructure for excellence in warrior care by distributing peer-reviewed grants to nonprofits working to meet the health, welfare and social integration needs of warriors, veterans and military families.

The potential of the nonprofit sector to leverage warrior care will never be optimized until DOD and VA work together to formally engage local and other private-sector partners as part of an overall military wellness strategy.

2. DOD and VA should institute a Comprehensive Interagency Continuum-of-Care Model. DOD and VA must, first and foremost, commit to a new interagency approach that establishes and enforces clear paths of communication and collaboration within and between the two departments. The departments should work together to set joint, consistent standards for addressing warrior and veteran needs; identify, plan and source programs and services that address all points along the continuum of need; and invest in strategic partnerships with outside agencies. Other governmental departments and agencies that serve military constituents and that have a presence in communities to which veterans return should also be integrated as stakeholders in the effort.

To adopt this model, DOD and VA should:

- ***Empower and adequately fund an accountable interagency office the sole charge of which, within the next year, shall be to write***

and oversee implementation of a bona fide strategic plan with milestones for success and standards for the sustainability of interagency cooperation. For purposes of efficiency, abolish, combine or force effective and measurable collaboration among VA's Office of Seamless Transition, the Joint Executive Committee and the Interagency Policy Committee, each of which is engaged intellectually in efforts pertaining to transition and interagency cooperation, but none of which has produced results that satisfy the charge.

- ***Create consistent standards for determining need.*** DOD and VA should not have disparate disability ratings. It is wholly inefficient that a warrior receive one set of diagnoses and ratings upon separation from active duty, only to face a likely different assessment of the same injuries and needs when seeking benefits and care from the VA. There should be a national standard that clearly defines service-related injuries, wounds and needs, and addresses those consistently among and between agencies.
- ***Provide troops, veterans and their families with "civilian readiness" training and follow it with comprehensive case management.*** When troops leave the military, they receive inadequate transitional information and assistance. Those in the reserve component and military family members receive uneven levels of outprocessing support. DOD and VA should develop a joint program of civilian readiness training that applies the same comprehensive approach to preparing combat veterans to leave the military as healthy, well and ready for the job market and community life as they were for the battlefield. An elemental component should be comprehensive training that helps veterans and their families spot signs of trouble and know where to go for help. Just as commanders flag soldiers who might be particularly vulnerable or need special care when they return from Iraq and Afghanistan, DOD should flag troops who are separating from the military and may warrant special care and attention from the VA after being discharged.
- ***Implement automatic registration with the VA for all service members.*** No veteran should have to face the indignity of having to "prove" or justify his or her service. If the AARP can find and solicit millions of Americans as they near the age of 50, DOD and VA can find a way to cull enough basic data on each service member to ensure that he or she becomes part of a system of care with consistent records and services.
- ***Track data consistently and promote ease of transition through the implementation of electronic records.*** When it comes to the documentation and distribution of data, all branches of the military keep their own records, which are not uniform in content, form or accessibility. This makes it unnecessarily challenging to identify and serve those troops and service members whose deployment-related needs may fall beyond the confines of what the government can provide. Protection of the individual's privacy should remain an inherent requirement of this evolution to 21st-century standards. Developing and implementing such a system will certainly be difficult, as DOD discovered in its efforts to create the now-defunct Defense Integrated Military Human Resources System (DIMHRS). However, there is still a significant need for a joint DOD-VA process to implement a more robust system to integrate and access records quickly and efficiently.
- ***Establish a high-level Veterans Policy Board (VPB) to provide rigorous and uncompromised advice for the VA Secretary, who must lead a needed overhaul of systems and organizational culture at the VA.*** The VA is a large and complex organization with health care services that are among the best in the world; it also includes

benefits administration that is widely reputed to be among the most outdated and inefficient of any government agency. Secretary Shinseki inherited an agency so entrenched in bureaucracy that his best intentions are as likely to be derailed by internal inertia as they are by external forces. Like the Defense Policy Board, the VPB should invite carefully selected national leaders and experts from across disciplines, to help provide the intellectual rigor, strategic advice and political savvy needed to guide change-making leadership.

3. Implement partnerships with nonprofit service providers. Meeting the needs of service members and veterans is a proposition that far exceeds the current capacities of DOD and VA. Both must prioritize and find effective ways to partner with nonprofit players and capitalize on the resources they have to offer. DOD and VA should engage leaders from the fields of organized philanthropy and the nonprofit sector to advise them as they learn more about working efficaciously with nonprofit partners. The departments can begin to foster this partnership through the following steps:

- ***Develop a national strategy to build and sustain excellent community partnerships in service to warrior care.*** This will require the establishment of unified government-approved vetting criteria by which nonprofit organizations shall be: 1. qualified as vendors or partners to government agencies, 2. referred to troops, veterans and their families; and 3. "weeded out" or deemed ineligible for government support if they violate the standards identified as necessary. The vetting process for community partners should be neutral, rigorous and periodically reviewed. The vetting infrastructure (whether by committee or internal office) must include experts in the fields of nonprofit management and philanthropy, alongside those with military expertise. Baseline standards for excellence in warrior and veteran care should be defined, and community partners held accountable to them. Nonprofit partners should demonstrate the ability to provide warriors and veterans with evidence-based, patient-centered, family-inclusive care. Requests for proposals should be targeted to nonprofit agencies that can provide services the government cannot provide adequately. This innovation-spurring strategy should be put into motion now.
- ***Abolish protocols that favor "official" VSOs.*** All nonprofit organizations with a central mission to serve troops and veterans and that meet stringent vetting criteria should be considered MSOs and VSOs. They should have equal access to opportunities for partnership with and recognition from government agencies. Organizations that have long been identified as official VSOs should be asked to demonstrate, like all other potential partners, their capacity, commitment and compliance, as well as their understanding of the circumstances unique to this generation of warriors. All MSOs and VSOs must be held to the same set of standards.
- ***Invest in the infrastructure necessary to support nonprofit military- and veterans-support services.*** DOD and VA can support coalitions, conferences and other mechanisms through which VSOs, MSOs and other organizations and agencies can network, collaborate and leverage the impact of each other's resources. They can invest in approaches that show the greatest promise to manage veterans' cases through local networks of care. One way of achieving this could be through the development of "regional" clusters where warrior and veteran needs can be grouped. Block grants and similar funding mechanisms can be made by federal agencies to these entities, which can take on increased case

management and local warrior-care responsibilities with far greater efficiency than can federal agencies. States, jurisdictions, coalitions of providers or other "umbrella" entities that can provide sound blueprints for regional approaches to warrior care are good examples of groups that might qualify as regional stakeholders. This approach plays to the strengths of communities – smaller, scalable clusters of stakeholders – who have the resources and relationships in place to work well together.

Conclusion

With each day, more families are coping with the mounting burden of repeated combat deployments. Increasingly, those burdens include troubling mental health challenges and, in the worst-case scenario, suicide. During and after active service, thousands of service members and veterans are still falling through the cracks of government and nonprofit safety nets. For these military and veteran families to get the support they have earned, policymakers, the private sector and the nonprofit and philanthropic community must work together in dramatically different ways. Preserving the wellness of service members and veterans is central to the effectiveness of the all-volunteer force and the ability of the U.S. military to perform its missions today and in the years to come. DOD and VA should embrace the opportunity to rally the dedication and resources of the American people through a new public-private partnership model of service to accomplish the critical mission of providing for those who have served.

Nancy Berglass is a Non-Resident Senior Fellow at the Center for a New American Security (CNAS), the Director of the Iraq Afghanistan Deployment Impact Fund (IADIF) of the California Community Foundation and the Principal of Berglass Community Investment Consulting.

The author wishes to acknowledge: the very hard work of Brian Burton and Dr. Kristin Lord; the insight and guidance of Nathaniel Fick, Dr. John Nagl and Lieutenant General David W. Barno, USA (Ret); the support of CNAS' bright and engaged Military Fellows; those whose volunteerism as external readers helped refine the ideas expressed here; the vision and generosity of IADIF founder David Gelbaum; and the exceptional support of the California Community Foundation and CNAS.

ENDNOTES

1. Andrew Tilghman and Brendan McGarry, "Medicating the Military," *Military Times* (17 March 2010): http://www.militarytimes.com/news/2010/03/military_psychiatric_drugs_031710w.

2. Department of Defense (DOD), "The Challenge and the Promise: Strengthening the Force, Preventing Suicide, and Saving Lives," Final Report of the DOD Task Force on Prevention of Suicide by Members of the Armed Forces (August 2010). See also Lisa Jaycox and Terri Tanielian, eds. ,"Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery" (Santa Monica, CA.: RAND Corporation, 2008); "Stanford Study Finds Staggering Rates of Post-Traumatic Stress Disorder Among Iraq and Afghanistan Veterans" (Swords to Plowshares Press Release, 19 Sept.2009): http://www.prweb.com/releases/veterans_affairs/swords_to_plowshares/prweb2905184.htm; Yu-Chu Shen, Jeremy Arkes, Boon Wah Kwan, Lai Yee Tan, and Thomas V. Williams, "The Effect of OEF/OIF Deployment Intensity on the Rate of Posttraumatic Stress Disorder Among Active Duty Population," National Bureau of Economic Research, Working Paper 15203, August 2009, http://www.nber.org/papers/w15203.pdf ; Jaine Darwin and Kenneth Reich, "Citizen Soldiers Changed Forever: The Impact on OEF/OIF on Reserve and National Guard Troops and their Families," Strategic Outreach to Families of All Reservists presentation, 2008: https://docs.google.com/viewer?url=http://uwf.edu/cap/HCW/materials/Darwin_ReichMay08.pdf.

3. There is a current debate as to whether or not the word "disorder" should remain included in a diagnosis of combat-related post-traumatic stress; those who argue against it decry the word as one that promotes the stigma associated with combat-related mental health problems. In this paper, out of respect for those living with combat stress and the many advocates working to eliminate stigma, the "D" for "disorder" shall not be hereafter referenced.

4. "Stanford Study Finds Staggering Rates of Post-Traumatic Stress Disorder Among Iraq and Afghanistan Veterans" (Swords to Plowshares Press Release, 19 September 2009); http://www.prweb.com/releases/veterans_affairs/swords_to_plowshares/prweb2905184.htm; and Jaycox and Tanielian, eds., "The Invisible Wounds of War."

5. "Military wellness" and "warrior wellness," terms used throughout this manuscript, are meant to describe the whole set of circumstances related to both readiness and health of the armed forces broadly, but also of the individuals and family members that collectively compromise the whole.

6. For the purposes of this policy brief, "warrior" is defined as any service member who has deployed to a combat zone, mainly Afghanistan or Iraq.

7. DOD, "Contingency Tracking System," Number of Deployments for Those Ever Deployed By Service, Component and Reserve Type for Operation Iraqi Freedom and Operation Enduring Freedom, as of 31 December 2009.

8. Anna Kline, Maria Falca-Dodson, Bradley Sussner, Donald Ciccone, Helena Chandler, Lanora Callahan and Miklos Losonczy, "Effects of Repeated to Iraq and Afghanistan on the Health of New Jersey National Guard Troops: Implications for Military Readiness," *American Journal of Public Health*, vol 100, no. 2 (February 2010): 276-283.

9. "Chronic Traumatic Encephalopathy in Athletes: Progressive Tauopathy After Repetitive Head Injury"; J Neuropathol Exp Neurol. American Association of Neuropathologists, Inc. Vol. 68, No. 7 (2009). Ann C. McKee, MD; Robert C. Cantu, MD; Christopher J. Nowinski, AB; E. Tessa Hedley-Whyte, MD; Brandon E. Gavett, PhD; Andrew E. Budson, MD; Veronica E. Santini, MD; Hyo-Soon Lee, MD; Caroline A. Kubilus; and Robert A. Stern, PhD.

10. Jaycox and Tanielian, eds, "The Invisible Wounds of War."

11. Stanford Study Finds Staggering Rates of Post Traumatic Stress Disorder Among Iraq and Afghanistan Veterans," Swords to Plowshares Press Release, 19 September 2009; http://www.prweb.com/releases/veterans_affairs/swords_to_plowshares/prweb2905184.htm.

12. JAMA and Archives Journals, "About One-Tenth of Soldiers Returning from Iraq May Be Impaired by Mental Health Problems, Study Finds," *Science Daily* (8 June 2010; 21 October 2010): http://www.sciencedaily.com / releases/2010/06/100607165621.htm.

13. Ibid.

14. Anita Chandra, Rachel M. Burns, Terri Tanielian, Lisa H. Jaycox and Molly M. Scott, "Understanding the Impact of Deployment on Children and Families; Findings from a Pilot Study of Operation Purple Camp Participants" (Santa Monica, CA: RAND Corporation, April 2008).

15. Ibid.

16. C. Erbes, J. Westermeyer, B. Engdahl andE. Johnsen, "Post-traumatic stress disorder and service utilization in a sample of service members from Iraq and Afghanistan," *Military Medicine* 172 (2007): 359-363.

17. "Nondependent abuse of drugs" refers to excessive or improper drug use without a full diagnosis of drug dependence. Alcohol dependence syndrome is "a maladaptive pattern of alcohol use, leading to clinically significant impairment or distress." (See: www.medicalcriteria.com/criteria/dsm_alcoholdep.htm) Data on usage from the VHA Office of Public Health and Environmental Hazards, "Analysis of VA Health Care Utilization Among US Global War on Terrorism (GWOT) Veterans Operation Enduring Freedom Operation Iraqi Freedom" (January 2009).

18. GEN Peter Chiarelli, foreword to Department of the Army, *Health Promotion/Risk Reduction/Suicide Prevention 2010 Report* (July 2010), ii; http://usarmy.vo.llnwd.net/e1/HPRRSP/HP-RR-SPReport2010_v00.pdf; Katherine McIntire Peters, "Soldiers Struggle Emotionally Under Stress of War," *Government Executive* (4 October 2010); http://www.govexec.com/story_page.cfm?articleid=46257&dcn=todaysnew.

19. Department of the Army, *Health Promotion/Risk Reduction/Suicide Prevention 2010 Report*: 73-75.

20. The report used two sources for its data on drug investigations that provided somewhat different figures. Army Centralized Operations Police Suite/Automated Criminal Investigation-Intelligence (COPS/ACI2) data recorded an increase from 6,391 drug subjects in FY2004 to 7,559 in FY2009, an 18 percent increase. Data from the Army's Drug and Alcohol Management Information System reported an increase from 6,243 in FY2004 to 7,907 in FY2009, a 26 percent growth. Ibid., 73-75.

21. See, for example, "Unemployment Rate for Young Veterans Hits 21.1 Percent," *Washington Post* (12 March 2010); www.washingtonpost.com/wp-dyn/content/article/2010/03/12/AR2010031204123.html; Lizette Alvarez and Deborah Sontag, "When Strains on Military Families Turn Deadly," *New York Times* (15 February 2008).

22. National Coalition for Homeless Veterans, "Homeless Veterans Facts"; http://nchv.org/background.cfm#facts. VA offers a figure closer to 110,000. See Department of Veterans Affairs Accomplishments Survey (26 July 2010). Also Scott Pelley, "Homeless Veterans: Stand Down," 60 Minutes (17 October 2010); http://www.cbsnews.com/video/watch/?id=6966795n&tag=related;photovideo.

23. Secretary of Defense Robert M. Gates, remarks at Duke University (29 September 2010); http://www.defense.gov/speeches/speech.aspx?speechid=1508.

24. See House Committee on Veteran Affairs: "Congressionally-Chartered Veterans Service"; http://veterans.house.gov/links/.

25. For listings of some vetted nonprofits serving military and veteran constituents, see Vanessa Williamson, "Supporting Our Troops, Veterans and Their Families: Lessons Learned and Future Opportunities for Philanthropy," A Report on the Iraq Afghanistan Deployment Impact Fund (IADIF) of the California Community Foundation (November 2009): 69. Also visit IADIF at http://www.calfund.org/learn/iadifgrants.php, and/or that of the Coalition for Iraq and Afghanistan Veterans at http://coalitionforveterans.org/who-we-are/meet-the-coalition/.

26. Vanessa Williamson, "Supporting Our Troops, Veterans and Their Families: Lessons Learned and Future Opportunities for Philanthropy" A Report on the Iraq Afghanistan Deployment Impact Fund (IADIF) of the California Community Foundation (November 2009).

27. Jaycox and Tanielian, eds, "The Invisible Wounds of War."

28. Joseph E. Stiglitz and Linda J. Bilmes, The Three Trillion Dollar War: The True Costs of the Iraq Conflict (New York: W.W. Norton, 2008).

About the Center for a New American Security

The Center for a New American Security (CNAS) develops strong, pragmatic and principled national security and defense policies that promote and protect American interests and values. Building on the deep expertise and broad experience of its staff and advisors, CNAS engages policymakers, experts and the public with innovative fact-based research, ideas and analysis to shape and elevate the national security debate. As an independent and nonpartisan research institution, CNAS leads efforts to help inform and prepare the national security leaders of today and tomorrow.

CNAS is located in Washington, D.C., and was established in February 2007 by Co-founders Kurt Campbell and Michéle Flournoy. CNAS is a 501c3 tax-exempt nonprofit organization. Its research is nonpartisan; CNAS does not take specific policy positions. The views expressed in this report are those of the authors and do not represent the official policy or position of the Department of Defense or the U.S. government.

© 2010 Center for a New American Security.
All rights reserved.

Center for a New American Security
1301 Pennsylvania Avenue, NW
Suite 403
Washington, DC 20004

TEL 202.457.9400
FAX 202.457.9401
EMAIL info@cnas.org
www.cnas.org

Press Contacts
Shannon O'Reilly
Director of External Relations
soreilly@cnas.org
202.457.9408

Ashley Hoffman
Deputy Director of External Relations
ahoffman@cnas.org
202.457.9414