

## **Community Solutions to Help Returning Iraq (OIF) and Afghanistan (OEF) War Veterans: Concepts and Strategies**

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For the family of a military man or woman serving in a war, there are two exceedingly important points of time; the day the service member left the house (or the U.S.) and the day of arrival back home from the war. There should be a day of real homecoming for every military war veteran, but aching, there is a small (in percentage) but large (in number) minority who do not come back alive to waiting arms. This number and this basic comparison are what make the news; not the sizable number of physically and/or psychologically wounded who return to waiting arms but start a new uncertain life.

Recently, however, the numerous homeless and unemployed veterans of the Iraq (Operation Iraqi Freedom) and Afghanistan (Operation Enduring Freedom) wars and the other Global Wars on Terrorism; the many veterans who suffered a plentitude of disfiguring limb and facial injuries and who now face serious challenges in physical, social, and emotional rehabilitation; the mandatory mental health screening programs for all returning soldiers before they leave the service; and the many reservists and guardsmen called from civilian life who returned home in coffins or medical evacuation flights all prove that a

### ***Point A (home)→war→return to Point A***

journey with successful acclimation may be more infrequent than expected for these war veterans. This is for both combat and non-combat veterans.

### **Concepts**

It can be hard for military members returning from combat in other foreign wars to put words and emotions to their experiences; these two present wars are no different. Their silence about wartime experiences is accepted by others around them in their daily lives, often with a sense of relief for not having to ask about these experiences. This is especially true for those veterans who are able to create basically productive lives around families and friends and work. Those who do not adapt well are judged for their behaviors, not their service. These judgments can be harsh and very divisive among the public and families and can prevent them from effectively understanding and appreciating veterans' wartime experiences.

Returning veterans expend significant mental energy in privately making sense of, processing, and compartmentalizing their experiences, all the while trying to adapt to the day-to-day demands and stresses of life back in America, remaining on active duty or getting out of the service, and hoping to find optimism. Loss of constructive optimism is one of the most dreadful and enduring casualties of war.

The Iraq and Afghanistan wars are unique. An all-volunteer force of active duty, guardsmen, and reservists are fighting it. The in-theater medical care is excellent and in

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place at the front. The level of care from the front back to increasingly sophisticated levels of critical care and tertiary care is also superb. Modern media have truly brought battlefield awareness and information into U.S. homes; the military savvy, bravery, and dedication of each soldier, marine, sailor, and airman are almost palpable through our television screens. It began as a vaunted war against terrorism, the good guys versus the real bad guys. The level of patriotism and the level of public support were very high at the beginning of the war.

But there are disturbing and dark sides to this war that undermine chances for optimism in returning veterans. It went from a victory of overwhelming technological force and a war declared “won” to grinding guerrilla warfare with no true winner. There are more survivors of combat per se, but their injuries are much more disfiguring in larger numbers. Younger military members bear the brunt. The huge number of reservists and guardsmen fighting and dying in these wars include older (early middle-aged and beyond) men and women who were pulled from their hometown lives in the zenith of productivity, potential, and responsibility. This subgroup returns to perhaps lost jobs, physical and emotional hardship from combat, and feelings of helplessness, confusion, and depression. Patriotism and public support for the war is much more mixed and polarized now.

The difficulties in reintegration for many veterans needs to be framed in the circumstances they endure and the coping mechanisms they use while overseas. Reintegration becomes either a continuation of, or a reaction to, life in the war. Important examples and recurring themes include the following:

1. Many soldiers and marines live in their vehicles for days if not months, because they are on missions far from the security of a protected base camp. The physical protection of a vehicle far overrides the use of tents in these instances. The sense of safety is reduced to the living space in, around, and under a vehicle. Returning home to the large space of a house or even an apartment can be sensory overload. Sleeping in a bed alone or with another person is foreign and uncomfortable, as well.

A corollary to this and in some ways the other extreme is the situation faced by many soldiers and marines who daily leave the relative security of a camp and drive or patrol into areas where the potential of death or injury from snipers, roadside bombs, or attacks is present until return to the camp. Repeating this routine day-in and day-out brings an ingrained wariness and very high level of arousal that may takes weeks if not months to fade when the veteran returns home. Social isolation and/or pronounced over-reaction to the slightest of stimuli or confrontation are consequences that family, friends, and the public have difficulty in tolerating.

2. Personal space is a matter of extremes and sudden shifts. A soldier stands in line to eat for one hour as part of a waiting line of thousands of camp personnel. When he finds a seat, he is pressured to eat quickly, get up, and make room for the next person who could be hovering at his shoulder. Showers and latrines are long distances away. Sleeping and living spaces are reduced to several cubic feet. This continues for days or months, and suddenly he is deployed to combat zones in the middle of the night with starkly different safe personal space. Once back in the U.S., comfortable personal space is hard to define.

3. It is one thing to worry about open attack or concealed attack (e.g., detonated bombs rigged in vehicles, debris, or animals) from the enemy. This creates a daily and enduring wariness of being “on guard.” In addition to this, there are deployed military members who are worried about assault by service members of the same or opposite

sex while in camps. For them, trust and safety are focused or limited to a few good friends and a “battle buddy” or escort for long treks at night to shower or latrine facilities. Other service members have witnessed gruesome scenes of injury or death among civilians or enemy insurgents, as well as among their own colleagues. Some have seen completed suicides among colleagues. All of the above experiences have cumulative effects on returning veterans; it can be very difficult for them to adjust or titrate personal involvement with routine social or business contacts in daily life.

4. The large number of women in combat zones includes those who had given birth recently, those with children left behind, and those whose military husbands were also deployed to the war, leaving their children in the care of others, for six or more months. This preys upon minds of these women while deployed overseas. It also makes a hard transition back to their children’s lives in the U.S. with a mixture of excitement, guilt, sadness and loss, as well as anxiety and worry about a recall back to the war zone.

The same thoughts, the same feelings, the same worries, and the same yearnings are experienced by married and single military fathers at war overseas.

5. U.S. civilian contractors provide services that military manpower can not (because of personnel shortages) or should not (politically or pragmatically) provide in these wars. Many of these persons are continually in harm’s way like their military counterparts. Despite these and other benefits of using civilians (American and foreign nationals from many countries), a down side is the perception and allegations in the media about huge uncontrolled spending by contractors for war and rebuilding efforts. This angers deployed military members and creates a serious morale and trust problem among them when at the same time they hear of reports that inadequate planning and funding for up-arming Humvees and other vehicles, as well as for improving personal armor, have cost military lives.

6. A starkness and simplicity to daily life—“basic life truths”—overseas for months on end without reliance upon possessions and conveniences are embraced by many military members as a welcome reordering of life’s priorities. “Not sweating the small stuff” is a recurrent theme after homecoming. A veteran who daily travels in fear of roadside bombs will not mind inconvenient traffic congestion at home; the latter means she is still “alive to drive” and can do so without fear. But returning home to others’ frenzied lives and lifestyles creates significant conflict and misunderstanding.

7. Veterans who return with disfiguring and disabling physical injuries and/or disabling psychological injuries, have expectable uncertainty about who will take care of them, and who will help pay, for the short term and the long haul of treatment and rehabilitation. Their egos, their body images, their confidence, their optimism, all are shaken and undermined. Injured regular active duty members who have the ability to remain on active (limited status) duty will have a better chance of receiving comprehensive health care for a longer time under the military umbrella, with a possibility of return to full active duty status. Injured reservists and guardsmen will have a different road, as their return to the U.S. may be more of a direct journey to their established homes and possible Veterans Affairs Medical Centers, after intermediate stops in military hospitals and then discharge or demobilization. [Regular active duty war veterans also have a chance to return to their old selves if they remain in service, because their identity and uniform are always with them as a baseline. Some reservists and guardsmen are fortunate to come home to established and enduring baselines for

income, employment, family stability, health care, and productivity. For others, the pre-war sense of self and identity tragically are “things of the past.”]

Combat veterans have access to free Department of Veterans Affairs (VA) health care for any illness possibly associated with their service during a period of hostility, for two years after the date of release from active duty. The VA regional office and the VA medical facility both assign points of contact (POC) for the local returning veteran and his or her family. This role is designed to promote access and care coordination for primary and specialty care services including behavioral health. There are also benefits related to educational and vocational rehabilitation that the veteran may be able to access. VA benefits staff meet with troops post deployment. The VA and the Department of Defense (DoD) health care systems are also collaborating better than ever before, taking lessons learned from past wars and implementing them to provide optimal continuity of care. The concept of seamless transition relies upon civilian community partnerships as well as the availability of VA Veterans Centers for Readjustment Counseling Services (“Vet Centers”) as potential resources when the veteran and his or her family desire support outside the traditional VA health care model. Combat veterans and their families have free lifetime use of Vet Center services. All of this information and much more is found at the VA Homepage Website [www.va.gov](http://www.va.gov) and particularly at its website [www.seamlesstransition.va.gov](http://www.seamlesstransition.va.gov).

TRICARE is the DoD medical and dental health care program for active duty (including some reservists and National Guard called to active duty) retired members of the uniformed services, their families, and survivors. These uniformed services are the: Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the U.S. Public Health Service (USPHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA). The eligibility requirements for care differ significantly among and within these service status categories. Ideally, regular or mobilized active duty members should have a workable knowledge of TRICARE eligibilities and completed enrollment for family members in place before deploying. The returning veteran should ideally have in place the appropriate TRICARE enrollment for herself and her family at demobilization and discharge, as well. However, with all of the other processing requirements of paperwork, directives, and meetings occupying the mind and time of the deploying member or returning veteran, TRICARE considerations easily fall through the cracks but surface quickly when health care needs arise after discharge. This whole process of TRICARE knowledge acquisition, enrollment, finances, and provider choices is very daunting and can seem insurmountable to the novice, especially when the stress of transitioning into civilian life is so great to start with.

8. Returning Iraq and Afghanistan war veterans share one very unsettling and disturbing fact: the very high likelihood of returning to the war, sooner or later. This is by far one of the harshest realities of these wars. The length of this war and the availability of needed combat forces dictate that second tours are common or commonly to be expected. For the military member who wants additional combat tours, there is no problem. For those who remain on active duty for other reasons and continue their identities, pay, and benefits, then a return tour is accepted as the price. But for those many reservists and guardsmen who especially want to return to families and civilian life as fully as possible, the specter of a repeat call-up overseas is a “sword of Damocles” hanging over any assimilation efforts until these wars are truly over.

9. One returning veteran talking with another can find the right words to share experiences, because they have a shared vocabulary of war and they can drop pretensions. Military psychiatrists, psychologists, nurses, chaplains, and social workers

with war and combat experience, Vet Centers (for combat veterans and their family members) staff, and seasoned Veterans Affairs chaplains and behavioral health care providers of all types know this. Shared war and combat experiences create an enduring and therapeutic trust that can be a stronger bond among returning veterans than in some cases with families and friends. Returning reservists, guardsmen, and active duty members are at a disadvantage if they come back to communities where there is no Vet Center, VA health facility, or even a chapter or group of other (disabled) veterans from foreign wars. Extra effort in outreach planning must be made for them before discharge.

10. The returning veteran can feel like a stranger even in his community of origin or current living. A military member leaves for war with a private and ingrained image of his community: the geography, the landscape and cityscape, social and recreational connections, family and friends, organizations, climate, and how her daily life fits in. Upon returning from war, there is an expectable human nature hope that things will look and feel the same.

However, the returning veteran is often out-of-touch with recent current events; lives and landscapes change in small and large ways even over six months. Couples who were married are now divorced. Those who were living are now dead or have moved away. Family and friends aged in worrisome or disappointing ways. Thriving businesses failed. New businesses with significant economic impact opened. Local natural or accidental disasters changed the landscape or the people living there. It may be a psychological and emotional “shock” to find out these changes abruptly and all at once. Initial confusion and distancing from others in a family, a church, a job, and so forth occurs while the veteran “figures this out.” He can feel embarrassed, foolish, confused, angry, and/or sad when “naïve” questions get unexpected answers from others in the know.

We—the local veterans of other wars and former military service members, community and business leaders, government officials, civilian and DoD/VA health care planners and providers, family service centers and social services staff, public transportation and housing officials, faith-based organizational leaders, education and training center heads, media executives, and others—must “walk with” the returning veteran. [This is not “walking ahead” where we presume to know what the veteran is going through, and this is not “walking behind” where we wait for the veteran to suffer the consequences and then ask.] We can do it with: grassroots efforts; community initiatives and meetings that are solution-focused, effectively led, and endorsed by mayors and county administrators; innovation and creativity; effective networking; and true community altruism.

### **Strategies**

The Department of Defense and the Department of Veterans Affairs are traditionally considered responsible for the welfare of the returning veteran. This works fine for many veterans, but there are likewise many veterans who face daunting challenges to community reintegration. Veterans may not be able to pursue reintegration if another recall overseas is in the future.

Everyone is expectably anxious: the returning veteran (most anxious), but also families (a “close second”), and friends and the community. Among veterans, anxiety can be more crippling than any physical injury. Among family and friends, anxiety can paralyze the best-intentioned actions, words, and thoughts. Community anxiety can

deter the best of efforts to reach out. So, the veteran's situation is really a community situation.

Local governments are in a key position as convening authorities to help this reintegration process succeed. The "official" recognition of overall jurisdictional responsibility and endorsement of practical and effective solutions from a mayor, city manager, or county administrator is well supported by her powers and the community's perception of her altruism for every citizen's well-being.

An open and listening mind from the community identifies the spectrum of potential and real challenges or choices of each returning veteran. Financial security and ability to pay bills? A roof over the family's heads and food on the table? Creative and productive employment capitalizing on strengths and creativity? Job security in the case of recall overseas? Children's educational, social, and emotional needs? Health care tailored to, and providers understanding of, the veteran's needs? Counseling or therapy for mental health and substance abuse problems, war-related or otherwise? Non-military spouse recognition and support outside the home? Husband and wife returning veterans? Future call-up overseas for one or both spouses if military? Appreciation and recognition for service rendered in harm's way? Easing into the community environment and culture at one's own pace? Public transportation that accommodates the needs of disabled veterans (e.g., amputees, partial or total blindness, deafness, cognitive impairment) who have to travel to medical appointments, jobs, or meetings when private transportation is not available? Financial and labor resources for modifying homes and apartments to accommodate the special needs of disabled veterans? Privacy versus openness about military service overseas? Retaining identification as a veteran versus anonymity? Being treated as "special" versus "different" versus "equally?" Specific spiritual resources available? Do certain community attributes make its citizens especially prone to the effects of disasters (natural, industrial, accidental) or terrorism? These are not inclusive, but they are part and parcel of that spectrum and can be addressed by a local returning veteran advisory council (see below).

The reintegration of the returning veteran into the community is an issue for the public's health in its broadest concept. Successful reintegration is dependent upon optimism, which is in turn dependent upon reestablishing social and emotional connections to the community (family, friends, mentors, community attributes, etc.), which is in turn dependent upon optimal physical and psychological wellbeing despite war-related consequences. Strategic solutions for all three levels should be identified concurrently.

Local government success in finding solutions can be obtained without redirecting budgeted funds. Designation of an effective facilitator and support of appropriate networking are two basic requirements for success here.

A deputy city manager, an assistant county administrator, a vice mayor, or another high level official would be in the best position to spearhead and facilitate such an effort. Another individual consideration, with the full endorsement of the mayor, city manager, or county administrator, would be a prominent leader within the community—e.g., veteran, businessman, health care provider, religious leader, public health director—who by the nature of his job, altruism, and personality be able to cut across partisanship and politics. She should be able to contact and interact comfortably with a broad spectrum of government and private agencies, businesses, religious and social institutions, the media, health care groups, community advocacy groups, and military activities and groups. Ideally, and for obvious reasons, he should have prior military experience.

One community strategy that has proven highly successful in the author's professional experiences is for a monthly meeting (not in a public or town hall venue) framed as an advisory council for the mayor or county administrator, chaired by one or two of the above candidates and include solution-focused member representatives from this broad spectrum of agencies and groups. Local Veterans Affairs and military facility (medical and/or non-medical) staff from the different services, National Guard and reservist units, Veterans of Foreign Wars (VFW) chapter, Disabled American Veterans (DAV) chapter, and TRICARE should ideally have representation on the council who have pivotal roles. Other military-associated members could be local representatives for national associations for specific military groups (e.g., special warfare, aviators) or for general purposes (United States Automobile Association or USAA, Military Officers Association of America or MOAA). Local public and private leaders in civilian medical and behavioral health care, family services, and education should be involved. Work and solutions can be accomplished outside regular meetings in small groups and brought back to regular meetings for discussion. All efforts are documented in the minutes, which stand as a public record and go to the mayor, city manager, or county administrator. Subcommittees for special focus, e.g., behavioral health, financial assistance resources, job opportunities and job stability, can be formed with added membership from the community. Special seminars or other meetings can be created and publicized to address special issues. Other community individuals and leaders can be invited to regular meetings to address unique topics of need and interest. A name such as the Returning Veterans Advisory Council (RVAC) says it all and has a catchy and easily remembered acronym.

The success of this RVAC relies upon altruistic and face-to-face networking: members talking with each other, sharing plans and ideas, and convincing their own bosses to fully support the work of this council. Open collaboration as a prerequisite allows for well thought out and creative strategies and solutions that are tailored and eminently accomplished. The dreaded "silo effect" or "stove piping" seen in traditional boundary-laden agencies and so impairing of outside initiative and collaboration, is greatly overcome in this type of meeting venue.

To borrow the theme from an earlier emergency preparedness conference held by Johns Hopkins University, the public is an asset to the solution of community problems; it is not the problem. This approach, and grassroots initiatives ("bottom-up" as well as "top-down" organizational collaborative strategies and solutions), will be key factors in the success of programs for our returning veterans, especially in the areas of the individual currently overseas, the welfare of the family remaining behind, and civilian employment.

One extremely important community strategy that the RVAC can direct is to have local citizens including military veterans "keep minutes of the world" and pass these on to deployed military members. These take all forms: local and national newspapers and magazines; flyers and brochures; recent best-selling DVD movies; local news videotapes and audiotapes; packages of locally-produced food goods and other tourism products; best-selling books (print, tape); notices of local reunions, weddings, or deaths; and personal letters. These are all on top of "care packages" of needed daily items, which are big morale-boosters.

A corollary strategy is to center on an overall "support and safety net" initiative for the welfare and daily lives of spouses and children who remain in the community while the husband or wife is deployed. This takes special coordination with local military installations and veterans groups. Persons and professionals with expertise in early

childhood and childhood attachment and relationships with parents can be invaluable resources for helping families of deployed parents, and the deployed parents as well, get ready for homecoming and reunion. Again, the RVAC “brings everyone to the table” here.

Health care coverage by TRICARE is another targeted project. Information and on-site access to TRICARE should be put in health care sites where veterans who did not investigate and enroll in TRICARE at discharge or demobilization now come with their families for urgent evaluation and treatment. TRICARE brochures for veterans could be displayed, and brief information sheets to educate office staff could be printed. The latter should also contain brief definitions of the various components (active duty, reservists, and National Guard) for the different services. These sites include health (medical and dental) fairs, hospital clinics and emergency rooms and inpatient floors, family services centers, military and VA facilities, academic and public and private health care (medical, behavioral health, public health department) offices and clinics, and dental care providers offices. [Media publicity through newspapers, regular television, local government access cable, and radio spots is valuable.]

The biggest help that office staff or a health care provider can provide is to assist the veteran in finding out right then and there what coverage he has or could have. Three regions comprise TRICARE in the continental United States plus Alaska and Hawaii, and separate federal contractors provide full spectrum service out of three regional offices with regional toll-free numbers for all services: TRICARE North Region/HealthNet Federal Services 1-877-874-2273; TRICARE South Region/Humana Military Healthcare Services 1-800-444-5445; and TRICARE West Region/TriWest Healthcare Alliance 1-888-874-9378. The staff/provider can place the call with the veteran present and then give him the telephone to ask the representative pertinent questions for determining eligibility, enrollment, etc. and how to start this process right away. The TRICARE websites can also be accessed for valuable information, but the telephone call will be optimal when answers to questions are needed right away.

[TRICARE Web Site [www.tricare.osd.mil](http://www.tricare.osd.mil); TRICARE Online internet portal [www.tricareonline.com](http://www.tricareonline.com) ; those who live *outside the continental U.S./Alaska/Hawaii* can access information on TRICARE and phone numbers to call, for each continent, through [www.tricare.osd.mil/overseas](http://www.tricare.osd.mil/overseas) ]

There are numerous instances where a soldier deployed to OIF/OEF has a child or children whose opposite sex civilian parent (girl or boy friend, fiancé) or guardian back in the U.S. is not TRICARE eligible. Soldiers do get information about how to have the children enrolled into the Defense Enrollment Eligibility Reporting System (DEERS) and then into TRICARE, before deployment. The child will have a military ID card as a military dependent; if it is a newborn, the military parent’s orders are all that is needed to obtain care for the baby. If the soldier does not get the child enrolled into DEERS before deployment, but there is already a person designated with a power of attorney (this topic is part of the pre-deployment informational briefings), then the latter can get the child enrolled into DEERS for DoD-sponsored care.

Another challenging aspect of community initiatives is how to cast a wide net of invitation (for participation) for all returned veterans from these wars. There are veterans who wish to remain anonymous or uninvolved in any public celebrations or singling out. There are others who wear their service on their sleeves. And there are many who fall within these two relative extremes. Overall privacy must be respected, so unsolicited contact lists of identified veterans would not be appropriate. The RVAC can spearhead the setting up of this initiative. Publicity about community solutions to the above challenges and choices come in many forms: newspaper articles, radio interviews,

television spots, local government web page information, announcements mailed in utility bills, church sermons, and other ways suitable for the particular community culture. Business and industry owners, unions, and health care providers are also good eyes and ears for this initiative. Tact, empathy, sincerity, and follow through are key elements here.

A behavioral health subcommittee of the RVAC is essential. It should have at least two primary goals: 1) the creation of a network of behavioral health resources in the community that will provide a spectrum of care tailored to the needs of the returning veteran and family members; and 2) the development of a psychologically-informed reintegration program. Membership on the subcommittee should be drawn from existing behavioral health resources in the community. Consideration should be given to private, public, military (active duty/reserve/National Guard) and Veterans Affairs Medical Center and Vet Center, school and university, hospital, substance detoxification and rehabilitation, patient and family advocacy, faith-based, public health, and agency (e.g., American Red Cross, social services) settings. Membership should also include already returned and assimilated OIF/OEF male and female veterans and VFW and DAV representatives.

For the first goal, it is best to think in broad brush strokes when defining “behavioral health resources” and care. Depending upon the size of the community, examples include: psychologists, psychiatrists and other physicians with significant interests in counseling and psychology, social workers, counselors, psychiatric nurses and nurse practitioners, art therapists, massage therapists, psychiatric physician assistants, psychoanalytically-trained educators/sociologists/anthropologists, clergy and faith-based counselors, teachers with special interest in counseling and psychology, and military enlisted behavioral health and religious affairs members. Subcommittee efforts should include a campaign to educate all behavioral health resources about the diagnosis and treatment of war-related stress disorders, family separation disorders, and reintegration adjustment disorders.

A “psychologically-informed reintegration program” (the author’s concept and term) assesses how ready the local community is to devote attention and support to the returning veterans. The collective community psyche and morale is affected by many tangible and intangible components, including local heroes and deaths from past wars, past and recent disasters, economy, socioeconomic status groups, businesses and industries, occupations and job stability, culture and ancestry, ethnic and racial diversities, the environment of landscapes/natural resources/climate, politics, redevelopment and new development, community resilience, local media and communication venues, transportation industry, overall health of the public, and spiritual diversities. The objective here is to first identify which of these are “positive” and which are “negative” factors. Next, creative efforts should be made to ensure that the negative ones minimally undermine reintegration efforts and the positive ones maximally enhance any Tipping Point, grassroots, and other strategies. Behavioral health professionals who are particularly interested and adept in this applied psychology area will be of immense value to the RVAC.

More than other illnesses, behavioral health disorders are too commonly associated with stigma on the part of the public, if not family and friends. Veterans in distress may not want to go to traditional behavioral health settings for that precise reason. Are there other non-stigmatizing places that a veteran can go and get help from behavioral health resources assigned/volunteering there? A local VFW or DAV chapter is one option; a local church is another; a public health department is a third. There are many more possibilities.

Are there other ways in which a veteran might be able to ventilate or talk confidently with someone who is a good listener and who may also have the knowledge and leverage to quietly steer the veteran to seek help? Hair salon stylists would have women and men veteran clients as captive audiences. So would bartenders. Clergy might; so might video storeowners and employees. Public library staff might be in pivotal positions, with veterans coming there to use computers. Mail carriers see people every day and may be in the best position to note changes in mood or behavior, or even just sociability, in a veteran who lives on a route. Teachers would be in an excellent position to observe and privately interact with veteran parents at school conferences about their children. These are just some examples of people who could be approached, given basic knowledge and information, and supported and valued in a network in which they can contact RVAC members or behavioral health resources—whoever is spearheading this type of project—for relaying information and receiving further guidance.

Are all the parts of a network, a safety net, an outreach program, or just good demonstrated community receptivity, sensitivity, and sensibility in place now and set to continue for the first many months and years thereafter? The OIF/OEF wars have continued for several years and could continue for several more years. War-related psychological distress among veterans may not manifest openly or privately enough to cause painful impairment and the need for care for one or many years later. Updated and available strategies have to be in place as much in the future as they need to be now.

*Now is the time when the veterans' overall behavioral health needs, much thought out and conceptualized by communities beforehand, are fitted to the unique attributes and strengths of the community glove. The glove needs to be extended and ready for all situations, to fit well for each veteran. It cannot be the reverse, where the veterans have to search and find the right glove, after many hit or miss attempts—or they give up trying altogether.*

RVAC success at the community level will only be as successful as the true interest and support from a state government. First, the governor should officially identify the needs of the returning OIF and OEF veterans and their families as a new state initiative and responsibility for state agencies down to local communities. She should direct the formation of a state level working group or advisory council that has membership similar to what is described above for RVAC's. Unique attributes of state or commonwealth government would dictate which state secretary, commissioners, or others should have overall responsibility(-ies) for organizing and supporting this working group. Subdivision working groups may be advantageous, e.g., behavioral health or psychosocial, general health and medicine. Working group membership composition should mirror the RVAC in approach and spectrum. The governor's endorsement should be sent to and filter down through all state agencies, DoD and VA facilities, academic institutions, private healthcare organizations or societies, and the "mayors and chairs" of all jurisdictions. With a strong endorsement that lets everyone know the needs of the returning veteran are an important state initiative, the stage is set for optimal collaboration at state down to local levels.

State level working groups should serve as true bridges between government and military officials and the local RVAC's. State working groups, as well as the VA and DoD, need to hear about efforts and lessons learned—what works well, what doesn't work well—from local RVAC's. This connected loop of outreach, education, information, and accomplishment is really about one person: it begins with the service member who leaves home to go to war, and it ends with that member who returns home as a veteran.

The Iraq and Afghanistan wars involving U.S. military forces may continue for years. There is a sense of urgency for communities to begin their work now. Every day brings with it more returning veterans who need their support.

### **Some Recommended Resources**

There is already much civilian and military professional, memoir, fiction, research, and advisory literature on the subject of the returning veteran from a foreign war. This can be helpful. But those with a position or need to follow through in their communities with the subject and themes of this article are strongly encouraged to read literature about finding solutions in communities. The following are highly recommended from the author, but readers obviously will have their own useful and recommended resources, too.

1. Malcolm Gladwell's The Tipping Point (Little, Brown and Company, Boston, 2000) is truly outstanding reading on how small but innovative ideas can lead to extremely effective solutions for community and public problems.

2. D. Michael Abrashoff's It's Your Ship. Management Techniques from the Best Damn Ship in the Navy (Warner Books, New York, 2002) is the definitive, highly readable, and extremely practical guide on "grassroots leadership" and its application to solving organizational and community challenges with input from everyone involved "bottom-up" as well as from the traditional and hierarchical "top-down."

3. The Public as an Asset, Not a Problem. A summit on leadership during bioterrorism was a conference held by the Johns Hopkins Center for Civilian Biodefense Strategies on February 3-4, 2006. The proceedings of this conference are available now through the University of Pittsburgh's Center for Biosecurity at [www.upmc-biosecurity.org/pages/events/peoplesrole/introduction.html](http://www.upmc-biosecurity.org/pages/events/peoplesrole/introduction.html)

It is extremely valuable for the breadth and depth of the speakers and information presented, and it has great utility for any public or community problem, not just for bioterrorism.

4. Gary Trudeau's The Long Road Home. One Step at a Time. A Doonesbury Book. (Andrews McNeel Publishing, Kansas City, MO, 2005) is a special collection of cutting edge cartoons by the Doonesbury creator. These chronicle the life-transforming journey of former football star and now Guardsman-called-to-OIF-duty "B.D.," from the time an RPG blows up his Humvee (and costs his leg and his ubiquitous helmet) through front line care back to the US and through the journey of physical, psychological, and social challenges in hospitals (Walter Reed Army Medical Center) and beyond that are part of the lives of thousands of real OEF/OIF veterans.

5. "Reintegration Roadmap. Shared Sense of Purpose" and "Becoming a Couple Again. How to Create a Shared Sense of Purpose After Deployment" are two well-written facts sheets on the returning veteran from the Courage to Care health promotion campaign of our federal medical school Uniformed Services University of the Health Sciences, Bethesda, MD [www.usuhs.mil](http://www.usuhs.mil). These sheets are downloadable and very practical and useful for distribution within a community.

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