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Well After Service *Veteran Reintegration and American Communities*

By Nancy Berglass and Margaret C. Harrell



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About the Report

“Well After Service” is a product of the Joining Forces project of the Military, Veterans and Society Program at the Center for a New American Security (CNAS). The Joining Forces project includes a range of research, analysis and convening activities that explore the impact of military service on service members, veterans and their families; their deployment-related needs; and the ways in which the country can best support them. This work complements and may inform, but is conducted independently from, the White House initiative of the same name.

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Cover Image

Spectators cheer and wave as they watch a parade to honor Iraq War veterans on Saturday, January 28, 2012, in St. Louis. Thousands turned out to watch the first big welcome home parade in the U.S. since the last troops left Iraq in December.

(JEFF ROBERSON/The Associated Press)

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A P R I L 2 0 1 2

Well After Service

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WELL AFTER SERVICE: VETERAN REINTEGRATION AND AMERICAN COMMUNITIES

By Nancy Berglass and Margaret C. Harrell

A P R I L 2 0 1 2

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I. EXECUTIVE SUMMARY

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America's veterans are not receiving the care and services they need to transition successfully from military to civilian life. Although many excel out of uniform, some veterans continue to face significant service-related challenges. Many of their concerns are familiar to veterans of past wars, but some attributes of post-9/11 military service are distinctive. Indeed, the past decade has witnessed exceptional rates of multiple and repeated deployments of active-component service members, historic deployment levels of Reserve and Guard personnel, excessive exposure to bomb blasts and unprecedented survival rates from grievous wounds.

All of these factors carry consequences for the mental and physical health of service members and veterans as well as their families and communities. Yet neither the Department of Defense (DOD) nor the Department of Veterans Affairs (VA) ensures that these service-related issues are addressed in any systemic way once service members leave active duty. No government entity adequately stewards the transition from military service, none is concerned with the long-term prospect of veteran reintegration with civilian society and none provides consistent guidance to the thousands of nongovernmental entities that inevitably shoulder the attendant public health and social welfare burdens.

Gaps in both leadership and services negatively affect many of those who have served the country and thus also affect the communities to which they return. The current governmental framework for veteran care does not and cannot accommodate the service-related needs of today's all-volunteer force. Federal agencies have insufficient reach into the communities from which veterans come and to which they return. In order to finally address the veteran reintegration challenge, federal agencies must restructure, refocus and recalibrate their programs, engaging public and private partners to deliver at the local level what large bureaucracies in Washington cannot

and embrace a comprehensive understanding of veteran wellness as their guiding goal.

This report offers a new understanding of veteran wellness that is informed by both military and civilian circumstances and experiences but is oriented toward the civilian goal of successfully reintegrating veterans back into communities, rather than the military goal of mission readiness. Our definition of veteran wellness places equal emphasis on the interrelated and multidimensional domains of psychological and physical well-being and on aspects of life that extend beyond fitness for duty, such as personal relationships, satisfaction of material needs and a sense of daily purpose. Unlike prominent civilian interpretations that emphasize the absence of illness or infirmity as a prerequisite for being well, we propose that the new paradigm for veteran wellness must emphasize the possibility of wellness despite physical and mental injuries caused by war.

This new understanding of veteran wellness should unify and guide the efforts of government agencies and policymakers, as well as the increasing number of community-based programs that serve veterans where they live. Toward that end, this report also analyzes the best practices for community-based veteran reintegration efforts which, in many cases, are delivering services swiftly and effectively.

The definition of veteran wellness and the guidance for community-based models for veteran reintegration that are presented here provide a framework for all stakeholders – government agencies, policymakers and community leaders – as they work together to address the service-related needs of veterans and reintegrate them within civilian society. To this end, this report makes four recommendations:

1. The president should charge the secretaries of defense and veterans affairs with swiftly developing an actionable interagency plan that directs

Who is a Veteran?

The U.S. Code (38 USC § 101) defines a veteran as “a person who served in the active military, naval, or air service, and who was discharged or released there from under conditions other than dishonorable.” For the purposes of this report, a veteran is defined as anyone who has served on active duty, in any job capacity, while a member of the Army, Navy, Air Force, Marines or Coast Guard active components or of the National Guard or Reserves, regardless of discharge status. The authors recognize that the changing nature of U.S. military operations indicates an increasing reliance on private contractors but do not include them as veterans for the purposes of this report.

and ensures accountability for the transition between service members’ separation from the military and their return to civilian society and that supports and provides guidance for the longer-term process of successful reintegration.

2. The secretaries of defense and veterans affairs should commit to a comprehensive reintegration strategy based on an understanding of wellness that is unique to veterans.
3. Civic, community and nonprofit leaders (including conveners of community-based reintegration efforts) should access or develop data on the veterans and military families in their catchment areas, develop the attendant needs analyses, inventory community resources available to address these needs and convene stakeholders in the design and implementation of a community reintegration model.
4. Grantmakers should help community leaders to address the needs of veterans effectively by properly vetting, and then supporting, organizations that serve veterans at the local level.

II. INTRODUCTION

Millions of American veterans have reintegrated with civilian society successfully after military service. Indeed, those who have served our nation in uniform are represented in every sector of American life, many in positions of leadership. Some veterans, however, particularly those of the wars in Iraq and Afghanistan, are not receiving the care and assistance required to address their service-related needs.¹ The distinct attributes of post-9/11 warfare have left many to contend with significant new challenges. Traumatic brain injury, post-traumatic stress, pain management and extensive dependence on prescription medications are some of the major health-related matters facing this generation of veterans, yet only half of these veterans seek and receive the health care benefits for which they are eligible.² Moreover, few transition from service having received support and training adequate to address the employment, education, housing and community-life hurdles that mark the return to the civilian landscape.

Inevitably – but too often at a point at which the veteran has fallen through society’s cracks – the burden of care is placed on under-resourced community-based providers that are neither familiar with service-related needs nor knowledgeable about how to address them effectively. A new and creative approach to solving the veteran reintegration challenge is required to both embrace the potential of today’s veterans and meet their needs. Critical components of such an approach include an informed understanding of what it means for veterans to be well, a broad strategy to locate and serve veterans effectively and the inclusion of a broad range of stakeholders. Addressing these concerns must be a matter of national priority in which federal agencies refocus, realign and recalibrate their programs, using veteran wellness as the guiding normative goal.

Three key factors limit the ability of both federal agencies and community organizations to serve these veterans effectively. First, the culture gap between civilian and military societies challenges the nation’s capacity to care properly for veterans.³ Fewer than 1 percent of Americans serve in today’s armed forces, so the military frame of reference, while fundamental to the identity of many veterans, is largely foreign to most civilians. Few Americans understand the transformative nature of military service and the many ways this transformation affects veteran wellness.

Second, veteran care faces a leadership gap. Despite their responsibilities to the military community, neither DOD nor VA takes responsibility for, oversees or offers substantial guidance to help a range of other stakeholders address the service-related needs of veterans. Such guidance would help reduce the inefficiencies that cost billions of dollars each year and would particularly help the thousands of community-based nonprofit organizations nationwide that provide a range of critical services to veterans every day.⁴ The 17th Chairman of the Joint Chiefs of Staff, ADM Michael Mullen, recognized this need when he tasked his Warrior and Family Support team to reach out to America’s communities and help turn goodwill toward service members into actionable support for veterans.⁵ Ultimately, however, veterans are not within the chairman’s official purview, and ADM Mullen’s successors are not required to cultivate the seeds he planted.⁶ Without a sustainable way to transform ADM Mullen’s vision into a mandate – within an agency officially tasked with the important job of veteran reintegration – the leadership gap will persist.

Third, there is a gap in services. DOD largely meets service members’ needs, but once they separate from the military, there is no official mechanism to transition them to the care of another organization, such as VA or an appropriate community-based organization.⁷ Although

VA is mandated by law to provide for all veterans, in practice, it only serves those who enroll proactively.⁸ Although VA's current leadership is improving or transforming some program strategies and delivery models, most VA services at this time address specific problems as they arise and do not focus on reintegration or overall wellness.⁹ VA acknowledges that it must do better to identify and serve those who do not connect with the agency on their own. Meanwhile, however, thousands continue to fall through the cracks, and the burden of meeting their service-related needs falls to local care providers, first responders, law enforcement and other local agencies.¹⁰

In 2011, President Barack Obama recognized this gap in his "Strengthening Our Military Families" and "DoD-VA Veterans Employment Task Force" initiatives, which called on agency heads to modernize their approaches and work together more closely and strategically during the military-to-civilian transition.¹¹ Both initiatives, however, focus on specific aspects of reintegration – such as the issues facing active-duty military families and those affecting transitioning veterans looking for employment – rather than examining the challenges of reintegration as a whole. Neither initiative mandates a systemic fix for the fundamental gap in services between the relatively short-term process of transition and the longer-term prospect of reintegration.

Although VA's budget has increased dramatically in recent years, resources are not the only answer to this problem.¹² Despite its abundant funds, VA has failed to reach, assess the needs of and serve nearly half of those known to have served in and separated from the military post-9/11.¹³ Moreover, a backlog of over 900,000 unadjudicated claims further compromises VA's overall ability to provide swift attention to those who are enrolled.¹⁴ Meanwhile, thousands of community nonprofits across the nation struggle to meet the myriad needs that veterans bring home,

with neither funding support nor strategic guidance from the very agency charged with veteran care. The Fiscal Year (FY) 2013 VA budget offers a number of promising recommendations for appropriations that are meant to "maximize efficiency and effectiveness," but most of the recommendations focus primarily on medical care and benefits payout rather than on the systemic change needed to move veterans through entitlement and medical care and toward wellness.¹⁵ On the contrary, the VA system is perceived by many veterans and advocates alike to penalize veterans as their health improves.

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The current VA strategy to meet veterans' needs and foster their successful reintegration into civilian society lacks focus and direction. It sets forth numerous goals, objectives and metrics but fails to articulate a coherent, focused and prioritized vision for the agency and, more broadly, for how the nation will care for its veterans. This report argues that the strategic focus should be wellness – and that this principle should guide all DOD and VA efforts to care for service members, veterans and their families. Adopting the principle of wellness – and institutionalizing it in the strategies of DOD and VA – will allow these agencies to work more effectively, efficiently and holistically to solve the challenges faced by many veterans.

Currently, federal agencies do not share a common understanding of veteran wellness. The Departments of Defense, Veterans Affairs, Homeland Security, and Labor, for example, all

serve the needs of military members or veterans, but each one focuses on its own agency mission. They rarely coordinate with, or leverage the resources of, other agencies or service providers whose collaboration – if informed by a strategic understanding of veteran wellness – could provide a far more effective continuum of care. Meanwhile, civilian stakeholders, from local governments to community institutions, increasingly understand veterans’ needs to be a civic concern, yet they lack a clear understanding of the military culture and veterans’ experiences. Stakeholders are largely focused on stove-piped approaches to transition, serving one need at a time. None of these groups are united by an understanding of comprehensive reintegration as a broad strategic goal.

This report argues for a new and creative approach to the reintegration and ultimate wellness of veterans. Our framework diverts substantially from current approaches for veteran care, including those that inform the White House’s Joining Forces initiative, which focuses specifically on veteran health, education and employment as single issues. Rather than viewing each of these issues separately, we argue that the overall wellness of veterans should be the foundation of any strategy to serve them. For example, we consider jobs and education as components of the broader category of “purpose,” one of several dimensions of wellness. Transitioning veterans to a job or an educational program is important and meaningful, but success in these areas alone signals neither successful reintegration nor, more broadly, an individual’s overall wellness. In order to bring veterans “all the way home” after service, we must see them through transition and toward full reintegration with family and community.¹⁶ Any strategy to do so must take into account the transformative impact of military service, leverage resources swiftly and effectively and address

What is a Community Organization?

Community (or community-based) organizations are nonprofit entities that exist to serve the specific needs of a given community – whether defined by geography, field of interest, affiliation or affinity – and whose leadership, mission and programs authentically reflect that community.¹⁷ Some community organizations officially incorporate as nonprofits with the Internal Revenue Service, whereas others are less formal, less sophisticated or otherwise formed ad hoc by people working together voluntarily to effect change or create new opportunities regarding a specific issue or population. Community organizations are generally understood to be a subset of the larger field of nonprofits, including but not limited to institutional entities (like some hospitals and universities), chapters or affiliates of national organizations, faith-based organizations (such as churches and synagogues), and fraternal and civic organizations.

In this report, we refer to community “organizations” and community “models.” Organizations are singular entities, usually self-governed by an appointed board of directors, operated by a paid or volunteer staff that is accountable to that board and driven by adherence to a clear and concise mission statement. Examples vary widely, from youth sports clubs to local chapters of prominent national organizations. There are over 40,000 nonprofit organizations in the United States known to provide assistance to service members, veterans and military families.¹⁸

Community models for veteran reintegration, by contrast, are coalitions or groups of organizations including nonprofit, civic, philanthropic and business entities, that come together strategically and in partnership to combine and leverage resources toward a common community goal. Some community veteran reintegration models, including a few represented in the working group assembled to inform this report, have incorporated to become stand-alone organizations;¹⁹ others are run cooperatively – most often on a volunteer basis – by leaders from the various organizations that are members of the larger group.

the challenges faced by veterans before they become larger and longer-term burdens.

This report aims to frame how the nation should:

- **Understand veteran wellness**, by offering a definition of wellness and a model on which stakeholders from government and community-based efforts can base or guide their efforts; and
- **Achieve veteran wellness**, using resources based in the communities where veterans reside, by:
 - » Encouraging support for community-based organizations,
 - » Assessing attributes of successful community-based models for the reintegration of veterans,
 - » Identifying best practices for community-based models for veteran reintegration, and
 - » Offering recommendations for a broad range of stakeholders to optimize the efficacy of their contributions to the wellness of our nation's veterans and military families.

III. UNDERSTANDING VETERAN WELLNESS

What is Wellness?

“Wellness” is a term often used but little understood among those who promote or seek to understand the health or quality of life of individuals, families, communities or entire societies. There are institutes dedicated to the study of wellness, philanthropic foundations committed to making grants that promote wellness and an enormous range of programs in both the public and private sectors aimed at helping people achieve it. Along with employment and education, First Lady Michelle Obama and Dr. Jill Biden chose wellness as one of three priority focus areas for their Joining Forces initiative, the first White House-based effort to mobilize Americans in support of the military since the advent of the all-volunteer force.²⁰ The Department of Health and Human Services’ *National Prevention Strategy*, which provides guidance to the historic Affordable Care Act, aims to move the United States from “a system of sick care to one based on wellness and prevention.”²¹ However, few of these efforts define the term, and none share a common understanding.

VA, whose very mission begins with the charge “to care for him who shall have borne the battle,” neither defines nor measures veteran wellness (or any other term that definitively frames the objective for the care they provide).²² VA’s strategic plan for FY 2011-2015 cites a major initiative to “perform research and development to enhance the long-term health and well-being of Veterans” but does not articulate the meaning of being well or clearly differentiate between well-being and health.²³ These are semantic distinctions, but they have important implications. Different words and concepts, which are only sometimes explained, come from different agencies of the same government.²⁴ The 2011 CNAS Joining Forces Veteran Wellness Working Group, convened by the Center for a New

American Security, revealed this inconsistency to be confusing, unproductive and sometimes divisive among those who work in support of veterans.²⁵ The varied efforts currently underway at VA and other stakeholder agencies to improve service to veterans could become transformative if guided and united by a common understanding of the goals of those programs and services.

A shared understanding of veteran wellness – of a “new normal” in which some veterans will experience wellness differently than they did before military service – is a vital first step to all efforts to support veterans and their families. A common definition of wellness will be fundamental for creating the strategic guidance needed to direct the federal agencies and civilian organizations – both individually and in partnership with each other – that are charged with supporting veterans effectively. Such definitional certitude has long been a strength of the military’s capability to keep service members “fit” and “ready,” terms whose meanings in a military context (where the focus is on standards for duty performance, such as the ability to deploy or function in a combat or operational environment) are arguably interchangeable with the concept of wellness in a civilian context (where wellness is often understood to apply more broadly). Understanding wellness provides the basis for measures of success; only a common definition of wellness permits an understanding of when veterans are well, which is fundamental to the identification of successful support interventions.

Many veterans return from war with infirmities – wounds both visible and not – that portend a lifetime of consequences. However, those veterans who learn to accommodate these infirmities, or to excel despite them, may not agree that they lack health or wellness. As Eugene Roberts, the double-amputee veteran who ran 3,100 miles across the United States asserted, “I’ve done everything I wanted to do, I’m blessed.”²⁶ In this report, we

recommend a definition of veteran wellness in which personal and social relationships, overall health, satisfaction of material needs and one’s very sense of purpose may be different than they were before serving. Despite injuries, infirmities or other new challenges, individuals such as Roberts can indeed be quite well.

The factors influencing veterans’ lives differ significantly from those affecting people still in uniform. Moreover, veteran wellness is informed by circumstances that are different from those of the general public. A definition of veteran wellness must reflect these differences.

Traditional Definitions of Wellness

There is abundant literature pertaining to wellness, which becomes even more expansive if one considers the extent to which the term is used interchangeably with, or as an alternative to, “health,” “well-being,” “fitness” and sometimes even “resiliency.”²⁷ There are clear differences, however, in the use and definition of these terms as they concern civilians on the one hand and military service members on the other. None of the traditional definitions reflect the wellness of veterans.

CIVILIAN NOTIONS OF WELLNESS

There are numerous civilian works dedicated to defining and understanding wellness. The most commonly cited and accepted civilian definition comes from the World Health Organization (WHO), which states: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”²⁸ This definition does not accommodate the service-related circumstances of many veterans. Military service necessarily exposes individuals to events that may not only cause infirmities but also, in some cases, portend “a lifetime of consequences.”²⁹ To infer that a veteran who lives with burns, limb loss or other such service-related infirmities will not, by virtue of these circumstances, ever

How Veterans Perceive Their Own Wellness

In November 2011, the Pew Research Center released the results of an extensive survey of veteran and service member attitudes about their military and post-military experiences. There were several notable findings:

- Among post-9/11 veterans, 44 percent reported that their readjustment to civilian life was difficult, in contrast to just 25 percent of veterans who served in earlier eras.
- About half of all post-9/11 veterans said they have experienced strains in family relations since leaving the military.
- Frequent outbursts of anger were reported by 47 percent of post-9/11 veterans surveyed.³⁰

Commendably, a growing body of data and analyses from other credible organizations is contributing to this critical field of research. For example, for many years, the Gallup organization has conducted a comprehensive survey of Americans' understanding of their own individual well-being. Recently, in partnership with Healthways, Gallup has begun to build on this effort by developing a survey meant to collect what may become the first known data on the well-being of U.S. veterans and military personnel.³¹ Drawn from the robust Gallup-Healthways Well-Being Index, this tool will assess veteran well-being across five elements that make up Gallup's understanding of the term: career, social, financial, physical and community well-being.³² The results of that work are eagerly awaited by researchers and veterans' advocates alike.

These research efforts come from organizations known for empirical integrity; the resulting data and analyses may help develop a definition of wellness that reflects the unique circumstances that influence veterans' lives in a civilian milieu. Neither study, however, explores whether or how well-being may be different for veterans than for non-veteran civilians.

be well or healthy, is counter-productive to any care or reintegration strategy and, arguably, is disrespectful.

MILITARY NOTIONS OF WELLNESS

The military emphasizes the notion of wellness, albeit by other terms, for all its personnel. In the past decade particularly, the U.S. military has refined the concept of military wellness as internal assessments revealed the need to shift from reactive measures to preventive and holistic approaches.³³ Not surprisingly, however, the services frame wellness in the context of the military mission. Military wellness focuses on psychological and physical "readiness" and emphasizes "resiliency," both of which differ significantly from the WHO definition of the civilian experience.³⁴ Moreover, neither the satisfaction of material needs nor the notion of purpose (beyond one's commitment to the mission) is considered in DOD's well-being frameworks, which makes the military definition of wellness unsuitable as guidance for veteran reintegration.

In 2010, the chairman of the joint chiefs of staff published the *Chairman's Total Force Fitness (TFF) Framework*. Derived from the fitness frameworks of the individual military departments, TFF is intended to support and augment those efforts by framing well-being as inclusive of the physical, environmental, medical and dental, nutritional, spiritual, psychological, behavioral and social fitness domains.³⁵ TFF indicates a decisive shift in norms away from the reactive manner in which military health was previously addressed and toward the current model that focuses on physical, as well as mental and emotional, needs and considers the wellness of a service member in relation to his or her family, organization and environment.³⁶ This shift is more reflective of the circumstances facing service members transitioning to veteran status, but like the WHO definition, it omits certain factors that influence the wellness of veterans.

VETERAN WELLNESS DEFINITION INFLUENCES

| ASPECT OF MILITARY SERVICE THAT INFLUENCES VETERAN WELLNESS | HOW IT SHOULD BE REFLECTED IN A DEFINITION OF VETERAN WELLNESS |
|---|--|
| Injury or illness | Adjustments are needed for what may be long-term consequences of injuries and pain; the presence of infirmity does not always indicate an absence of wellness. |
| Military experiences, from the rewarding (unit cohesion, mission accomplishment) to the traumatic (severe injury, loss of a buddy), may change one's values regarding social and personal relationships | Relationships and networks – particularly with other veterans – may be equally important to, or even supersede, the role of family, non-veteran friends and spirituality in a veteran's life, especially during times when a veteran experiences emotional difficulty related to service. This indicates neither a lack of well-being nor a demotion of family, friends or faith-based relationships but, rather, elevates the importance and value of social networks among veterans. |
| Shelter, housing, paychecks and other aspects of material existence are often facilitated or provided by the military and sometimes do not require significant personal diligence | The fulfillment of material needs can be a barrier to wellness for some veterans, especially for those who did not experience adulthood in civilian society before joining the military. The ability to find resources for housing, employment, financial management, legal services and even daily material goods is a major component of both psychological and physical well-being for many veterans. |
| Events both traumatic and rewarding fundamentally change a person | Adapting to civilian society anew as a changed person is a process. Its duration neither precludes nor portends wellness. Rather, the extent to which one is able to function sufficiently throughout that process, while adapting and becoming increasingly well, is part of a veteran's "new normal." |

Defining Veteran Wellness

In October 2011, we convened a working group of over 30 esteemed leaders representing the military, academic, and policy and veterans' services sectors to help identify those aspects of veteran wellness that are not accounted for in the generally accepted civilian or military definitions. Semantics posed a particular challenge for working-group participants, who, representing different organizations and professional fields, often disagreed about the

meanings of "wellness," "well-being," "fitness" and "resiliency."³⁷

Nevertheless, the working group identified four critical aspects of the military experience that distinguish veteran wellness from the wellness of other populations.³⁸ These include injury or illness, the effect of military experiences on social and personal relationships, material needs that had previously been satisfied by the military and significant events experienced while in the military.

The outcomes of the working group, in concert with extensive review and analysis of wellness literature, suggest the need not only for a new definition of wellness specific to veterans but also for understanding well-being as something different from (yet influencing) wellness. Wellness is an optimal state toward which one strives, and physical and psychological well-being are each minimal baseline elements of that wellness. We offer these definitions of well-being and wellness for veterans:

Physical Well-Being and Psychological Well-Being are the satisfactory and sufficient conditions permitting individuals to function as necessary. Physical and psychological well-being are each informed by four dimensions: social/personal relationships, health, fulfillment of material needs and purpose. These dimensions are interrelated and mutually supporting. When an individual achieves both physical and psychological well-being, that individual experiences basic wellness.

Veteran Wellness is the dynamic and multi-dimensional quality of one's existence overall, as informed by both civilian and military experiences and circumstances. It reflects both physical and psychological well-being and is thus based on the four interrelated dimensions listed above. One strives toward increased wellness.

THE WELLNESS MODEL: UNDERSTANDING THE NEW DEFINITION FOR VETERAN WELLNESS

Our model for veteran wellness asserts psychological and physical well-being as two core, interrelated domains, each of which is a prerequisite for wellness. Psychological well-being and physical well-being represent the satisfactory and sufficient conditions within the four key dimensions of one's existence.

Social and Personal Relationships reflect the extent to which a veteran interacts with and feels nurtured, supported or otherwise upheld by others, including family, social networks (friends, social

Physical Well-Being and Psychological Well-Being are the satisfactory and sufficient conditions permitting individuals to function as necessary.

groups and other veterans, for example) and, where relevant, faith, spirituality or religion. In addition to providing emotional support, these relationships also facilitate physical well-being because wounded and injured veterans in particular may depend on social networks for access to health care, material goods and other services.

Mental and Physical Health are sufficient to function on a daily basis in accordance, at a minimum, with general public standards. In our model, access to quality health care is an attribute of both psychological and physical well-being for veterans. Although most veterans are eligible for some VA health care, the statutory and regulatory framework for VA care generally limits such care to service-related issues. Even so, only half of recent veterans seek or receive the VA health care benefits for which they are eligible. This increases demand for veteran health care from community-based providers, even though many practitioners outside the VA system do not have the training or resources needed to address service-related needs adequately.³⁹ Moreover, if a veteran is not ambulatory or resides in a place where neither VA nor community-based care providers are accessible, his or her physical and psychological well-being may be significantly compromised.

Satisfaction of Material Needs is especially important for veterans, as compared with active-component military personnel, because their

Veteran Wellness is the dynamic and multi-dimensional quality of one's existence overall, as informed by both civilian and military experiences and circumstances.

personal responsibility for fulfilling those needs increases substantially when they leave the military. The material needs component of our model reflects the requirement for financial and legal stability, safe and appropriate shelter, and access to the goods and services necessary for a complete and rewarding life. This dimension is generally not addressed in military models.

Purpose reflects the need for individuals to fill their time with activities that they enjoy, that they find stimulating or rewarding and that facilitate their well-being. For many, but not all individuals, these activities will also provide income. One's purpose may be associated with a job or a career outside the home, or it may be found in other activities, including parenting and volunteerism. For many individuals, education increases the options to participate in activities that provide purpose.

Veteran wellness is achieved by satisfying both basic psychological and physical needs in light of the effects (both positive and negative) of military service and thereby optimizing the life experience in a civilian context. Thus, when an injured veteran embarks on a path to becoming well, he or she reaches physical well-being and psychological well-being when able to function on a daily basis as necessary, given his or her service-related circumstances. One may be an amputee, for example, and still achieve physical well-being. In this way,

sufficiency is an important aspect of well-being. As a veteran grows increasingly comfortable with life after military service and achieves better social and personal relationships, health, satisfaction of material needs and purpose in life, he or she may become increasingly well.

This framework diverges from current trends, including those that inform the White House's Joining Forces initiative, which position a triad of health, education and employment as the key elements of veteran reintegration. Instead, our model groups employment and education as variable attributes of the larger notion of "purpose," to accommodate the many veterans who are either unable or temporarily unready to succeed in one or both milieus but who may nevertheless find purpose and achieve well-being in other ways. Likewise, it acknowledges the fulfillment of material needs as a core component of both psychological and physical well-being.

The overall context of the wellness model is the geographic community: the place to which a veteran returns and in which he or she settles and seeks fulfillment of the wellness dimensions. This construct emphasizes the importance of the leaders and service providers who oversee the successful reintegration of veterans at the local level.⁴⁰

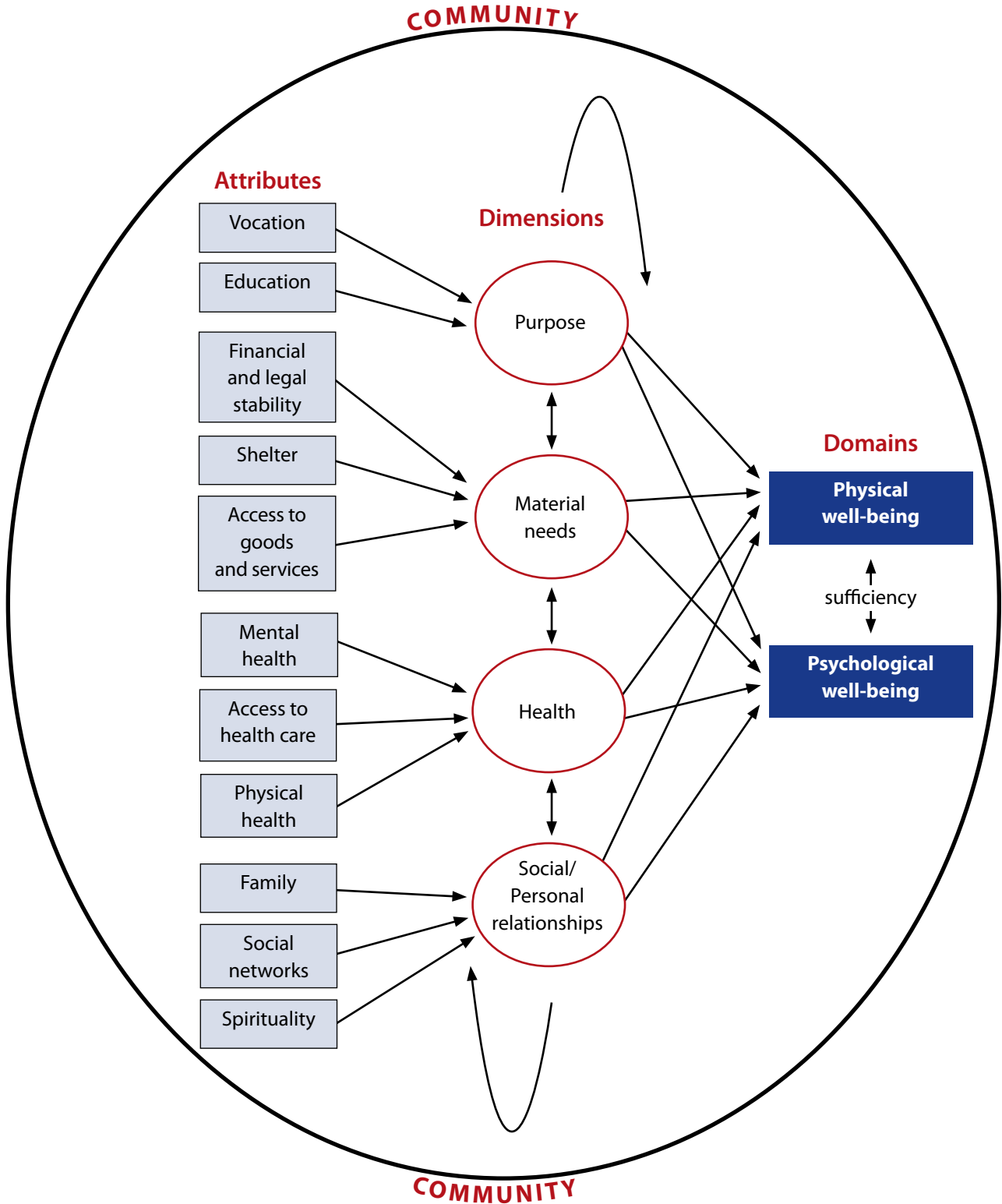
The model is illustrated in Figure 1 on the next page.

A Unique Understanding of Veteran Wellness

This understanding of veteran wellness differs from both military and civilian precedents.

DOD focuses on readiness – defined largely by physical fitness, basic training and acquisition of skills, and unit integration – rather than wellness. Yet in a military context, readiness and wellness are similar objectives. Readiness indicates the capability to perform the military mission. This does not imply that DOD is unconcerned with

FIGURE 1: THE VETERAN WELLNESS MODEL



wellness, but rather that the military context is different from the veteran and civilian contexts. The DOD emphasis on fitness as a primary attribute of its wellness framework is important because individual fitness can affect the readiness of a larger force; in the military context, it is both logical and imperative that DOD understand and quantify the extent to which the total force consists of individuals sufficiently fit to perform as required. Overall wellness is important to the individual, the family, the community and the nation, but it is not necessarily vital to a fighting force. As a result, although veteran wellness incorporates many of the same components and attributes that are present in readiness models such as Total Force Fitness and Comprehensive Soldier Fitness, there are also differences that account for the experiential and circumstantial gaps between military and civilian life. Chief among these in the veteran wellness model is the idea that a physically fit individual may or may not be psychologically well, and therefore may not achieve overall wellness, yet individuals can achieve a moderate level of wellness and psychological well-being without being physically fit. Additionally, our model emphasizes the inclusion of material needs such as shelter, access to goods and services, and financial and legal stability, which are absent from the fitness orientation.

The veteran wellness model presented here also includes purpose as a fundamental aspect of both psychological and physical well-being. Civilian models for health and well-being tend to emphasize employment, which – particularly for severely wounded veterans – is not always an option. The inability to work, however, does not preclude wellness; one may find purpose in other activities such as volunteerism or parenting. Thus, in this aspect as well, civilian models for health and well-being are inappropriate for many veterans. Similarly, WHO's broadly recognized and influential definition of health as "a state of complete

Resiliency and Wellness

Understandably, the military emphasizes resiliency: the extent to which an individual can recover from a stressful event, crisis or catastrophe. Stressful events are among the few certainties in the lives of service members and their families. Given fitness and performance demands on service members, a more resilient force is a more ready force; if the severity and duration of the negative effects of stressful events can be reduced, the force suffers from less downtime when individuals cannot perform their duties as required and is thus more ready overall to work toward fulfillment of any given mission.

Although service members may face stressful events more frequently than civilians, negative things happen to civilians as well. Resiliency, therefore, is also an important characteristic for veterans and their families. An individual's capacity to cope with, work through and move on from stressful events in any of the social and personal, health, material needs and purpose dimensions of wellness directly informs his or her psychological and physical well-being.

Resiliency, however, is not synonymous with wellness, nor is it a dimension or attribute of wellness as described in this report (although well individuals are more resilient than those who are not). Rather, resiliency remains an inherent characteristic of one's overall wellness, informing both the psychological and physical domains of well-being.⁴¹

physical, mental and social well-being and not merely the absence of disease or infirmity" is appealing in that it establishes the aspirational nature of wellness, but its assertion that the absence of infirmity is a prerequisite for health is not applicable to many veterans.

IV. ACHIEVING VETERAN WELLNESS

In our definition of veteran wellness, the different dimensions of one's well-being are interrelated. No government agency, however, provides programs and services that take into account veterans' service-related needs in the realms of social and personal relationships, health, satisfaction of material needs and purpose as anything other than isolated events. There is also a lack of connectivity between the government agencies officially charged with military and veteran care and the many service providers and other stakeholders in communities nationwide who shoulder much of the burden of that care where veterans and their families reside.

Although DOD and VA are working to improve, and in some cases transform, services for their charges, it is both impractical and unrealistic to think they can or will successfully address the challenge of reintegrating veterans alone. Concerns pertaining to the inefficient and impersonal natures of bureaucracies, the lack of an effective inter-agency approach and the influx of so many new constituents highlight the need for new strategies by which to reintegrate more than 2 million service members from post-9/11 military operations. The seminal white paper *Sea of Goodwill: Matching the Donor to the Need*, which was written in 2010 for then-Chairman of the Joint Chiefs ADM Mullen, noted that "no single agency or organization has the manpower, resources, or intellectual capital to provide a lifetime of care and support to our military family."⁴² Indeed, only a partnership of stakeholders – informed by a common goal, committed to best practices and operating in a scalable way in the communities to which veterans return – can satisfy our national imperative to reintegrate veterans as successful, well citizens. These stakeholders must embrace reintegration strategically, as an opportunity, before the unmet service-related needs of these veterans become problems of public health and welfare.

Neither DOD nor VA should be excused from their congressionally mandated responsibilities to care for those who serve and have served. However, after 40 years of an all-volunteer military, the U.S. government cannot support and dignify the service-related needs of its veterans with only the current DOD and VA practices, policies and programs. Agency reform consistent with revised strategic guidance should be a matter of federal priority, but as with all things governmental, this will inevitably take time that should not be wasted. Meanwhile, across the nation, businesses and nonprofit organizations are demonstrating remarkable vision, leadership and effectiveness in their efforts to address the needs of service members, veterans and their families.⁴³ A new and increasingly effective paradigm for local veterans' support has emerged. The community-based provision of veteran support services should be embraced strategically and in bona fide partnership with both DOD and VA so that their effort from Washington is leveraged at the local level to help veterans achieve self-sufficient well-being and, subsequently, optimal wellness.

This section of the report:

- Describes the context in which communities provide wellness care to veterans,
- Analyzes the community-based models and available resources for support of veterans and military families, and
- Provides guidance for federal agencies and other stakeholders to leverage resources and improve care so that veterans are successfully reintegrated with civilian society.

The Community Context

Individuals are personally responsible for adopting healthy habits and lifestyle choices. This ethos is shared by civilian and military societies alike. The pursuit of wellness, however, is more than an individual endeavor. Social, environmental, economic

The pursuit of wellness is more than an individual endeavor. Social, environmental, economic and other external factors significantly influence the wellness of both individuals and the communities of which they are a part.

and other external factors significantly influence the wellness of both individuals and the communities of which they are a part.⁴⁴ Furthermore, the unprecedented post-9/11 deployments of members of the Reserves and National Guard – service members who live and work in civilian communities when not training or activated – means that, for the first time since the advent of the all-volunteer force, military service may substantially affect both the individual and communal experience of wellness.⁴⁵ Just as scholars and experienced grant-makers understand that groups of people working together can promote health effectively by, for example, mobilizing to reduce pollution or teen pregnancy where those challenges exist, so should community leaders collaborate to deploy resources that strategically address the needs and harness the strengths of those who have returned from war.⁴⁶

Community-based health and wellness interventions, however, are often “complex, programmatic, and context dependent.”⁴⁷ Measurement of their effectiveness must consider a range of complex factors.⁴⁸ In the realm of veteran support, the “scale” of any given community’s relationship to the military (how many residents have deployed, how often, in which service and for how long) and the culture of support for the military (the

extent to which goodwill toward service members and veterans is shared and emphasized) factor prominently in the success of reintegration efforts. Infrastructure is another important factor; communities that enjoy adequate resources for health and welfare, engaged interaction between the business and nonprofit sectors, collaborative municipal agencies and accessible civic leadership are best positioned to leverage existing resources to provide service to any population, including veterans.

Yet as noted earlier, despite the public’s enormous “Sea of Goodwill” toward those who have served, many civilian and community-based efforts will fail at the greater task of bringing veterans “all the way home” to optimal wellness because of a lack of strategic guidance that could direct efforts toward a definitive wellness objective. Nationwide, community groups are increasingly coordinating and deploying local resources in great service to veterans, and as discussed below, many demonstrate enormous potential to succeed. However, these efforts are relatively new and operating largely without guidance and support from the very federal agencies whose missions they benefit. There is no office at VA, for example, that provides technical support to the countless community volunteers who assist veterans, nor is there any mechanism that facilitates coordination, learning, improvement or accountability among them. Perhaps ironically, the only such resource known to exist at the federal level comes from the Warrior and Family Support Office, which resides in the Office of the Chairman of the Joint Chiefs of Staff, whose stated purview is the military, not veterans. Nevertheless, coordination and guidance from that office and its staff has been the singular catalyzing force for community-based efforts supporting veterans in the post-9/11 era. In 2010, ADM Mullen asked COL David Sutherland to visit 50 states in 50 weeks; his attendant inventory of community-based resources for service members, veterans and military families has yet to be analyzed or used strategically by other leaders within DOD

or at other federal agencies with responsibilities for veterans. The effort of the Warrior and Family Support Office could be continued and leveraged by VA, were it to demonstrate a similar level of support for community stakeholders by establishing a peer office within its own infrastructure. In and of itself, the Chairman of the Joint Chiefs' Warrior and Family Support Office is neither fully equipped nor mandated to provide community stakeholders with the strategic guidance needed to unite their efforts.

Finally, it is a notable leadership shortcoming that, after a decade of war's tolls, neither DOD nor VA has capitalized on the ample and ready resources of American business and nonprofit providers, many of which offer pre-existing, evidence-based programs and services that can be (and in some cases, with private support, are already being) delivered swiftly and effectively to hundreds of thousands of veterans. Both DOD and VA commonly cite legal constraints to justify the general lack of systemic partnership with community providers, yet both have quietly engaged with select nonprofit operators for years.⁴⁹ Meanwhile, VA's strategic plan for FY 2011 to 2015 calls for creating "innovative public-private partnerships that enable VA to increase services to Veterans and their families, maximize the use of underutilized property, and further community goals," but that plan does not clearly identify objectives, parameters and timelines and does not demonstrate a strategy to deploy community resources toward those ends.⁵⁰ The field of organized philanthropy has likewise demonstrated a surprising lack of leadership, largely failing to make connections between the organizations it already funds in areas such as homelessness, mental health and substance abuse treatment and the needs of thousands of veterans who will, inevitably, join the ranks of those constituencies.

Resources would not rank so prominently on the list of complexities that affect the efficacy of community-based efforts to support veterans if the following conditions were met: federal agencies

pinpointed the areas of service delivery where veterans could be more effectively served via public-private partnerships at the local level; federal agencies identified, evaluated, partnered with and provided resources to community-based partners and held them accountable for outcomes; and grantmakers invested in and built up the capacities of those organizations to expand their cultural competencies and serve veterans appropriately.

Reintegrating Veterans: Community-Based Models

In communities across the nation, leaders from the nonprofit, civic, philanthropic and business sectors are marshalling available resources to serve returning veterans. In some cases, efforts are motivated by patriotism or a sense of gratitude; in others, stakeholders are motivated by the desire to mitigate public impacts such as increased homelessness or an over-representation of veterans in local emergency rooms and hospitals. Regardless, each is a community-specific "model," a framework for how local communities can leverage available resources to increase knowledge, efficiency and effectiveness in addressing the challenges of veteran reintegration. As we examine different models for community-based reintegration of veterans, we must consider not only the nuances and complexities that distinguish one community from another but also the external factors that influence their capacities to promote veteran wellness effectively. These factors will influence – but not solely determine – the success of a given model.

Our research found that the most effective community-based reintegration models (hereafter referred to as "community models," or just "models") for delivering appropriate care and services for veterans at the local level are those that base operations at a credible, local nonprofit organization that coordinates and deploys both public and private resources and stakeholders to address the needs and recognize the skills of service members, veterans and their families. Additionally, their

basic attributes can be codified, manipulated or changed to accommodate external influences or different resources without compromising the original intent and can be replicated in other places.

In December 2011, we convened a working group of 15 leaders representing community-based reintegration models from across the country.⁵¹ The group focused on efforts that address the reintegration of veterans as a community-wide concern, requiring extensive intergroup planning and collaboration.⁵² The models examined were founded within and based at:

- Nonprofit organizations and civic coalitions (sometimes including stakeholders from the business and government sectors),
- Academic institutions and research centers, or
- Community foundations.⁵³

Representatives from each of these fields or “vocational platforms” gave presentations of their models, explaining the community circumstances, theory of change, composition of stakeholders, and program, resources and evaluation measures that make up their effort. Intergroup discussions addressed which aspects of these models work, where the challenges lie and where there is sufficient evidence to suggest best practices.

The community-based veteran reintegration efforts that were examined, and that inform the best-practices framework offered here, display a high level of strategic thought, preparedness, competence and promise of success, despite the lack of coordinated support from federal agencies and philanthropic investors. Some offer lessons that can inform similar efforts in other communities.⁵⁴ Despite some differences among them, these models also demonstrate efficiencies of scale and how to meet a continuum of service-related needs by building on existing community resources. Where possible and efficient, these efforts involve local representatives of federal agencies on their leadership teams.⁵⁵

Despite the positive attributes, these models could be replicated far more widely and effectively if they shared a common understanding of veteran wellness to ensure that community-based efforts contribute most effectively to shared national goals regarding veteran reintegration.

THE MODELS PRESENTED AND THE LESSONS LEARNED

The community models we studied include notable differences and clear commonalities. Because the core competencies of the organizations and leaders representing each model differ, the specialties or strengths of the models vary. Where the effort emerged from the military spouse community, for example, we see a high degree of collaboration with military stakeholders and a strong emphasis on family support. Where the efforts are based in academia, we see a strong emphasis on data collection. In addition, some models reflect particular resources, cultural attributes and values of their communities and thus may not be exactly replicable in other places.

As a general overview, however, all the successful models we studied:

- **Are Well Informed**

They assess the veteran population’s needs, the services already provided and the gaps in those services, with an emphasis on leveraging local resources and opportunities.

- **Connect**

The military emphasis on resiliency is sometimes perceived as suggesting that those with needs are weak, a stigma that can follow veterans into their civilian lives and keep them from seeking the help they need to address lingering service-related issues. Successful community reintegration models thoughtfully and respectfully reach out to veterans and military families, not only to identify them but also to earn their trust, which facilitates the provision of services.

- **Strategize**

Successful efforts build an action plan, based on data and information, that matches community resources with veteran needs.

- **Collaborate**

Community-based reintegration efforts work best when leaders identify, create strategic partnerships with, and define the respective roles of a range of stakeholders. Successful and strategic collaborations leverage resources, mitigate unnecessary duplication of services, and strengthen the overall “culture of support” within a given community by creating a network of opportunities by which to reach and serve veterans and encourage the volunteerism of the public.

- **Use a Case Management Approach**

The community models we studied report greatest success with “personal-touch” programming in which each veteran is understood to be an individual with unique needs and circumstances and through which he or she is directed to the right resources to address the attendant range of interrelated needs.

- **Evaluate**

Regardless of size or focus, community-based efforts need to assess the efficacy of programming and partnerships.

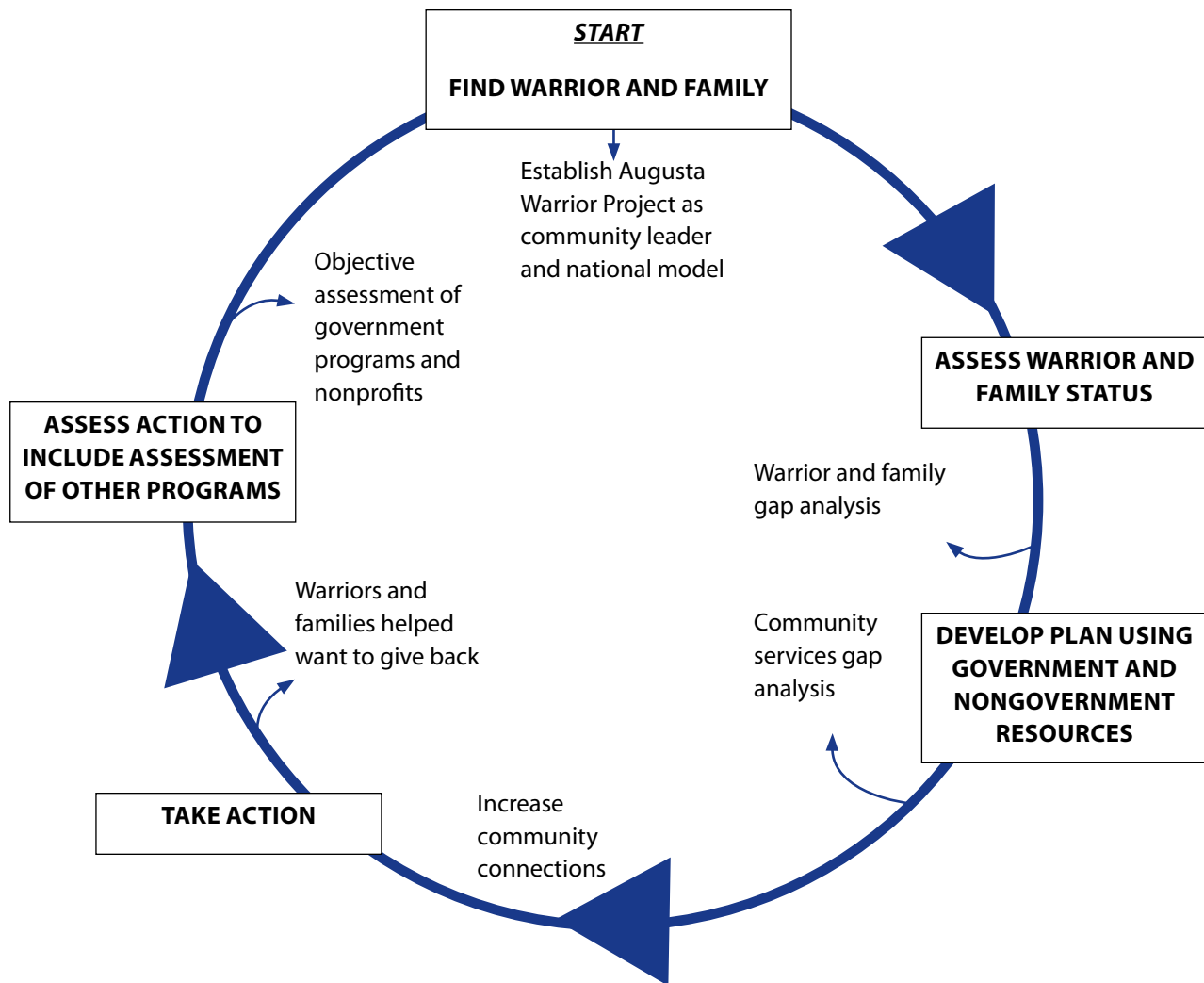
Within this general framework, the specific ways in which communities organize to support veterans vary. An urban community with strong links to a local military base or installation and several thousand Marines in its catchment area, for example, will provide services differently than will a rural area whose businesses and neighbors may be located miles apart from each other. The vocational platform on which the model is based also matters; a coalition of nonprofit service agencies will organize differently than will a community foundation or a university. All three platforms can provide successful community reintegration

models, but they work from different bases of expertise. However, the various models share a common objective, which – as is well-articulated in the vision statement of the Arizona Coalition for Military Families – is to connect service members, veterans and their families with “the right program, service and/or benefit at the right time.”⁵⁶ Fulfilling this promise requires a personal-touch approach that exceeds the capabilities of federal agencies but plays to the strengths of local communities, whether their conveners are nonprofit, scholarly or philanthropic organizations.

Figure 2, for example, demonstrates a model that works well in Augusta, Ga., where the Augusta Warrior Project determined that, of the 66,000 veterans living in its catchment area, fully 40 percent (or 27,000) are young, post-9/11 veterans who are not accessing the abundant local resources available to help address their service-related needs, which largely fall in the “material needs” and “health” dimensions identified in this report as key elements of veteran wellness. With abundant local resources for healthcare and research, and with a high community value placed on military support, the Augusta Warrior Project has organized a coalition of over 50 nonprofits, state and federal programs, businesses and national or community institutions that collaborate on a holistic approach to address veteran needs on a case by case basis. By leveraging the unique resources of each coalition partner, in the last quarter of 2011 alone, the Augusta Warrior Project helped 65 veterans secure employment, 28 homeless veterans move into permanent housing and 26 veterans enroll in college and vocational training, and the project is providing these veterans with ongoing support services.⁵⁷

Another effective approach comes from the nonprofit Charlotte Bridge Home (CBH), of Charlotte, N.C., which found that 54,000 veterans reside in the immediate Charlotte-Mecklenburg community, another 154,000 live in the surrounding counties and 4,000 new veterans are expected to

FIGURE 2: AUGUSTA WARRIOR PROJECT SERVICE STRATEGY

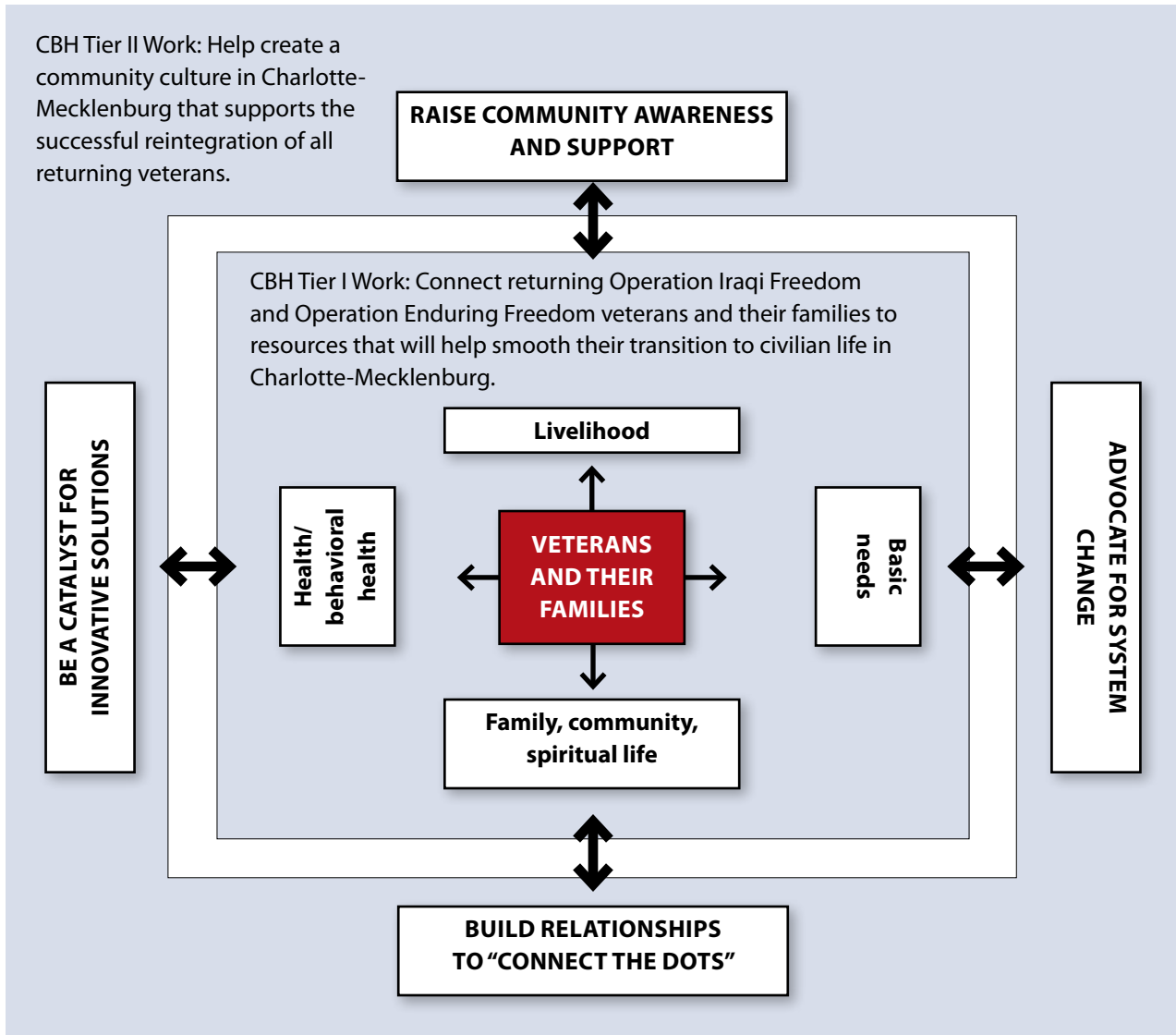


Source: Content used with the permission of Jim Lorraine, Augusta Warrior Project.

settle there this year. With such a large veteran population, a small group of concerned citizens began discussions in early 2011 with the Center for Public Private Partnership and the SOCOM Care Coalition on the subject of how they might cooperatively engage the community in helping Charlotte’s veterans to reintegrate successfully. They chose a two-pronged strategy, as shown in Figure 3. First, by developing a coalition of Charlotte’s leading businesses, philanthropic

organizations and community institutions committed to leveraging their resources in service to veteran reintegration, CBH was established as a community-driven organization set up to manage the individual needs of veterans and military families. CBH connects individuals and families with qualified community partners specializing in four areas of need – livelihood; basic needs; family, community and spiritual life; and health – which roughly correspond to the key elements of wellness

FIGURE 3: CHARLOTTE BRIDGE HOME (CBH) SERVICE STRATEGY

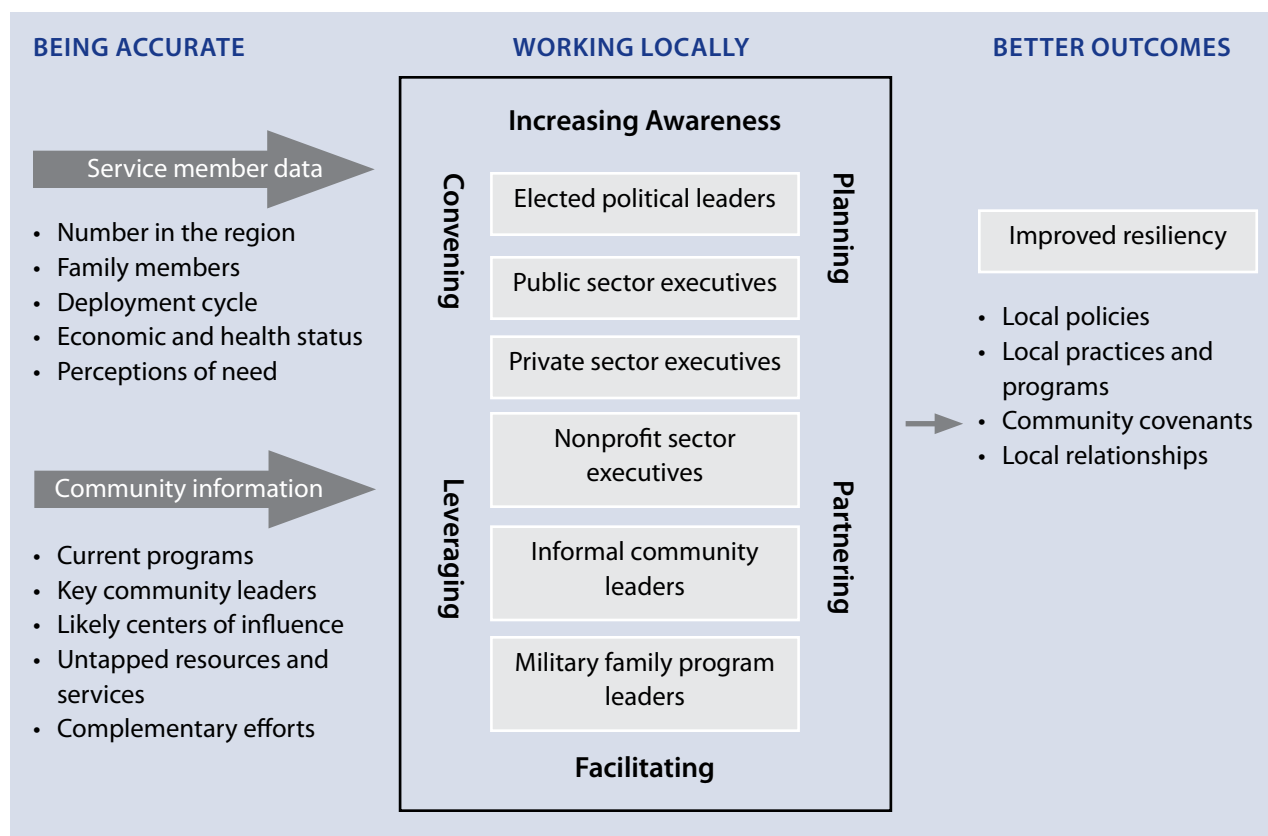


Source: Content used with the permission of Thomas Norman, Charlotte Bridge Home.

identified in this report. Second and simultaneously, CBH sought to learn what resources were available to veterans and to assess the extent to which providers and veterans were connected. It conducted a study, nearly complete as of April 2012, in partnership with the Foundation for the Carolinas. The study’s findings will identify ways that nonprofits, healthcare providers, educational

institutions and VA programs in the area can support veterans in a holistic manner and will also raise broad community awareness and build support. In its first six months of operation, CBH has managed the cases of 35 veterans and their families by assessing all of their service-related needs and connecting them with community stakeholders to help address each issue.

FIGURE 4: CITIZEN SOLDIER SUPPORT PROJECT SERVICE STRATEGY



Source: Content used with the permission of William Abb, Citizen Soldier Support Project, University of North Carolina at Chapel Hill.

In contrast, Figure 4 shows the model of the Citizen Soldier Support Project (CSSP) at the University of North Carolina at Chapel Hill, an effort based in academia and conducted in partnership with DOD. Deploying its considerable academic resources and strong relationship with the military, CSSP concentrates on understanding, analyzing and strategically disseminating information about the unique needs of the men and women of the Reserves and National Guard. With the data it collects, CSSP designs interventions and trains those who serve, represent and work with veterans in “geographically isolated, rural and underserved regions to more effectively serve Reserve Component members and their families,” where the infrastructure for veteran support

may be minimal.⁵⁸ CSSP’s model helps small and under-resourced communities develop their own reintegration models, using evidence and best practices that have been identified as being effective even in places that lack certain advantages often found in cities like Augusta or Charlotte.

Finally, the field of organized philanthropy offers a different but equally effective community reintegration approach. Figure 5 illustrates the model of the Lincoln Community Foundation (LCF), in Lincoln, Neb. Inspired by a call-to-action made in a keynote address to the Council on Foundations in 2010 by then-Chairman ADM Mullen, LCF assessed issues facing veterans within its catchment area and

FIGURE 5: LINCOLN COMMUNITY FOUNDATION SERVICE STRATEGY



BECOME INFORMED

Identify needs, identify resources and understand military

STRATEGIZE

Develop grantmaking strategy, non-grantmaking strategy or exit strategy

INVEST

Test, evaluate and re-invest

COLLABORATE

Build relationship and share information

PLAN FOR SUSTAINABILITY

Leverage resources and ensure ongoing needs are met

Source: Content used with the permission of Barbara Bartle, Lincoln Community Foundation.

found that employment, education and the impact of deployment on families were among the core issues. Despite widespread goodwill toward the military, however, the local civilian community was largely unaware that these service-related needs were not being met. With the capacity to convene stakeholders as its core competency, LCF developed a community reintegration model to leverage that asset by engaging service providers, civic and institutional leaders, and donors in strategy sessions to address veteran needs in their respective areas of expertise. When representatives of the Chairman of the Joint Chiefs’ Warrior and Family Support Office visited Lincoln, for example, LCF convened focus groups for clergy, nonprofits, education and business leaders – representing the core leadership sectors of the Lincoln community – and drew 500 participants. The results informed three separate but related initiatives. To focus on veteran employment, LCF facilitated

a partnership between the Lincoln Chamber of Commerce, the Nebraska Department of Labor and Economic Development and the former state adjutant general to organize a job fair and an employment training series for veterans that will engage over 100 regional employers. LCF replicated this convening model among leaders in education and criminal justice. These initiatives led to the formation of a statewide task force to assess, address the needs of and share information about how to serve student veterans and to the development of a “veterans’ court” that is piloting alternative-sentencing programs in conjunction with local VA campuses for veterans who have committed misdemeanors. Although not a direct service provider, LCF demonstrates that community foundations – with their immense convening powers and philanthropic resources – can catalyze and facilitate the implementation of community-based veteran reintegration efforts.

There is no one preferred model, no single approach to community-based veteran support that will work everywhere, yet all communities can and should implement programs and services that are consistent with best practices.

Although these and other models presented by our working group participants sometimes differ in significant ways, they all connect veterans with needed resources and provide sustained support as a veteran moves from transition toward reintegration.⁵⁹ There is no one preferred model, no single approach to community-based veteran support that will work everywhere, yet all communities can and should implement programs and services that are consistent with best practices.

Best Practices in Community-Based Veteran Reintegration

We offer a best practices framework for community-based veteran reintegration that draws on generally accepted standards for the assessment of public health and wellness interventions, as inspired by the *Mission, Goals and Philosophy* statement of the California Wellness Foundation. Community-based models for veteran reintegration must:

- Build on existing community strengths;
- Emphasize and/or expand the community potential to realize and sustain positive public health

and social welfare outcomes; and

- Foster self-determination among the population being served.⁶⁰

Beyond these generally accepted standards, there are additional best practices for those that specifically address and serve veterans. Such efforts are most effective when they are:

- **Credible**

The leaders of any community initiative should authentically reflect and be informed by the unique values, culture and resources of both the veterans and local communities. Those programs that engage and involve local veterans and their families, as well as current military families and/or others who have a track record of credibility within the veteran community, are most successful.

- **Data Driven**

Successful models begin with a scan of the local environment or other research that defines the scope, demographics, service affiliation, needs and other attributes of the target population and inventories both available resources and gaps in service.

- **Community Focused**

Most, but not all, of the models examined define their communities in geographic terms. Alternatively, or in addition, some define their communities in terms of service affiliation or wounded status. In all cases, the community to be served should be well defined.

- **Culturally Competent**

Behaviors, attitudes, language and policies that reflect authentic knowledge of and sensitivity to the needs and issues of both the community and its constituents are required not only to work effectively in cross-cultural situations but also, importantly, to develop effective interventions.

- **Outcome Focused**

Only reliable data- and evidence-based programs can inform the smart and strategic provision of programs and services for optimal veteran wellness.

FIGURE 6: ARIZONA COALITION FOR MILITARY FAMILIES COALITION PARTNERS



Source: Content used with the permission of Nicola Winkel, Arizona Coalition for Military Families.

• **Wellness Oriented**

Each of the models places a high value on a continuum-of-care approach, one that understands veteran wellness as a dynamic process in which the needs and opportunities facing a veteran are interrelated. Each of the models recognizes that veteran wellness includes many components beyond health, which is consistent with the definition of wellness presented in this report.

• **Connected**

Although each community has its own distinct attributes, connection to broader networks – at both the regional and national levels – enables local models to access information and resources that can inform and improve their programming. For communities that focus on serving Guard and Reserve families, as well as

rural communities and other places without easy access to VA facilities, connections with larger-scale networks are particularly important because they can make it quicker for easily isolated veterans to access the government programs and benefits for which they are eligible.

• **Inclusive**

Community reintegration models are of most value to veterans and military families when they engage the greatest possible cross-section of community members – from the government, military, business and civic sectors – as stakeholders in veteran wellness. Figure 6, the “Coalition Partners” diagram from the Arizona Coalition for Military Families, captures the cross-sector approach shared by most successful reintegration models.

The Role of Academic and Philanthropic Organizations in Veteran Reintegration

In many communities, large and well-established organizations and institutions, such as colleges, universities and grantmaking foundations, have the convening power and community-wide credibility needed to cultivate early support and resources from, and conduct effective outreach to, the community. Most of the community reintegration models we examined were coalitions of small nonprofit organizations, but we also examined two models based at universities and two at community foundations that maintain excellent ties to the grassroots community through partnerships, convenings and shared resources.

Because of their leadership positions in many communities, colleges and universities can be a natural foundation on which to build a community reintegration model. The two university-based models we examined were the Citizen Soldier Support Project of the University of North Carolina at Chapel Hill and the Military Family Research Institute at Purdue University. Academic centers like these, particularly those with both

expertise and cultural competence in the areas of the military and military life, can inform reintegration efforts with data and evidence critical to effective service delivery.⁶¹ Moreover, because of the community-wide trust and credibility that they tend to enjoy as major institutions, colleges and universities lend themselves to partnership with the military. Both of these models benefit from stronger ties to (and funding from) military programs and offices than do their nonprofit and community foundation peers. Furthermore, because many colleges and universities have pre-existing relationships with care providers in their regions, they can often facilitate collaborations and demonstration projects more swiftly than others.

Because they exist at the intersection of the public, private and philanthropic sectors, community foundations across the nation have often played a major leadership role in developing and facilitating cross-sector solutions to pressing challenges.⁶² Like academic institutions, many community foundations are well positioned to

be leaders on issues of veteran reintegration. The Lincoln Community Foundation and the San Antonio Area Foundation are two examples of community foundations that are leading such efforts. Because the San Antonio Area Foundation also runs a management support center for local nonprofits, that resource has been leveraged to develop a Veterans Service Academy, which provides the training and technical assistance that many small nonprofits serving veterans need to operate effectively and succeed.

Tasked with addressing complex issues in a local context, community foundations – through their expertise in grantmaking, convening and, sometimes, program development – have extensive on-the-ground intelligence about community needs and resources. Their transparency and accountability to the public have earned most community foundations rare credibility among major institutions, positioning them well to convene the major public, private and philanthropic agents needed to implement a sound cross-sector approach to veteran reintegration.

COMMON CHALLENGES FACING COMMUNITY-BASED VETERAN REINTEGRATION MODELS

In addition to best practices, there are consistent challenges common to community-based efforts in support of veterans. Notably, some of these could be mitigated via strategic partnerships with, and investment from, DOD and VA, as well as from philanthropic entities.

Major challenges facing community-based veteran reintegration efforts include the following issues:

- **Lack of Support and Resources from Military, Government and Philanthropic Stakeholders**
Despite the value of the services provided by community organizations to veterans across the nation, neither military nor government agencies

have harnessed those assets by engaging community providers as bona fide partners in any consistent way. Likewise, grantmakers, whose contributions to community wellness are critical and enormous on nearly every other front, have yet to demonstrate an understanding of the impact of war on the homeland by making grants that address veteran needs in the realms of housing and homelessness, health, economic development and other categories in which they are already providing funding.

- **Lack of Strategic Guidance**

The models studied for this report have succeeded largely because their leaders are particularly knowledgeable, resourceful, charismatic and driven, and not because they are informed by strategic guidance. To sustain successful veteran reintegration and reduce the dependence on a few individuals, national leaders – the president and the secretaries of defense and veterans affairs – will need to guide the goodwill of the American people toward principles, standards and practices of effective veteran care. In this way, diverse stakeholders work toward common, rather than isolated, goals and do so in a manner that is strategic and leverages and maximizes resources, while collecting data and evidence of efficacy that can improve and inform best practices.

- **Difficulty Reaching Veterans**

Despite abundant data that demonstrate the scope and breadth of need among the current generation of veterans, those poised to address their needs consistently report difficulty in identifying and conducting successful outreach to these veterans in need.⁶³ There are varying theories as to why, after a decade of warfare, post-9/11 veterans remain so hard to identify and serve. Common themes indicate that – because of the perceived stigma of being in need, the collective impact of multiple deployments and exposure to traumatic events, and sometimes, a mistrust of

the system perceived to have contributed to their negative circumstances – today’s veterans are not enrolling with VA, self-identifying to social service agencies or reaching out for help elsewhere.⁶⁴

- **Inconsistencies in Organizational Sophistication and Capacity**

Ad hoc coalitions and small nonprofits can lack sophistication and resources, especially when compared with universities, grantmaking foundations or other large entities found at the hub of many community reintegration efforts. This challenge is not insurmountable, but resources and leadership need to be scaled in accordance with capacity.

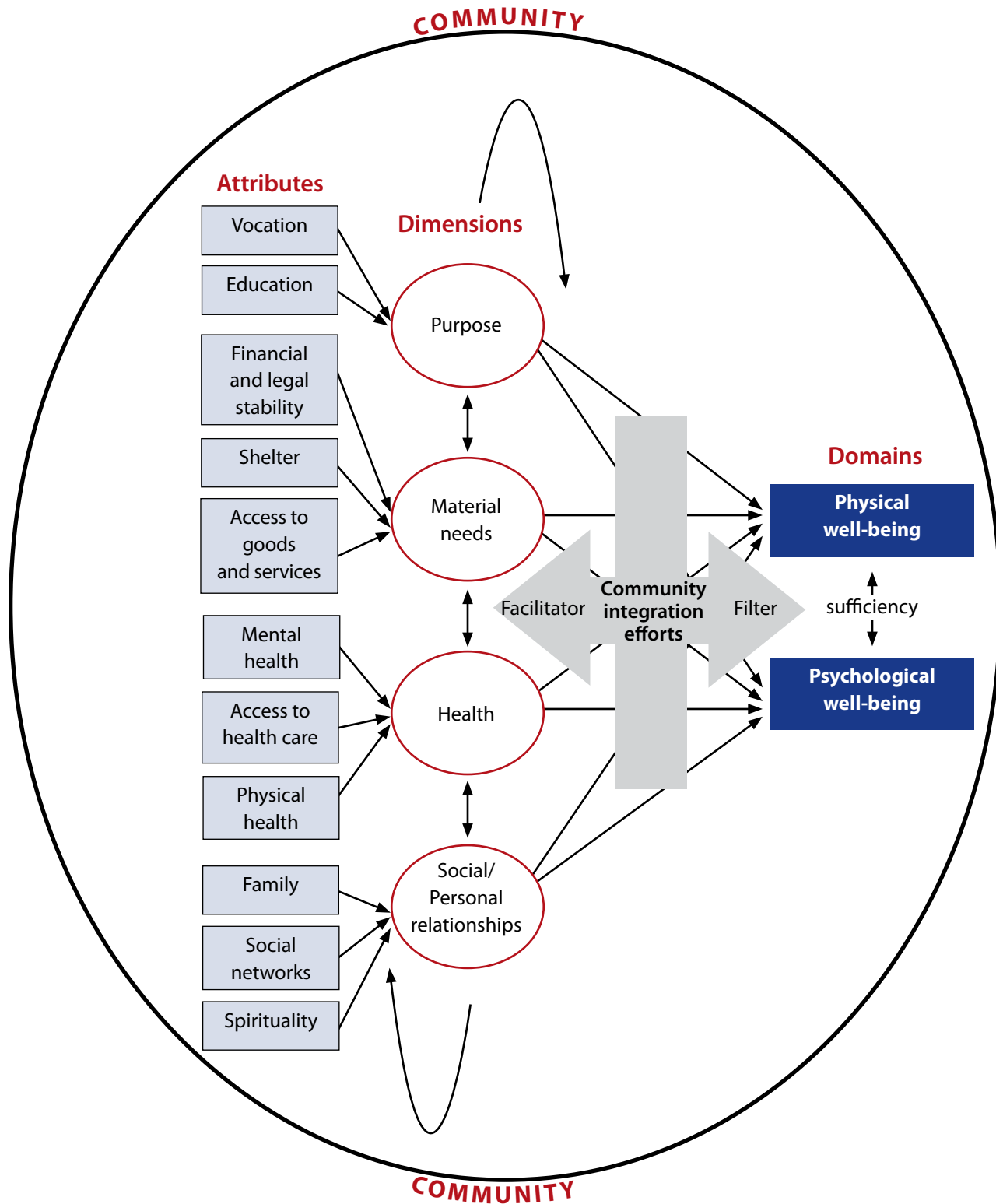
SUMMARY

In communities nationwide, nonprofit, academic and philanthropic groups and institutions are taking the lead in researching, informing, implementing and evaluating programs to support the full and complete reintegration of veterans. These community organizations are the nation’s only stopgap for the many thousands of veterans who fall through the cracks of a system ill-designed to transition them from military service to civilian reintegration.

Community-based models for veteran integration should share an understanding of wellness that is based on physical and psychological well-being and informed by the four core dimensions of life experience identified in this report. Community-based reintegration efforts can both *facilitate* wellness by connecting veterans with carefully selected, credible, accountable partners and can also *filter* out predatory lenders and others that might profit from veterans’ vulnerabilities. Figure 7 illustrates this concept.

DOD, VA and other government agencies have a critical role in veteran reintegration but have not fulfilled their potential.⁶⁵ By contrast, at the community level, public and private partners – sometimes despite the absence of adequate funding

FIGURE 7: THE VETERAN WELLNESS MODEL WITH COMMUNITY FILTER/FACILITATOR ROLE ILLUSTRATED



Source: Center for a New American Security.

and guidance – are helping veterans and their families access programs and services that address their service-related needs and improve their wellness. DOD and VA benefit immeasurably from the effort of community-based programs. However, their failure to codify those resources and incorporate them into an overall wellness plan that defines and dignifies the transition from the military is short-sighted. These federal agencies need to change their approach. For instance, a 2010 RAND report identified significant duplication among 211 programs sponsored or funded by DOD to address psychological health and/or traumatic brain injury.⁶⁶ Given these considerable, albeit inefficient, efforts, these federal agencies need not do more, *per se*; instead, they should strategically partner with those who can achieve locally that which federal bureaucracies cannot from Washington.

V. RECOMMENDATIONS AND CONCLUSION

It is both logical and just to care for and ensure the success of those who have voluntarily served their country. With suboptimal coordination among U.S. government agencies, however, the nation's many nonprofit service providers need strategic guidance to help them become more effective. Moreover, there is no current infrastructure to facilitate partnerships between federal agencies and the capable veteran-serving organizations in American communities, leaving veterans vulnerable to significant pitfalls in the military-to-civilian transition.

In August 2011, President Obama mandated the creation of a joint DOD-VA Task Force to investigate military transition programs and recommend improvements. He specifically noted that “we spend months preparing our men and women for life in the military, but we spend much less time preparing them for life after they get out.”⁶⁷ The Task Force report is anticipated to extend the transition period and recommend more comprehensive counseling and guidance for service members before they separate from the military. If implemented intelligently, this may significantly improve the effectiveness of the transition process.

The Task Force, however, is likely to focus primarily, if not entirely, on the specific issues of employment and education. Although these two areas are critical to the long-term wellness of most people, neither one accounts for the specific needs and circumstances of many injured and disabled veterans or the support systems needed to ensure that the new transition outcomes are good and sustainable. Revising official transition programs is an excellent first step, but other critical actions are needed to fully reintegrate transitioned veterans into their civilian communities.

There is no current infrastructure to facilitate partnerships between federal agencies and the capable veteran-serving organizations in American communities, leaving veterans vulnerable to significant pitfalls in the military-to-civilian transition.

Federal agencies can neither solve every problem nor provide the solution to every challenge; their reach into the communities from which veterans come and to which they return is insufficient. Community-based and private organizations, by contrast, can operate on a scalable level to reach more individual veterans. As framed by the White House's own initiative, it is time for all of these stakeholders to "join forces" strategically, swiftly and permanently.

Therefore, we make the following recommendations:

The president should charge the secretaries of defense and veterans affairs with swiftly developing an actionable interagency plan that closes the transition gap between service members' separation from the military and their return to civilian society and supports their longer-term reintegration.

This plan should include:

- A national standard for veteran wellness to frame and guide optimal reintegration while recognizing the characteristics unique to veteran wellness

as compared with civilian or military wellness;

- A delineation of each federal department and agency's responsibilities for veteran reintegration; and
- A mandate for public-private partnerships to engage, remunerate and hold accountable non-governmental actors when they can act more effectively than federal agencies.

The secretaries of defense and veterans affairs should jointly reframe and commit to a comprehensive reintegration strategy. This strategy should adopt a united understanding of veteran wellness and commit to deep strategic engagement with well-vetted community stakeholders and service providers.

To be effective, DOD and VA should jointly:

- Study, assess the efficacy of, determine best practices for and implement department-appropriate models for community outreach and partnership, along the lines of the Warrior and Family Support Office established in the Office of the Chairman of the Joint Chiefs of Staff;
- Develop strategic criteria for partner engagement with community-based nonprofit and business providers to achieve veteran wellness goals and objectives swiftly and effectively; and
- Establish a VA Office on Community Reintegration, modeled after the Warrior and Family Support Office, that is professionally staffed and resourced to ensure that public and private stakeholders are informed, networked and supported in their efforts to provide excellent and accountable reintegration support to veterans and military families at the local level.

At a minimum, this office should:

- » Maintain an inventory of community-based resources for veterans and military families;
- » Publish best practices for implementing community-based services for veterans;

- » Disseminate quality scientific research and information about evidence-based practices that pertain to the care of veterans;
- » Facilitate technical assistance to community stakeholders that seek to improve local support for veterans; and
- » Maintain an active and robust Internet presence that facilitates information sharing, networking, and access to resources among and across stakeholder constituencies.

Civic, community and nonprofit leaders (including conveners of community-based reintegration efforts) should access or develop data on the veterans and military families in their catchment areas, develop the attendant needs analyses, inventory community resources available to address these needs, and convene stakeholders in the design and implementation of a community reintegration model.

Successful community-based efforts will:

- Be informed by a definition of veteran wellness and an understanding of the factors that influence it;
- Be guided by a theory of change that identifies a common understanding of problems and opportunities and a common framework for how they can be best addressed;
- Work toward scalable and achievable goals that are informed by the best practices identified in this report;
- Involve those affected by programming (military and veteran communities) in planning and leadership;
- Leverage resources by identifying where collaborations may improve efficiency;
- Connect with other regional and national stakeholders for professional development, information sharing and networking; and
- Reflect local values, culture and resources in

terms of both leadership and service delivery, while benefitting from guidance and resources available from DOD, VA and other stakeholder agencies.

Grantmakers should recognize their extraordinary role in helping community leaders address the needs of veterans effectively. Strategic investment in organizations that have both veteran-centric and general missions is likely to yield the best results, particularly when grantmakers leverage their ability to serve as conveners as well as funders and when they help grantees work with each other for greatest impact.

To be successful, grantmakers at the community level should:

- Recognize that vetting and selecting veteran support organizations requires additional expertise;⁶⁸
- Examine how the needs of local veterans fit within preexisting grant programs and conduct effective outreach to leaders in the fields represented therein to increase their awareness of veterans’ needs; and
- Coordinate with other grantmakers to ensure community-wide strategies that leverage resources, reduce redundancy and spur innovation.

Conclusion

Although the vast majority of veterans are thriving and will continue to contribute far more to American society than they ask or need from it, some veterans require more and better care and services than they are getting to address the service-related needs they face.

To best serve those who have served the nation, U.S. government agencies, nonprofit organizations and others concerned with their reintegration should adopt a broader conception of veteran wellness that recognizes veterans’ particular needs.

This new understanding of wellness will appreciate both its holistic nature and the fact that those with service-related injuries can become well, even if those injuries have permanent effects. Importantly, this new understanding of wellness will facilitate both a broader and more effective range of services for those who need it by laying the groundwork for baseline standards in veteran care. Perhaps most importantly, a unified definition for veteran wellness empowers both veterans and leaders in the communities in which they settle, to work together through the transition from military service, and toward the longer-term goal of total and complete reintegration as healthy and successful members of civilian society.

Glossary of Terms Used in this Report

COMMUNITY

A group of any size whose members understand their existence in relation to each other through shared residence in a specific locality; shared government; shared personal, occupational, vocational, recreational, cultural or other interest-informed experience; shared need; common cultural and/or historical heritage; or fellowship affiliation.

COMMUNITY-BASED

Refers to organizational, programming or service-oriented efforts and entities that are established within and by a community, whose leadership includes representation of that community and whose philosophical and practical attributes reflect the community's values and characteristics.

COMMUNITY-BASED MODEL

Coalitions or groups of organizations, including nonprofit, civic, philanthropic and business entities, that come together strategically and in partnership to combine and leverage resources toward a common community goal.

CULTURAL COMPETENCE

A set of congruent behaviors, attitudes and policies that comes together in a system, agency or group of professionals, reflecting authentic knowledge of and sensitivity to the needs and issues of the communities and constituents involved and enabling effective work in cross-cultural situations.

MODEL

A representation, whether theoretical, illustrated or three dimensional, that is communicated with words and/or imagery; that serves as a pattern for, or representation of, an idea, plan or event; and that, by its very nature, is incomplete and can be changed or manipulated with relative ease without compromising its original value or message.

PROGRAM

An effort, based within and administered by a larger organization, agency or business, that provides services, resources or interventions that address a well-defined issue or need (or a set of issues or needs) pertaining to the wellness of individuals, families or communities.

ENDNOTES

1. In this report, “veteran” is defined as anyone who served on active duty, in any job capacity, while a member of the Army, Navy, Air Force, Marines or Coast Guard active components or of the National Guard or Reserves.
2. According to the Veterans Health Administration, Office of Public Health, 53 percent of separated veterans from Operations Enduring Freedom, Iraqi Freedom and New Dawn have utilized VA healthcare. See 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, from 1st Qtr FY 2002 through 4th Qtr FY 2011*, (November 2011), 5, <http://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2011-qtr4.pdf>. For more information on community-based providers providing healthcare to veterans, see Polly Noel et al., “A Pilot Survey of Post-Deployment Health Care Needs in Small Community-Based Primary Care Clinics,” *BioMed Central Family Practice*, 12 no. 71 (2011), <http://www.biomedcentral.com/content/pdf/1471-2296-12-79.pdf>; Terry Schell and Terri Tanielian, eds., *A Needs Assessment of New York State Veterans: Final Report to the New York State Health Foundation* (Santa Monica, Ca.: RAND Corporation, 2011); and Citizen Soldier Support Program, “Program Overview,” (December 12, 2011), <http://www.citizensoldiersupport.org/lib/resources/CSSP%20Program%20Overview%20Dec%202011.pdf>.
3. See, for example, the classic works of Samuel Huntington, *The Soldier and the State* (Cambridge, Mass.: Belknap Press of Harvard University Press, 1957); and Morris Janowitz, *The Professional Soldier: a Social and Political Portrait* (New York: The Free Press, 1960). For more contemporary works, see Peter Feaver, *Soldiers and Civilians: The Civil-Military Gap and American National Security* (Cambridge, Mass.: MIT Press, 2001); and Peter Feaver, “The Civil-Military Problematic: Huntington, Janowitz and the Question of Civilian Control,” *Armed Forces & Society*, 23 no. 2 (Winter 1996), 149-178.
4. According to the National Center for Charitable Statistics at the Urban Institute, as of March 2012, there were 40,848 nonprofits registered with the Internal Revenue Service that specifically support service members and veterans. To locate this data, submit a data query using the Custom Table Wizard on this webpage: <http://nccs.urban.org/tools/index.cfm>. Then, sort for Registered Nonprofits by NTEE code for March 2012 (the most recent date at time of publication) and input W30 Military & Veterans Organizations for the NTEE coding category. To learn more about nonprofits that serve veterans generally, see Nancy Berglass, “Investing in the Best: How to Support the Nonprofits that Serve Veterans, Service Members and Their Families,” Center for a New American Security (Washington, April 2012).
5. John Copeland and David Sutherland, “Sea of Goodwill: Matching the Donor to the Need,” (Office of the Chairman of the Joint Chiefs of Staff, 2010).
6. By law, the Chairman of the Joint Chiefs of Staff serves as the principal military adviser to the Secretary of Defense and the President. See 10 U.S.C. § 153. Notably, the chairman does not command military forces or have direct responsibility for the recruiting, training, equipping and care of military personnel. Those responsibilities fall to the combatant commands and the services, respectively. Consequently, most of what the Chairman can do with respect to personnel and readiness issues is accomplished through influence and indirect action, as opposed to direct command and control.
7. Each service has a Transition Assistance Program (TAP), a partnership between the Departments of Defense, Veterans Affairs, and Labor, whose current curricula were developed in 1991 in response to the post-Cold War reduction in forces and are largely considered inadequate for the needs of today’s service members. In August 2011, President Obama mandated the formation of a Joint DOD-VA Task Force to make policy recommendations to promote the idea that every member of the military should receive the training, credentials and education needed to successfully transition to civilian society. That report is forthcoming and is widely expected to reform TAP, but no indication yet exists that any agency will be given responsibility for the transfer of service members from DOD’s purview and into VA’s. For more information on the White House directive to support military families, see The White House, *Strengthening Our Military Families*, PSD-9 (January 2011).
8. VA’s statutory mandate defines which veterans are eligible for which programs and services and when; the system of criteria is highly complex and notoriously difficult to navigate. A number of variables, sometimes but not always pertaining to eight distinct priority groups, determine one’s eligibility for pensions, burial options and disability compensation, as a few categorical examples. Generally speaking, those who were discharged under less-than-honorable conditions, or who served less than 90 days on active duty (with the exception of those who obtain a service-related disability prior to 90 days of service), are not eligible for VA programs and services. For more on VA priority groups, see <http://www.va.gov/healthbenefits/assets/documents/publications/FS164-2.pdf>. For more on eligibility for VA services, see http://www.va.gov/healthbenefits/resources/priority_groups.asp.
9. VA’s official mission statement is “To fulfill President Lincoln’s promise ‘To care for him who shall have borne the battle, and for his widow, and his orphan’; by serving and honoring the men and women who are America’s veterans.” See Department of Veterans Affairs, *Strategic Plan Refresh for FY2011-2015*, (November 2010), 5, http://www.va.gov/VA_2011-2015_Strategic_Plan_Refresh_wv.pdf.
10. The VA FY2011-2015 Strategic Plan identifies “Educate and empower Veterans and their families through proactive outreach and effective advocacy” as one of its three integrated objectives. See Department of Veterans Affairs, *Strategic Plan Refresh for FY2011-2015*, 23. As referenced in endnote 2, the fact that only 53 percent of eligible veterans of Operation Enduring Freedom, Operation Iraqi Freedom and Operation New Dawn have enrolled to use VA health services reflects the inadequacies associated with outreach to veterans of this generation. In addition, RAND’s 2011 study of veterans in New York indicates a clear increase in the demand for services from local, community-based providers. See Schell and Tanielian, eds., *A Needs Assessment of New York State Veterans: Final Report to the New York State Health Foundation*.
11. See endnote 7.
12. Department of Veterans Affairs, *FY 2013 Budget Submission*, (February 2012), 1B-1, http://www.va.gov/budget/docs/summary/Fy2013_Volume_I-Summary_Volume.pdf.

13. 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, from 1st Qtr FY 2002 through 4th Qtr FY 2011*, 5.
14. Department of Veterans Affairs, Monday Morning Workload Report, (March 26, 2012). As of March 26, 2012, 905,229 claims were considered pending, 66 percent of which had been pending for longer than the strategic processing goal of 125 days. Information on pending claims is updated and published every Monday and can be found at <http://www.vba.va.gov/REPORTS/mmwr/index.asp>.
15. Department of Veterans Affairs, *VA 2013 Budget Fast Facts*, (January 2012), http://www.va.gov/budget/docs/summary/Fy2013_Fast_Facts_VAs_Budget_Highlights.pdf.
16. The notion of bringing veterans "all the way home" is attributed to comments made by BG Loree Sutton, USA (Ret.), from the December 6, 2011 CNAS Joining Forces Community Models Working Group.
17. In the Glossary of Terms on page 36 of this report, the authors define "community" as a group of any size whose members understand their existence in relation to each other through shared residence in a specific locality; shared government; shared personal, occupational, vocational, recreational, cultural or other interest-informed experience; shared need; common cultural and/or historical heritage; or fellowship affiliation.
18. See endnote 4.
19. See Appendix B to this report for a list of working group participants. See also Center for a New American Security, "Community Models for Reintegration and Support," <http://www.cnas.org/communitymodels>.
20. In April 2011, the Center for a New American Security was selected as an independent research and analysis partner to the White House's Joining Forces initiative. This report complements and may inform the White House initiative but was conducted independently from that effort and was neither influenced by nor beholden to it.
21. Department of Health and Human Services, *National Prevention Strategy: America's Plan for Better Health and Wellness* (June 2011), 3, <http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>.
22. Department of Veterans Affairs, *Strategic Plan Refresh for FY2011-2015*, 5.
23. *Ibid.*, 61.
24. See references to "wellness," "well-being," "fitness," "readiness" and "resiliency" later in this report.
25. On October 28, 2011, the authors hosted the CNAS Joining Forces Wellness Working Group of over 30 leaders with expertise in the health and well-being of service members, veterans and military families. For the list of participants, see Appendix A.
26. Department of Veterans Affairs, "Amputee Marathon Man Inspires Vets Across the Nation," Washington, DC VA Medical Center, November 10, 2009, http://www.washingtondc.va.gov/news/veteran_runner.asp.
27. For other resources on the study of health, wellness, well-being and fitness, see Daniel Kahneman, Ed Diener and Norbert Schwarz, eds., *Well-Being: The Foundations of Hedonic Psychology* (New York: Russell Sage Foundation, 1999); Martin Seligman and Michael Matthews, eds., *American Psychologist*, 66 no. 1 (January 2011); Wayne Jonas et al., "Total Force Fitness for the 21st Century: A New Paradigm," *Military Medicine: International Journal of AMSUS*, 175 no. 8 (August 2010); Tom Rath and Jim Harter, "The Economics of Wellbeing," (Gallup Consulting, 2010); Richard Easterlin, "Explaining Happiness," *Proceedings of the National Academy of Sciences*, 100 no. 19 (September 2003), 11176-11183; and John Helliwell and Robert Putnam, "The Social Context of Well-being," *Philosophical Transaction of the Royal Society of London*, 359 no. 1449 (September 2004), 1435-1446.
28. World Health Organization, "Definition of Health," <https://apps.who.int/aboutwho/en/definition.html>.
29. Scores of definitions are available for the word "infirmary." For the purposes of this paper and the arguments it makes, the authors understand the term to mean any state of physical or mental health in which one's optimal state of well-being is changed or compromised due to weakness, frailty or debility. In reference to all living veterans of U.S. foreign wars (and not just those from post-9/11 conflicts), a recent report from the Pew Research Center suggests that "one out of every ten veterans alive today was seriously injured at some point while serving in the military, and three-quarters of those injuries occurred in combat. For many of these 2.2 million wounded warriors, the physical and emotional consequences of their wounds have endured long after they left the military." This paper argues that such consequences of infirmity do not preclude wellness. See Paul Taylor et al., "For Many Injured Veterans, a Lifetime of Consequences," (Pew Research Center, November 8, 2011), 2, <http://www.pewsocialtrends.org/files/2011/11/Wounded-Warriors.pdf>.
30. See Paul Taylor et al., "The Military-Civilian Gap: War and Sacrifice in the Post-9/11 Era" (Pew Research Center, October 5, 2011), 1-4, <http://www.pewsocialtrends.org/files/2011/10/veterans-report.pdf>.
31. For more on the Gallup-Healthways Well-Being Index partnership, see <http://www.well-beingindex.com/overview.asp>.
32. Rath and Harter, 3.
33. One of the "action imperatives" resulting from the 2000 review of Army well-being was to "use continuity and consistency of well-being programs across installations to maintain the integrity of the Army as an institution, and as a basis for metrics to track progress and success as defined by goals." See Robert Bray et al., "A Well-Being Framework for the U.S. Army," (U.S. Army War College, January 21, 2000), 30. See also Michael Mullen, "On Total Force Fitness in War and Peace," *Military Medicine: International Journal of AMSUS*, 175 no. 8 (August 2010), 1-2, <http://www.siib.org/news/1099-SIIB/version/default/part/AttachmentData/data/Total%20Force%20Fitness%20for%20the%2021st%20Century--A%20New%20Paradigm.pdf>.
34. The Army fitness model is psychologically based. See, for example, Christopher Peterson, Nansook Park and Carl Castro, "Assessment for the U.S. Comprehensive Soldier Fitness Program: The Global Assessment," *American Psychologist*, 66 no. 1 (January 2011), 10-18; and George Casey,

"Comprehensive Soldier Fitness: A Vision for Psychological Resilience in the U.S. Army," *American Psychologist*, 66 no. 1 (January 2011), 1-3.

35. Department of Defense, *Chairman's Total Force Fitness Framework*, CJCSI 3405.01 (September 1, 2011), A1-3.

36. For a concise summary of past DOD policies toward wellness of a reactive nature, see Beverley Land, "Current Department of Defense Guidance for Total Force Fitness," *Military Medicine: International Journal of AMSUS*, 175 no. 8 (August 2010), 3-5, <http://www.siiib.org/news/1099-SIIB/version/default/part/AttachmentData/data/Total%20Force%20Fitness%20for%20the%2021st%20Century--A%20New%20Paradigm.pdf>.

37. Some, but not all, of the semantic differences revealed in the working group can be ascribed to their relative foci on either veterans or service members specifically. Not surprisingly, differences in understanding of these terms were also drawn neatly between civilian and military personnel.

38. The reader should note that military experience is not the same for all service members. Some individuals may be affected by some but not all of the circumstances identified in the table. Consideration must be made for different experiences between those who saw combat action, for example, and those who did not, or those of the Active Component and those in the Reserve Component.

39. 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, from 1st Qtr FY 2002 through 4th Qtr FY 2011*, 5. For more on community-based providers providing healthcare to veterans, see Noel et al., "A Pilot Survey of Post-Deployment Health Care Needs in Small Community-Based Primary Care Clinics;" Terry Schell and Terri Tanielian, "Better Understanding the Needs of Veterans in New York State," Research Brief No. 9586 (RAND Corporation, April 5, 2011), http://www.rand.org/content/dam/rand/pubs/research_briefs/2011/RAND_RB9586.pdf; and Citizen Soldier Support Program, "Program Overview."

40. Other communities – such as friends, other Marines or soldiers, or one's faith community – are represented within the social and personal relationships component of the model as dynamic attributes of one's well-being.

41. See Center for a New American Security, "Community Models for Reintegration and Support," <http://www.cnas.org/communitymodels>.

42. Copeland and Sutherland, "Sea of Goodwill: Matching the Donor to the Need," 7.

43. This report concentrates primarily on the role of the nonprofit sector and on comprehensive reintegration models. Businesses across the country are likewise providing numerous opportunities for veterans where the government has not or cannot; employment, skills training, employee volunteers and corporate philanthropy are just a few examples of corporate citizenship in service to veterans. Most of these, however, are single-focus programs or morale programs rather than comprehensive reintegration efforts.

44. For further discussion, see James Garbarino, *Children and Families in the Social Environment* (New Brunswick: Transaction Publishers, 1992); and Urie Bronfenbrenner, *The Ecology of Human Development: Experiments by Nature and Design* (Cambridge, Mass.: Harvard University Press, 1979).

45. Certainly, the first Gulf War and other military events have called on service members and their families to deploy, serve and sacrifice since the advent of the all-volunteer force. The numbers deployed, length of deployment and nature of those operations, however, were of a significantly smaller scale than has been the case for Operations Enduring and Iraqi Freedom. Moreover, the unprecedented deployment levels post-9/11 of Guard and Reserve members, who live and work in civilian communities when not activated by the military, underscore the impact of military and veteran wellness as of concern to the civilian community.

46. See The California Wellness Foundation, "Grantmaking for a Healthier California," http://www.calwellness.org/about_us/mission.htm.

47. Lucie Rychetnik et al., "Criteria for evaluating evidence on public health interventions," *Journal of Epidemiology and Community Health*, 56 no. 2 (2002), 119, <http://jech.bmj.com/content/56/2/119.full.pdf>.

48. Ibid.

49. DOD, for example, enjoys a strong partnership with Operation Mend at the University of California, Los Angeles, a surgical reconstruction program serving the severely wounded. VA benefits appreciably from its partnership with the Fisher House Foundation, which builds housing for the families of VA patients on VA campuses. Both agencies enjoy significant contributions from the Intrepid Fallen Heroes Fund, which raises funding for and constructs world-class facilities that serve the wounded on-site at military properties. All are nonprofit organizations.

50. See the following section later in this report: *Common Challenges Facing Community-Based Veteran Reintegration Models*. Also, see Department of Veterans Affairs, *Strategic Plan Refresh for FY2011-2015*, 99.

51. For information on the working group participants, see Appendix B: CNAS Joining Forces Community Models Working Group Participants List. See Center for a New American Security, "Community Models for Reintegration and Support," <http://www.cnas.org/communitymodels>.

52. Although the authors understand the contributions of single-issue providers and morale-boosting efforts, the authors did not examine those sorts of endeavors. Single-focus providers and morale programs are examples of efforts that might fall under a comprehensive strategy but are not reintegration models per se.

53. Community foundations are tax-exempt public charities serving thousands of people who share the common interest of improving the quality of life in their community by administering, investing and leveraging the impact of funds established by individuals, families, businesses and organizations. According to the Council on Foundations, "All community foundations are overseen by a volunteer board of leading citizens and run by professionals with expertise in identifying their communities' needs. In the United States, community foundations serve tens of thousands of donors, administer more than \$31 billion in charitable funds, and address the core

concerns of nearly 700 communities and regions.” See Council on Foundations, “Community Foundation Services,” <http://www.cof.org/whoweserve/templates/311.cfm?ItemNumber=16057&navItemNumber=14849>.

54. The strategic and long-term use of community models as a fundamental component of a national veteran reintegration strategy will require proper resourcing, leadership and cooperation from pertinent federal agencies.

55. Most of the models presented at our working group include officials from the local VA campus – for example, the state adjutant general – or other military and veteran-agency leaders at the local and regional levels to participate in their efforts or to otherwise join in coordinating programs and services.

56. Arizona Coalition for Military Families, “ACMF Intro,” <http://arizonacoalition.org/about-acmf/acmf-intro>.

57. Communication between author Nancy Berglass and James Lorraine, Executive Director, Augusta Warrior Project, March 11, 2012.

58. For more information on CSSP, visit <http://www.citizensoldiersupport.org/>.

59. See Appendix B to this report for a list of working group participants. See also Center for a New American Security, “Community Models for Reintegration and Support,” <http://www.cnas.org/communitymodels>.

60. For more on this framework, see The California Wellness Foundation, “Grantmaking for a Healthier California.”

61. See Center for a New American Security, “Community Models for Reintegration and Support,” <http://www.cnas.org/communitymodels>.

62. The Council on Foundations (COF) defines a community foundation as “a tax-exempt, nonprofit, autonomous, publicly supported, nonsectarian philanthropic institution with a long term goal of building permanent, named component funds established by many separate donors to carry out their charitable interests and for the broad-based charitable interest of and for the benefit of residents of a defined geographic area, typically no larger than a state.” COF further notes that there are over 700 community foundations nationwide, representing the pooled assets of their communities; grants are usually researched and recommended by paid professional staff and ratified by a volunteer board of directors, on behalf of donors. See Council on Foundations, “Definition of ‘Community Foundations,’” (March 4, 2008), http://www.cof.org/files/Documents/Community_Foundations/commfounddef.pdf.

63. Unprecedented rates of post-traumatic stress, traumatic brain injury, abuse of prescription drugs, unemployment and homelessness have been well documented among post-9/11 veterans. See endnote 2.

64. These assertions were corroborated by field research conducted by the authors in September and October 2011, involving qualitative interviews with homeless veterans and social service providers in California.

65. For instance, as mentioned in endnote 7, the Departments of Defense, Veterans Affairs, and Labor are partner agencies in administering TAP, but problems with the program remain.

66. Robin Weinick et al., *Programs Addressing Psychological Health and Traumatic Brain Injury Among U.S. Military Servicemembers and Their Families* (Santa Monica, Ca.: RAND Corporation, 2011), 22 and 73, http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR950.pdf. Also, as referenced in endnote 2, the fact that only 53 percent of eligible veterans of Operation Enduring Freedom, Operation Iraqi Freedom and Operation New Dawn have used VA health services reflects the inadequacies associated with outreach to veterans.

67. President Barack Obama, “Remarks by the President on the Administration’s Work to Prepare our Nation’s Veterans for the Workforce” (Washington Navy Yards, Washington, August 5, 2011).

68. Berglass, “Investing in the Best: How to Support the Nonprofits that Serve Veterans, Service Members and Their Families.”

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APPENDIX A: PARTICIPANT LIST: CNAS JOINING FORCES WELLNESS WORKING GROUP

OCTOBER 28, 2011*

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* The professional affiliations noted here reflect those of each participant on the date of the CNAS Joining Forces Wellness Working Group.

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* The professional affiliations noted here reflect those of each participant on the date of the CNAS Joining Forces Community Models Working Group.

APPENDIX C: AN OVERVIEW OF FEDERAL AGENCIES' SERVICES FOR VETERANS AND THE MILITARY COMMUNITY

| WHAT CATEGORIES OF SERVICE-RELATED NEEDS ARE ADDRESSED BY WHICH GOVERNMENT AGENCY? | WHAT SERVICES DO THESE AGENCIES OFFER TO MEMBERS OF THE MILITARY AND VETERAN COMMUNITIES? | | | |
|--|--|--|---|---|
| | Department of Defense | Department of Veteran Affairs | Department of Labor | Department of Health and Human Services |
| Employment | <ul style="list-style-type: none"> Provides full-time employment for active-duty personnel Provides part-time employment for reservists | Assists disabled veterans* with vocational rehabilitation | Oversees veterans' employment issues for the federal government | |
| Housing | Provides housing for some active component and some reserve military personnel (although most receive a housing allowance and rent/buy their own housing) | Works with the Department of Housing and Urban Development to provide grants and vouchers to support housing for homeless veterans | | |
| Education | <ul style="list-style-type: none"> Provides professional training and education for active and reserve personnel Provides tuition assistance for active and reserve personnel Funds educational assistance tied to enlistment | <ul style="list-style-type: none"> Administers the GI Bill for veterans Provides vocational rehabilitation and education for disabled veterans | | |

| WHAT CATEGORIES OF SERVICE-RELATED NEEDS ARE ADDRESSED BY WHICH GOVERNMENT AGENCY? | WHAT SERVICES DO THESE AGENCIES OFFER TO MEMBERS OF THE MILITARY AND VETERAN COMMUNITIES? | | | |
|--|---|---|---------------------|---|
| | Department of Defense | Department of Veteran Affairs | Department of Labor | Department of Health and Human Services |
| Health Care | <ul style="list-style-type: none"> • Provides comprehensive, free health care for active-duty military personnel and their families • Provides comprehensive, free health care for reservists while they are mobilized • Provides TriCare (a type of HMO) for retirees** and military families | <ul style="list-style-type: none"> • Provides health care to eligible veterans on a prioritized basis (VA does not have the resources to provide health care to all 22 million eligible veterans) <ul style="list-style-type: none"> » Veterans with service-connected disabilities receive priority • Veterans of Iraq and Afghanistan receive priority during their first five years after active duty • Provides caregiver support services for some families of veterans injured in the line of duty | | <ul style="list-style-type: none"> • Provides Medicare and other health care support to veterans over the age of 65 • Supports medical care for indigent veterans through federal programs and grants to states |
| Case Management or Coordination of Multiple Need Categories | Provides some case management for severely wounded patients | Provides limited case management for homeless veterans | | |

* A veteran is defined in Title 38 of the U.S. Code as a person who has served in the active military, naval or air service (including reserve duty) and who was discharged or released under conditions other than dishonorable. A significant portion of the active-duty and reserve population counts under this definition as “veterans” even though they are still serving. Civilian government employees and contractors do not count as veterans under this definition, even if they deploy to Iraq or Afghanistan and serve with the U.S. armed forces there. A disabled veteran is a veteran who has been judged to have a service-connected disability, either by the Department of Defense or the Department of Veterans Affairs, with a rating of 0 through 100 percent.

** Retirees are military personnel who have formally retired from military service, usually after a career of 15 or more years of service. They receive a defined-benefit pension, as well as other benefits such as commissary access and health care. Retirees also include people who are medically retired from service, such as personnel who suffer extreme injuries in the line of duty.

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