

7-1-2015

Post-Deployment Treatment for Successful Reintegration

Michelle Zielenski

Follow this and additional works at: <http://repository.law.miami.edu/umnsac>

 Part of the [Military, War and Peace Commons](#), and the [National Security Commons](#)

Recommended Citation

Michelle Zielenski, *Post-Deployment Treatment for Successful Reintegration*, 5 U. Miami Nat'l Security & Armed Conflict L. Rev. 35 (2015)

Available at: <http://repository.law.miami.edu/umnsac/vol5/iss1/5>

This Contribution is brought to you for free and open access by Institutional Repository. It has been accepted for inclusion in University of Miami National Security & Armed Conflict Law Review by an authorized administrator of Institutional Repository. For more information, please contact library@law.miami.edu.

Post-Deployment Treatment for Successful Reintegration

Michelle Zielenski, LCSW*

ABSTRACT

Individuals display a wide range of motivations in choosing to join the United States Armed Forces, such as expressions of patriotism, service to country, family traditions, educational programs and opportunities, and escape from traumatic pasts. With these vastly different components come different and unique difficulties for Operation Enduring Freedom (“OEF”)/Operation Iraqi Freedom (“OIF”)/Operation New Dawn (“OND”) veterans returning from deployment.¹ Multiple common issues prove two things: the validity and significance of their struggles, as well as the commonality between their reactions to their experiences while being deployed. Although

* Michelle Zielenski, LCSW is the Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Program Manager for the Miami VA Healthcare System. She received her MSW from the University of Maryland at Baltimore School of Social Work. Zielenski was awarded the South Florida Federal Employee of the Year, Professional, 2012 and the Miami VA Healthcare System Employee of the Year 2013. This article was written as additional support of the University Of Miami School of Law National Security and Armed Conflict Law Review’s 2014 Symposium. My contributions to this symposium were enhanced by the support and assistance of OEF OIF OND Veteran and Social Worker, Tyson Hetzel, MSW. I would like to thank specifically Michael Kranzler and Laura Scala and for all of their assistance during the symposium and throughout this publication process. It was an honor to be included in this symposium and work with professionals in the community who are just as passionate about veteran reintegration.

¹ For a brief overview of each operation see generally Into Afghanistan: Operation Enduring Freedom Marks 4 Years, U.S. DEP’T OF DEF., http://www.defense.gov/home/features/2005/Afghan_4/ (last visited Apr. 15, 2015); U.S. DEP’T OF DEF., OPERATION IRAQI FREEDOM THREE YEAR ANNIVERSARY PROGRESS FACT SHEET (Mar. 23, 2006) available at [http://www.defense.gov/home/pdf/09%20Apr%20-%20Iraqi%20Freedom%20Day%20MSG%20\(V8\).pdf](http://www.defense.gov/home/pdf/09%20Apr%20-%20Iraqi%20Freedom%20Day%20MSG%20(V8).pdf); Donna Miles, ‘New Dawn’ to Open New Potential for Iraq, AM. FORCES PRESS SERV. (Aug. 25, 2010), <http://www.defense.gov/news/newsarticle.aspx?id=60598>.

they have different experiences, they have the same difficulties when transitioning to the civilian sector. Some of these key struggles will be described below, as well as what the Veterans Healthcare Administration (VHA/VA) is doing to address these issues in order help veterans have a successful reintegration into civilian life.

Table of Contents

ABSTRACT.....	35
I. INTRODUCTION	36
II. REINTEGRATION STRUGGLES: A CASE STUDY.....	37
<i>A. LCpl Chong: From Injury to Discharge to Incarceration</i>	<i>38</i>
<i>B. Rehabilitation and Reintegration.....</i>	<i>40</i>
III. OVERVIEW OF TRAUMATIC BRAIN INJURIES.....	41
IV. THE POLYTRAUMA TREATMENT APPROACH.....	42
V. SELF-HARM AMONG VETERANS AS A COPING MECHANISM	44
VI. RESOURCES FOR AT-RISK VETERANS	45
VII. CONCLUSION.....	46

I. INTRODUCTION

Operation Enduring Freedom is the longest war in American history, and Operation Iraqi Freedom is the third longest war in American history.² From October 1, 2001 through September 30, 2014, there have been 1,866,128 OEF/OIF/OND veterans eligible for healthcare through the Veterans Healthcare Administration.³ The majority of these veterans are former active duty and the remaining 744,453 are activated in the Reserves and National Guard.⁴ Out of the 1,866,128 veterans who are eligible for VA healthcare, 1,126,173 of them have accessed healthcare at a VA medical center and 87.8% have been males and 12.2% have been

² U.S. DEP'T OF DEF., *Obama, Hagel Mark End of Operation Enduring Freedom* (Dec. 28, 2014), <http://www.defense.gov/news/newsarticle.aspx?id=123887>; Adam Taylor, *These Are America's 9 Longest Foreign Wars*, WASH. POST (May 29, 2014), <http://www.washingtonpost.com/blogs/worldviews/wp/2014/05/29/these-are-americas-9-longest-foreign-wars/>.

³ U.S. DEP'T. OF VETERANS AFFAIRS, ANALYSIS OF VA HEALTH CARE UTILIZATION AMONG OPERATION ENDURING FREEDOM (OEF), OPERATION IRAQI FREEDOM (OIF), AND OPERATION NEW DAWN (OND) VETERANS 3 (2015), *available at* <http://www.publichealth.va.gov/epidemiology/reports/oefoifond/health-care-utilization/>.

⁴ *Id.* at 4.

females.⁵ Army veterans make up the largest part of this population with 58.5%, followed by the Marine Corps and Navy with 14% each, the Air Force comprising of 13.3%, and the Coast Guard being 0.1%.⁶ Veterans who were enlisted make up 91% of the OEF/OIF/OND users of VA Healthcare.⁷

All Department of Veterans Affairs Medical Centers have an OEF/OIF/OND Care Management Program.⁸ The team usually consists of a Program Manager, a Transition Patient Advocate, a Social Work Case Manager and a Nurse Case Manager.⁹ The primary goal of the team is to assist veterans with a seamless transition from the Department of Defense to the Veterans Healthcare Administration and to assist with their reintegration into the community by providing patient-centered integrated care.¹⁰ Referrals to the OEF/OIF/OND team come from multiple sources, including Military Treatment Facilities, Vet Centers, Veteran Service Officers, outreach events, newly registered Veterans at the VA, self-referrals, and providers in the community, as well as within the VA including the Suicide Prevention Coordinators, Mental Health Providers, Healthcare for Homeless Veterans, Social Workers and Primary Care Providers.¹¹

II. REINTEGRATION STRUGGLES: A CASE STUDY

The OEF/OIF/OND Case Managers screen veterans for high risk issues and case management needs which include but are not limited to evaluating for stable housing, psychiatric needs, diagnosis and hospitalizations, traumatic brain injury diagnosis, substance abuse, emergency room visits, suicidal/homicidal ideations, plans and attempts, problems accessing VA healthcare, problems with family, spouse, or children, legal problems, poor compliance with treatment plans, and acute or chronic medical conditions requiring assistance with coordination of care.¹² The case managers provide crisis intervention,

⁵ *Id.* at 5-7.

⁶ *Id.* at 7.

⁷ *Id.*

⁸ *VA Transition and Care Management Teams*, U.S. DEP'T. OF VETERANS AFFAIRS, <http://www.oefoif.va.gov/caremanagement.asp> (last visited Apr. 15, 2015).

⁹ *Id.*

¹⁰ U.S. DEP'T. OF VETERANS AFFAIRS, *VHA Handbook 1172.01 1* (2013) available at http://www.va.gov/optometry/docs/vha_handbook_1172_01_polytrauma_system_of_care.pdf.

¹¹ *Id.* at 8.

¹² *VHA Handbook 1172.01*, *supra* note 10 at 2-3; U.S. DEP'T. OF VETERANS AFFAIRS, *VHA Handbook 1010.01 A2-A3* (2009) available at <http://www.google.com/url?sa=t&rct=j&q=&src=s&source=web&cd=1&ved=0CCUQFjAA&url=http%3A%2F%2F>

advanced case management, individual and family therapy, care coordination, and assistance accessing benefits.¹³ The team also provides support and education to veterans' families and caregivers, providers within the VA, and community partners.¹⁴ The case managers provide intensive services to all OEF/OIF/OND veterans who are seriously ill and/or injured.

Below is an example of a veteran who experienced complicated reintegration due to his injuries sustained while deployed and the psychosocial challenges he faced as a result. His experiences show how difficult reintegration can be and how quickly life can change. It also shows the importance of providing these men and women with immediate assistance and guidance upon discharge, in order to connect them to the appropriate resources for treatment.

A. *LCpl Chong: From Injury to Discharge to Incarceration*

Leonard "Jason" Chong was raised by his mother in Jamaica until he was 11 years old, when he and his sister moved to Miami to live with his father and step mother.¹⁵ Chong enjoyed high school and got good grades.¹⁶ He was the captain of the soccer team and after graduating from high school, he played soccer with a club team and then for a national team in Jamaica.¹⁷ At the age of 23, he joined the United States Marine Corps and in 2005 he went to boot camp.¹⁸ Chong describes the experience as the "best time of my life" and he wishes he could do it again.¹⁹ His military occupation specialty was Infantry and his highest rank was Lance Corporal ("LCpl").²⁰ In 2006, LCpl Chong had his first deployment to Iraq.²¹ He was deployed with his infantry unit and describes it as being a "life-changing experience."²² LCpl Chong was glad to come home but knew very quickly he would never be the same. In 2008, LCpl Chong was deployed for a second time to Iraq. During this deployment his job was to be a point man, due to his proven leadership skills and past experiences with leading his squad on several missions,

www.va.gov%2Fvhapublications%2FViewPublication.asp%3Fpub_ID%3D2093&ei=RYkuVf6wKfKxsASal4DgDA&usg=AFQjCNHd-RwY5-XLsILun0v-xUeJQ-5pBg&bvm=bv.90790515,d.b2w.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Interview with Leonard Chong (June 3, 2009).

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ Interview with Leonard Chong, *supra* note 15.

²² *Id.*

bringing everyone back safely. In June 2008, he was in a Mine Resistant Ambush Protected vehicle that was hit by an Improvised Explosive Device (“IED”).²³ LCpl Chong was knocked unconscious and woke up two days later. He was medevaced and transferred to Germany for medical treatment. Once he was medically stable, he was then transferred to Bethesda Naval Hospital and then to the James A. Haley VA Polytrauma Rehabilitation Center for intensive inpatient rehabilitation.

Once LCpl Chong completed his treatment he returned to the Marine Corps base at Camp Lejeune. He had difficulty reintegrating back into the military culture, which was once very easy for him and something he loved being a part of. LCpl Chong faced disciplinary problems and eventually he was discharged from the military and given an Other than Honorable discharge. As a result, he was not given a medical discharge or medical retirement from the Marine Corps and was denied his VA service connection disability rating. When LCpl Chong left the military in 2009, he was still having symptoms from his injuries, which included Traumatic Brain Injury (“TBI”), Post Traumatic Stress Disorder (“PTSD”), lower back pain, seizures and migraine headaches. The only income he had at this time was social security disability.

LCpl Chong came to the Miami VA Medical Center and met with the OEF/OIF/OND Care Management Team and a Polytrauma Social Worker, who helped him begin treatment for his service-related injuries. His biggest obstacle was getting his discharge upgraded so he could receive the benefits he deserved from his service in the military. The Polytrauma Social Worker was able to connect him to an attorney in a local legal aid office. The attorney thought he had a good chance of receiving a discharge upgrade because prior to his injuries, LCpl Chong had been a stellar Marine, a leader to his squad, and a Purple Heart recipient. The attorney thought the circumstances leading to the Other than Honorable discharge were directly related to his TBI and PTSD.

While beginning treatment at the Miami VA Medical Center and waiting for the results of his discharge upgrade request, LCpl Chong’s girlfriend became pregnant. He tried looking for employment, but with his Other than Honorable discharge and treatment needs for his medical conditions, he was not able to find employment. After many months of being unemployed, LCpl Chong felt like he had to take charge of his life and find a way to provide for his family. Unfortunately, the only opportunity he felt was available to him at this time was dealing drugs. Eventually he was caught and charged with conspiracy to import marijuana. He was placed on house arrest and his case was assigned to a public defender who was not familiar with his struggles and his prior

²³ *Id.*

history in the military. LCpl Chong and his public defender solicited the expertise of his Polytrauma Social Worker at the Miami VA Medical Center and the United States Marine Corps Wounded Warrior Regiment, who educated the judge, defense attorney and prosecuting attorney about the struggles he faced as a returning veteran suffering from TBI and PTSD. In the end, LCpl Chong was sentenced to one year at the NeuroRestorative Brain Injury Rehabilitation Center as well as one year and one day in prison.

B. Rehabilitation and Reintegration

The intensive rehabilitation LCpl Chong participated in at NeuroRestorative proved to be an awakening for him. He learned coping skills for his disabilities, started taking college classes and playing soccer again on a community team. He was surprised by how successful he was with these areas of community reintegration. After his year at NeuroRestorative, he served his time in prison and was released early for good behavior after eleven months.

Since his release from prison in November 2013, LCpl Chong has become a full-time student at Miami Dade College. He also participates in community-based outreach programs for veterans and participated in the FOCUS Marines Foundation program in October 2014 which helps veterans reintegrate into society and become active and productive civilians. LCpl Chong also submitted an audition video to the National Paralympics Soccer Team and was selected to attend the training camp in Atlanta, which he recently attended, and hopes to be chosen to play on the team.

LCpl Chong has received his VA service-connected disability rating and his discharge has been upgraded to Honorable. LCpl Chong's Polytrauma Social Worker also helped him apply for his United States Citizenship, which is pending due to his current probation and felony conviction. Although LCpl Chong is trying hard to move forward with his life, he is concerned his felony conviction will hold him back from having a professional career and successful life. He also feels embarrassed and ashamed when he has to disclose his felony charges, which he feels overshadows the fact he is an Honorably Discharged Marine who served in two combat deployments and is a Purple Heart Recipient.

This is just one example of many OEF/OIF/OND veterans who return from deployment with "invisible wounds" such as PTSD, TBI, and musculoskeletal injuries resulting in chronic pain, which although they are not visible, create large challenges with reintegrating into the community. Oftentimes, veterans will become homeless because they are

not able to work or have difficulty staying employed. They also begin to use drugs and alcohol as a way to escape, cope and treat their chronic pain, which can lead to long term substance abuse. Unfortunately, some veterans cannot overcome the haunting effects of war and commit suicide.

III. OVERVIEW OF TRAUMATIC BRAIN INJURIES

TBIs can be difficult to treat and diagnose because each brain injury is different as is the recovery. In combat, TBIs often happen as a result of a blast from an IED, suicide bomber, land mines, mortar rounds and rocket propelled grenades. They can also be caused by falls, motor vehicle accidents, and embedded fragments in the brain. According to the Defense and Veterans Brain Injury Center, there have been 309,386 service members diagnosed with TBI²⁴ from 2001-2014. The majority of combat related TBIs are mild, otherwise known as a concussion.

TBI can often be a result of a Polytrauma injury, which is defined as “two or more injuries, one of which may be life threatening, sustained in the same incident that affect multiple body parts or organ systems and result in physical, cognitive, psychological, or psychosocial impairments and functional disabilities.”²⁵ The VA offers a National Polytrauma System of Care that provides specialized rehabilitation programs for Polytrauma and Traumatic Brain Injuries. There are four levels of care available to veterans based on their injuries, treatment needs, and home location. The Polytrauma Rehabilitation Center provides comprehensive acute rehabilitation for veterans with complex and severe Polytrauma and TBI. The Polytrauma Network Site provides inpatient and outpatient rehabilitation care and the Polytrauma Support Clinical Teams provide and coordinate interdisciplinary rehabilitation services within the catchment area of their medical facility. This team also conducts comprehensive evaluations of patients with positive TBI screens, and develops and implements individualized rehabilitation and community reintegration plans with the veterans. The Polytrauma Point of Contact are VA sites that do not have a Polytrauma System of Care program and serve as a referral source to a facility or program capable of providing the appropriate level of care.²⁶

²⁴ DoD Worldwide Numbers for TBI, available at <http://dvbic.dcoe.mil/dod-worldwide-numbers-tbi>.

²⁵ VHA Handbook, *supra* note 10.

²⁶ *Id.*

IV. THE POLYTRAUMA TREATMENT APPROACH

The Polytrauma Team consists of an interdisciplinary approach to help ensure the proper treatments are being provided in order to assist veterans with meeting their goals. Team members can include the veteran and the family; Psychiatrist; Rehabilitation Nursing Staff; Social Worker; Clinical Neuropsychologist; Rehabilitation Psychologist; Occupational Therapist; Pharmacist; Physical Therapist; Recreational Therapist; Speech-Language Pathologist; Family Counselor; Driver Rehabilitation Specialist; Kinesiotherapist; Blind Rehabilitation Specialist; Prosthetist; Orthotist and Vocational Rehabilitation Specialist. Most veterans with TBI are treated by the Polytrauma Team. Treatment for Traumatic Brain Injury can often be frustrating for the veteran, especially when they have another diagnosis such as Post Traumatic Stress Disorder, which can cause similar symptoms such as trouble concentrating, memory problems, irritability, insomnia, and difficulty with decisions.

Posttraumatic Stress Disorder is a psychiatric disorder that can occur in people who have experienced or witnessed life-threatening trauma.²⁷ Experiencing or witnessing such events can create ongoing common reactions to PTSD such as: fear and anxiety, re-experience of the trauma, increased arousal, avoidance, numbing, grief, depression, negative self-image, and distorted views of the world.²⁸ PTSD has been around for many years but it was not officially added to the DSM III until 1980.²⁹ Prior understanding of PTSD, in the 1970's, focused on Vietnam veterans showing signs of severe anxiety disorder, which they labeled as "shell shock."³⁰ The lack of established early interventions resulted negatively for both trauma survivors and society, as a whole. An estimated 37–92% of all people will be exposed to a traumatic event

²⁷ *Let's Talk Facts About Posttraumatic Stress Disorder (PTSD)*, American Psychiatric Association, available at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.psychiatry.org%2Ffile%2F520library%2Fmental%2520illness%2Flets%2520talk%2520facts%2Fapa_ptsd_2011.pdf&ei=iI1HVdW_ItL_ggTG_YCACg&usq=AFQjCNGUGv6SFGmde8evpWMF82jz4UMe3g&sig2=YVThux17UmorsUiGCmOmrw&bvm=bv.92291466,d.eXY&cad=rjt

²⁸ *DSM-5 Criteria for PTSD*, U.S. DEP'T OF VETERANS AFFAIRS, available at http://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp.

²⁹ Michael R. Trimble, *Post-traumatic Stress Disorder: History of a Concept*. Trauma and its wake: The study and treatment of Post-Traumatic Stress Disorder (Charles R. Figley, ed.) (1985).

³⁰ Dennis McLellan, *PTSD--Shellshock--Hit Vietnam Vets Hardest*, L.A. TIMES, April 27, 1995, available at http://articles.latimes.com/1995-04-27/news/ls-59532_1_vietnam-war.

during their lifetime;³¹ surveys suggest 6.8% of adult Americans currently have PTSD.³² The prevalence is significantly higher in military personnel as 13.8% of veterans of the wars in Iraq and Afghanistan met DSM-IV criteria for PTSD.³³

As shown above, PTSD has been a problem for combat veterans throughout history, and this generation is no different. According to the Veterans Affairs Health Care Utilization Records, there are approximately 262,000 OEF/OIF/OND veterans who have been treated for PTSD from 2002 to 2014.³⁴ This staggering number only includes those who have sought treatment at the VA. When a Veteran enters the VA seeking help, an assessment is completed. For those displaying PTSD symptomology it is important to ensure PTSD is the primary presenting problem. Often times depression, anxiety, substance abuse, and other Axis I diagnoses can be associated with PTSD. Prior to beginning treatment it is imperative to verify PTSD is the primary diagnosis. Once the proper diagnosis is identified, treatment can begin. If another Axis I diagnosis is the primary, this must be addressed first, for it can create a barrier for PTSD treatment.

The VA Medical Centers have a Posttraumatic Stress Disorder Clinic Team (“PCT”) that focuses on the treatment of military related PTSD, which was a result of a traumatic event experienced while on active military duty. The team consists of psychiatrists, nurses, social workers, and other medical staff, who are all specifically trained to treat those whom are diagnosed with PTSD. Once again, the VA is taking charge by providing the best patient care possible, which aids veterans to achieve positive results while participating in their healing process. Treatments provided by PCT are primarily evidence-based. They include but are not limited to trauma-focused process groups, PTSD coping skills group, anger management groups, Cognitive Processing Therapy, Prolonged Exposure Therapy, and seeking safety groups for those with a dual diagnosis of PTSD and substance abuse.³⁵ As of 2014, over 6100 VA therapists have received training in either Cognitive Processing Therapy

³¹ Megan C. Kearns et al, *Early Interventions for PTSD: A Review*, 29 DEPRESSION AND ANXIETY 833 (Oct. 2012).

³² *Id.*

³³ *Id.*

³⁴ *Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) Veterans*, VETERANS HEALTH ADMINISTRATION, available at <http://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2013-qtr1.pdf> (2014).

³⁵ Erin R. Barnett, Nancy C. Bernardy, Aaron B. Jenkyn, Louise E. Parker, Brian C. Lund, Bruce Alexander & Matthew J. Friedman, *Prescribing Clinicians’ Perspectives on Evidence-Based Psychotherapy for Posttraumatic Stress Disorder*, Oct. 21, 2014, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4287697/>.

or Prolonged Exposure, which are cognitive-behavioral therapies, time-limited, and highly effective.³⁶

The main goals of treatment are symptom management and symptom reduction.³⁷ The primary objective of symptom management is to learn techniques and tools to better manage symptomology, eventually allowing the veteran to take control of the symptoms which have been interfering with their lives.³⁸ These newly-introduced tools encourage veterans to engage in their favorite activities again and to regain control of their lives.³⁹ The goal of symptom reduction is for veterans and service members to participate in the necessary treatment that will lead to a reduction in the frequency and intensity of PTSD symptoms.⁴⁰

V. SELF-HARM AMONG VETERANS AS A COPING MECHANISM

Many returning veterans use alcohol and drugs to try to escape the memories they have of combat. Oftentimes veterans will “self-medicate” with drugs and alcohol to help them relax, fall asleep, feel better, reduce muscular skeletal chronic pain and many other reasons.⁴¹ Alcohol use has been historically acceptable among service members and veterans and embraced as part of the military culture.⁴² According to the VA Health Care Utilization report, there are 132,088 OEF/OIF/OND veterans who have been identified as having alcohol dependence syndrome and nondependent abuse of drugs from October 2002 to September 2014.⁴³ This number is based on patient report to their

³⁶ *Id.*

³⁷ National Council on Disability, *Invisible Wounds: Serving Service Members and Veterans with PTSD and TBI*, March 4, 2009, available at <http://www.ncd.gov/publications/2009/March042009/section4> at 25.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ Edna B. Foa et al, *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*, 2nd Edition (2008).

⁴¹ See Josef I. Ruzek, PhD, et al, *Treatment of the Returning Iraq War Veteran*, Jan. 3, 2014, available at <http://www.ptsd.va.gov/professional/treatment/vets/treatment-iraq-vets.asp>.

⁴² See Norman M. Camp, *US Army Psychiatry in the Vietnam War: New Challenges in Extended Counterinsurgency Warfare* at 323, available at <http://www.cs.amedd.army.mil/FileDownloadpublic.aspx?docid=41977b31-eb55-4aa1-b9d3-5ad1557cf0dd> (2014).

⁴³ Post-Deployment Health Group Office of Public Health Veterans Health Administration Department of Veterans Affairs, *Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans*, June 2014, available at <http://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2014-qr2.pdf>.

providers. The VA providers screen all OEF/OIF/OND veterans for alcohol and drug use as part of their initial primary care visit.⁴⁴ The VA offers intensive outpatient treatment, residential care, medically managed detoxification, continuing care and relapse prevention, self-help groups, marriage and family therapy, drug substitution and newer therapies to reduce cravings.⁴⁵ VA providers have seen the detrimental destruction substance abuse can have on a veteran's life, and as a result are committed to helping veterans receive the appropriate treatment for recovery.

Sadly, suicide is ranked as the 10th leading cause of death within America.⁴⁶ According to the Veteran's Affairs central office, in 2010, there were approximately 38,000 suicides nationwide; according to the VA 21% of those suicides were veterans.⁴⁷ Notably, of the 18 daily veteran suicides, only 5 of those veterans were receiving care in the Veteran's Health Administration.⁴⁸ In the fiscal year 2009, reports show there were 738 veteran suicides; 98 of those were veterans from the OEF/OIF era.⁴⁹

VI. RESOURCES FOR AT-RISK VETERANS

The VA has put numerous programs into place to assist with the prevention of suicide. Each VA Medical Center has at least one Suicide Prevention Coordinator (SPC), who follows veterans who have been deemed high risk for suicide.⁵⁰ The coordinators maintain regular contact with these individuals to ensure they are receiving the services and counseling they need.⁵¹ The SPC also has the responsibility of educating employees within the VHA on how to recognize the warning signs of

⁴⁴ *VA Services: Substance Abuse Programs*, <http://www.oefoif.va.gov/substanceabuseprograms.asp>.

⁴⁵ *Id.*

⁴⁶ *National Suicide Statistics at a Glance*, http://www.cdc.gov/violenceprevention/suicide/statistics/leading_causes.html (last visited April 13, 2015).

⁴⁷ Robert M. Bassarte, Foreword to *Veteran Suicide: A Public Health Imperative* at vii (1st ed. 2013).

⁴⁸ Department of Veterans Affairs, *VA Suicide Prevention Program: Fact Sheet* at 3 (April 2010), available at http://www.ivbhn.org/site/files/8812/9623/1434/April_2010_Fact_Sheet-Suicide_Prevention_FINAL.pdf.

⁴⁹ *Id.*

⁵⁰ Department of Veterans Affairs Office of Inspector General, *Suicide Risk and Alleged Medical Management Issues* at 3 (March 30, 2015), <http://www.va.gov/oig/pubs/VAOIG-14-02139-156.pdf>.

⁵¹ *Id.*

suicide.⁵² As a result of this education, employees have developed a level of ease and confidence when assessing a person who is at a high risk for suicide, saving many Veterans' lives.⁵³

Another popular resource for veterans is the Veterans Crisis Line, which accepts calls, texts, and online chats from veterans who are feeling suicidal, depressed, lost, or having an emotional crisis.⁵⁴ Since the Veterans Crisis Line began in 2007, they have answered over 1,625,000 calls.⁵⁵ Veterans are able to speak directly with trained responders who are available 24 hours a day, 7 days a week.⁵⁶ In the event of an emergency, responders can alert emergency services to the veteran's location if needed; responders also simultaneously alert the Suicide Prevention Coordinator at the VA closest to the veteran.⁵⁷ The SPC will contact the veteran in order to connect him or her with needed resources and treatment.⁵⁸

VII. CONCLUSION

Discharging from the military can be an emotional and complicated time for many veterans, which can result in a poor transition and reintegration into civilian life. The VA offers an array of services specialized to meet each individual's needs whether it be TBI, PTSD, drugs and alcohol, depression, suicide, marital and familial problems, or financial issues, in helping veterans acclimate to daily life. The primary objective is to help support and guide veterans into a life that is meaningful and successful. Each veteran comes with a different story and diagnosis, therefore, it is vital for the VA to meet veterans where they are and provide them with the best patient-centered treatment possible.

⁵² The Wiche Center for Rural Mental Health Research, *Suicide Prevention Primer* at 4, <http://www.sprc.org/sites/sprc.org/files/primer.pdf> (last visited April 13, 2014).

⁵³ *Id.*

⁵⁴ U.S. Department of Veterans Affairs, *Veterans Crisis Hotline*, http://www.mentalhealth.va.gov/suicide_prevention/ (last visited April 13, 2015).

⁵⁵ *Id.*

⁵⁶ *Id.* In addition to providing a telephone hotline, the VA also provides veterans with a confidential online chat option as well as text messaging with VA responders.

⁵⁷ *Id.*

⁵⁸ *Id.*