2016 SYMPOSIUM REPORT

MANY NATIONS...ONE MISSION

RESILIENCE ★ RECOVERY & REHABILITATION ★ REINTEGRATION

Compiled by the U.S. Department of Defense Office of Warrior Care

Version 1.0
Executive Summary

This report summarizes presentations and discussions that occurred during the Warrior Care in the 21st Century (WC21) 2016 Symposium (“the Symposium”).

The United States hosted the second annual WC21 Symposium from October 25 – 27, 2016, in Tampa, Florida at MacDill Air Force Base and the James A. Haley Veterans’ Hospital. Over 120 attendees from 15 nations attended the three-day event, which centered on the three WC21 work group focus areas of resilience; recovery and rehabilitation; and reintegration of wounded, ill, and injured Service members. During the Symposium, over 20 speakers provided work group updates, guest speaker presentations, demonstrations of a force readiness modeling and simulation capability and telehealth medical communications software, and a guided tour of a polytrauma center for Veterans.

Following the Symposium, WC21 coalition members will continue to engage in work group activities. Canada will host the third annual WC21 Symposium in September 2017 in Toronto, Ontario.

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Introduction

For fifteen years, United States allies and coalition partners have suffered similar combat injuries. Although advances in battlefield medicine have increased severe trauma survival rates, the improvement to follow-on non-clinical care has not kept pace. Despite successful international collaboration efforts focused on military training and combat operations, efforts to improve non-clinical warrior care remains mostly isolated, leaving the potential benefits of international warrior care collaboration unrealized.

The need for multilateral collaboration was further amplified during the multi-national Recovery Summit, held in conjunction with the inaugural 2014 Invictus Games. Co-led by the United Kingdom and United States, the Recovery Summit initiated a multilateral conversation around warrior care that identified the need to establish a coalition of partnering nations. It was agreed that these nations would participate in regularly scheduled meetings to further Summit discussions, thus enabling partnering nations the opportunity to exchange information, develop, and validate workable solutions to short- and long-term challenges surrounding the resilience, recovery and rehabilitation, and reintegration of our wounded, ill, and injured Service members.

The Department of Defense (DoD) developed the Warrior Care in the 21st Century (WC21) Coalition using the United States Department of Defense “Continuum of Care” model as its foundation (Figure 1). The WC21 coalition incorporates the principles of the Continuum of Care into three focus areas or work groups: Resilience (Work Group 1 – led by Australia); Recovery and Rehabilitation (Work Group 2 – led by the United Kingdom); and, Reintegration (Work Group 3 – led by the Republic of Georgia).

![Figure 1. Wounded, Ill, and Injured Warrior Continuum of Care.](image)

The first WC21 Symposium (“the Symposium”) was conducted October 20-22, 2015, at the Uniformed Services University of the Health Sciences, located at Naval Support Activity Bethesda, Maryland. The event gathered senior personnel and medical leaders from 11 countries. Following the 2015 Symposium, a “kick-off” meeting was conducted in January 2016 to map objectives and identify WC21 coalition representatives to participate in each work group. Work group leads began conducting monthly meetings with their respective members, reporting progress to the co-leads and other work group leads during quarterly WC21 leadership meetings. Finally, the Department of Defense worked with the Uniformed Services University for Health Services, Bethesda, Maryland, to establish the International Warrior Care Portal (https://iwcp.usuhs.edu/) as an online

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1 Afghanistan (not able to attend), Australia, Canada, Denmark, Estonia, France, Georgia, Germany, Italy (not able to attend), Netherlands, New Zealand, United Kingdom, United States
resource collaboration tool for work group members. The portal is a joint hub to share publicly available policies, operational documents, research documents, and news stories related to warrior care.

The WC21 2016 Symposium included 18 nations\(^2\), focused on exploring topics identified by the work groups throughout the year. The first two days of the WC21 2016 Symposium, held at the Davis Conference Center at MacDill Air Force Base, consisted of plenary sessions surrounding each work group focus area. Work group leads shared their work groups’ progress through prepared briefings and conducted smaller breakout sessions with all attendees to address distinct discussion topics and inform work group efforts over the next year.

Day 1 focused on Work Group 1’s topic of resilience, and featured a review of 2016 objectives, lessons learned, and best practices. Additionally, day 1 featured a resilience-focused breakout session, and two guest speaker presentations. Day 2 featured Work Group 2 (Recovery and Rehabilitation) and Work Group 3 (Reintegration) 2016 reviews, and included two guest speaker presentations and a networking reception. Day 3, held at the James A. Haley Veterans Hospital, consisted of a moderated panel discussion on International and Interagency Relationships, guest speaker luncheon, facility tour of the Tampa Polytrauma Rehabilitation Center, and a demonstration of the United States Department of Veterans Affairs telehealth capability.

**WC21 2016 Symposium Opening Remarks**

**Leadership and Host Remarks**

Mr. James Rodriguez, Deputy Assistant Secretary of Defense for Warrior Care Policy and 2015-2016 Co-Chair, WC21, United States

Mr. James Rodriguez began the Symposium by thanking those nations returning from the 2015 Symposium and welcoming new participants attending this year’s symposium. He stressed the importance of continuing to build on what the coalition learned during last year’s Symposium by identifying innovative concepts and best practices related to the challenges that wounded, ill, and injured Service members face. Mr. Rodriguez then focused on

\(^2\) Afghanistan, Australia, Canada, Denmark, Estonia, France, Georgia, Germany, India, Italy, Jordan, Lithuania, Netherlands, New Zealand, Romania, Ukraine, United Kingdom, United States.
the importance of thoroughly examining the research presented by each of the work groups to ensure nations leave with the best outcome possible for their wounded, ill, or injured Service members. His points were further amplified in the opening video that highlighted the significance of each work group.³

Colonel Cary Harbaugh, Director, United States Special Operations Command (USSOCOM) Care Coalition

Colonel Cary Harbaugh expressed the USSOCOM Commander’s gratitude and interest in the Symposium, and in seeking the best possible care for wounded, ill, and injured Service members among all partnering nations. The Care Coalition provides recovery care and unit reintegration programs for USSOCOM Service members. Current challenges include growing numbers of Traumatic Brain Injury (TBI) and Post-Traumatic Stress (PTS). Both conditions are “invisible” and often misunderstood or misinterpreted. The Care Coalition currently provides recovery, care, and advocacy for over 10,000 Special Operations Service members, Veterans, and family members across the joint force care program.

Many Special Operations activities are executed in alignment with coalition partners. Because of this, USSOCOM maintains a robust coalition representation and allocates Care Coalition resources to the greatest possible extent for the care of wounded, ill, and injured Service members of partnering nations. The Care Coalition benefits from collaboration with the Department of Veterans Affairs, initiatives within the Department of Defense, Warrior Care programs throughout the United States military departments, medical research and treatment facilities, and community-based organizations.

Dr. Karen Guice, Acting Assistant Secretary of Defense for Health Affairs (AASD(HA))

“The best offense is a good defense.”

On behalf of the United States Secretary of Defense, and Acting Under Secretary of Defense for Personnel and Readiness, Dr. Karen Guice stressed that all attendees share the common goal of providing the best care for our wounded, ill, and injured Service members. This must include care that extends after the wounds heal and into recovery and reintegration. In addition to the non-medical aspects of warrior care, she recommended that participants focus on infections, halting epidemics, and improving medical logistics which reinforce the importance of collaboration and sharing common challenges that can lead to innovative solutions. She ended her remarks by stressing that now is not the time to become complacent or lose focus, rather participants must anticipate future challenges: “The best offense is a good defense.”

³ The video that opened the WC21 2016 Symposium can be viewed at https://www.youtube.com/watch?v=JiR3ZvCRWEc.
Warrior Care in the 21st Century Review

Mr. James Rodriguez, Deputy Assistant Secretary of Defense for Warrior Care Policy, and 2015-2016 Co-Chair, WC21, United States

Brigadier Timothy Hodgetts, Medical Director for Defence Medical Services, and Co-Chair, WC21, United Kingdom

The WC21 coalition co-chairs, Mr. James Rodriguez and Brigadier Timothy Hodgetts, explained that the Symposium is designed to: 1) provide opportunities for networking and informal conversation; 2) consider the body of work undertaken as a result of the 2015 Symposium; and 3) identify objectives of each work group for 2017.

Lieutenant General Richard Nugee, Chief of Defence People, United Kingdom

Lt Gen Richard Nugee, the senior-most United Kingdom representative in attendance, addressed the importance of developing both physical and mental resilience in Service members to further enhance readiness. Specifically, he stated, “It’s important that each nation turn their brilliant and brave soldiers into a much tougher group, so that when they do hit shock and trauma ... they can cope with it better.” Lt Gen Nugee noted that resilience is the area “where we are still pushing the bounds” and emphasized the need to make Service members better able to cope with the rigors of “what we, as generals, throw at them when we push them into battle.”

Modeling Force Readiness: IDES Simulation Modeling Tool

Dr. Ray Nason, Senior Associate, Booz Allen Hamilton (United States)

To further understand the importance of better preparing the force, a member of the Office of Warrior Care Support Team presented the Integrated Disability Evaluation System (IDES) Simulation Modeling tool that provides the Department of Defense and Military Departments the opportunity to readily assess the impact of increases or decreases in the number of Service members moving through disability process has on overall readiness.

The complex nature of the world and on-going conflicts presuppose that Service members often come home with a wide variety of combat-related injuries and illnesses. In 2007, the Disability Evaluation System (DES) Pilot was formed to improve the consistency and timeliness of disability evaluations as well as expedite the delivery of Veterans Affairs benefits to our Service members. Later named the Integrated DES (IDES), the newly developed disability system integrates independent Department of Defense and Department of Veterans Affairs disability evaluation processes into a single, more efficient solution. While the IDES has seen significant timeliness benefits in comparison with the original DES, the Office of Warrior Care Policy (WCP), in its constant efforts to improve upon IDES timeliness, began development of the IDES Simulation Model.

The IDES Simulation Model is a discrete event model, simulating the Integrated Disability Evaluation System process. The simulation looks at a wide variety of historical IDES data and Subject Matter Expert input. It simulates the processing of both historical and projected cases through the IDES, thus allowing the user to perform verification and validation of the model results, and run a variety of “what-if” scenarios. For example,
what if the US entered a new, major ground conflict and cases referred into the IDES spiked for a short period of time? If nothing in the DES process changed, how long would it take to recover and continue to meet timeliness goals. How long would it be until we see the impact of that demand spike? What resource reallocation could be done to minimize the impact of this increased demand, while minimizing the cost of hiring new resources?

The IDES Simulation Model operates with up-to-the-minute accuracy, tracking Service members from the moment they are referred for an injury or illness to the moment they return to duty or begin the military-to-civilian transition. The model provides a robust simulation capability for measuring and projecting disability related impacts to force readiness.

Focus Area: Resilience

Resilience is one of the three primary warrior care focus areas of the WC21 coalition, and is supported by WC21 Work Group 1. The goal of Work Group 1 is “to improve efforts to build and maintain resilience levels in Service members and their families.” During the 2016 Symposium, several activities centered on resilience, including a guest speaker presentation by a representative from the Walter Reed Army Institute of Research, United States, a presentation by the WC21 Work Group 1 (Resilience) Lead, and group breakout sessions with group outbriefs.

Guest Speaker Presentation: Resilience and Early Interventions: A Military Occupational-Health Perspective

Dr. Amy Adler, Clinical Research Psychologist at the Walter Reed Army Institute of Research

Dr. Adler’s presentation was structured around the occupational context of the military, Service members seeking treatment, and resilience training methodology. Dr. Adler stressed that military organizations cannot use civilian sector practices and apply them to the military without first considering the occupational context of the military. Likewise, military organizations must be sensitive to the way in which Service members seek care, and the attitudes that will influence that choice. Finally, military organizations have a chance to build resilience, but there are specific ways to boost the efficacy of resilience training programs.

Accounting for the occupational context of the military, the speaker described the Occupational Health Model, which aims to improve occupational health by accounting for the individual’s background and influences. The model distinguishes between demands (e.g., getting along with peers and superiors, and trauma), outcomes (reactions such as symptoms or any range of feedback), and goals (e.g., health, work, relationships, and life enjoyment). The model provides a context for observing which personal resources and occupational resources are important. Personal resources, which can play a role in the model as a result of demands or outcomes, includes coping strategies, such as the importance of acceptance in the civilian world, as found in a United States-Australia joint study, and social support. Occupational resources include training opportunities, unit support, and leadership influence on the individual. Each of these factors need to be acknowledged when determining proper practices and care for Service members. However, treatment remains a component of this
model because Service members, both active duty or post-Service, can still struggle despite having access to the best resources available. Dr. Adler’s team worked to determine whether there is a link between Service members’ attitudes and their decisions to seek or avoid treatment. Her study used age, rank, gender, and presence of post-traumatic stress as categories, and found that rank had a significant effect on mental health care utilization. The study evaluated stigma, practical barriers to care, positive attitudes, and self-management. The team determined that stigma may not be the most significant variable in seeking treatment; rather, positive attitudes and self-management can have a greater influence. Given this finding, the speaker recommends that military organizations take a different approach to how they provide care. Specifically, introducing the Service member to a coaching model rather than connect to a Service member through broad, indirect communications and messaging campaigns.

Historically, United States Army training programs teach universal skills such as cognitive behavioral education, self-control, attention control, and goal setting. There is evidence that this approach is effective at stages throughout the Service member’s Service cycle, including basic training, pre-deployment (e.g., in reducing anxiety), post-deployment, as well as social fitness training within work groups, which reduces loneliness and possibly suicide, by extension. Dr. Adler noted that “one-size-fits-all” training is parallel to the approach that militaries typically take in other forms of training, such as combat-related training. This also relates to the importance of an awareness of the “military context.” Studies that show “universal” training works found small effect sizes—0.2-0.3% of the population. Even though the effected population is small, this means that about 500,000 Service members are receiving some form of support. Effects of these trainings are still significant, though not sufficient.

The United States Army tends to regard Service members as having similar psychological states, thus justifying similar treatment for all Service members. However, Service members’ psychological states vary across a wide spectrum and require different care techniques. Therefore, training should be tailored to each Service member’s “individual stage of thinking,” as described in the “Stages of Change Model.” The “individual stages of change thinking” include: Pre-contemplation (uninterested), Contemplation (mildly interested), Preparation (taking mental steps), Action (active steps), and Maintenance (maintaining change).4 Under the “Stages of Change Model,” the individual in Pre-Contemplation thinks, “I don’t need it”; a person in Contemplation or Preparation thinks, “I hope training will help me understand myself better”; someone in the Action stage thinks, “I have been practicing resilience”; and the individual in Maintenance thinks, “I want to continue practicing resilience.” The study indicated that individuals in Pre-contemplation express more symptoms than individuals in the Preparation and Action stages. The speaker suggested that implementation

4 The type of intervention provided would differ based on the individual’s stage. If a Service member is at the pre-contemplation stage, for example, he or she needs to know the risks of not changing, as opposed to knowing how to change.
of the “Stages of Change Model” would signify a move away from a one-size-fits-all system, resulting in clinicians thinking in terms of a precision medicine model, through tailoring information to subgroups.

The last area addressed by Dr. Adler described the role of leaders, and the leaders’ ability to build resilience within the military organization. Leaders make a critical difference in each Service member’s success. Effective leadership correlates with better mental health in civilian, peacekeeping, and combat scenarios. General leadership skills are relevant in many situations and span transactional or transformational behaviors. Borrowing from the civilian-based concept of “domain-specific leadership,” which focuses on drawing discrete leadership behaviors into practice, previous research in safety-specific, health-specific, and family-supportive leadership might be applicable to the military. Dr. Adler’s team has experimented with applying several of these concepts to the military, as outlined below.

- **Combat and Operational Stress Control (COSC) leadership** is one existing methodology that identifies a set of behaviors associated with effective leadership. The speaker and her team codified these behaviors in a manual and distributed the manuals among leaders in the military. A survey presented to Service members determined that COSC Leadership behaviors accounted for better behavioral health outcomes, such as lower symptoms, greater care seeking, and more comfort speaking with a behavioral health provider. Therefore, providing guidance through COSC or similar principles to young leaders responsible for the mental health of Service members may prove effective.

- **Health-promoting leadership**, such as emphasizing professional standards, physical care, mental care and similar health-promoting leadership behaviors to Service members was found to predict “burn-out.”

- **Resilience training leadership** showed that training seemed more useful and improved unit climate from its presence. This entails holding leaders accountable for resilience training, showing an interested in receiving resilience training, and encouraging resilience skills in conversations within their units. Service members reported enjoying resilience training more if their leaders had also been engaging in these trainable behaviors to reinforce resilience. Resilience training is feasible for junior leaders in particular, and improves organizational support and cohesion.

These examples demonstrate that leadership holds an important role in resilience, and the importance of military organizations engaging leaders more directly and individually to leverage benefits across entire units. Lastly, resilience training can be more personalized with training programs matching Service members to the appropriate form of training. Dr. Adler closed by indicating additional research will include studies on sleep leadership, post-traumatic growth leadership, and emotion regulation leadership.

**Work Group 1 Introductory Presentation**

Mr. David Morton, Director, General Mental Health for Psychology and Rehabilitation, Australia, and Lead, Work Group 1 (Resilience)

Mr. David Morton provided a summary of the work group’s efforts over the last year. He outlined Work Group 1’s four objectives and noted that while the group critically reviewed each objective, they determined there was a need to sharpen Work Group 1’s focus to ensure their results were feasible. The four objectives include:
• Identify a flexible definition of “resilience”;
• Establish feasible metrics, collection techniques, and reporting methods to measure program effectiveness;
• Identify practices that incorporate Service members’ families into resilience training; and
• Outline criteria for a longitudinal study to address Post-Traumatic Stress.

**Objective:** Identify a flexible definition of “resilience”

Potential definitions of “resilience” generally pertained to the capacity to recover and thrive; the physical and psychological ability to cope with adversity; situations of risk; potentially traumatic events; challenging environments—which may exist within a Service member’s garrison, training, operational deployment, and personal life; and the ability of a Service member to remain operationally effective. The Group ultimately took a holistic approach to defining “resilience”, beginning with an existing working definition formulated by The Technical Cooperation Program (TTCP) Action Group (AG) 21 – Resilience, which incorporates the military concepts of transition and recovery. Based on their research, WC21 Work Group 1 recommended the WC21 coalition adopt the following definition for resilience:

> “Resilience is the capacity of the individual, team, and organization to recover quickly, resist, and possibly even thrive in the face of direct/indirect stressors and adverse situations in garrison, training, and operational environments. Building and sustaining resilience involves a range of psychological, social, and environmental factors and is critical to mission performance and an individual’s well-being over the course of his or her career. This includes during transition and recovery, following illness or injury, to return to duty or civilian life.”

**Objective:** Establish feasible metrics, collection techniques, and reporting methods to measure program effectiveness

The ability to determine the efficacy of resilience programs requires a thorough understanding of the drivers and outcomes of resilience. Being able to identify the medium- and long-term effects requires one to focus on identifying the methods of measurement. As noted by the Work Group 1 Lead, “The solution is resilience. What we are looking for is the problem.” Resilience has become a popular improvement topic supported by good intentions. However, there is the possibility that the enhanced focus on resilience comes with unrealistic expectations. Commanders may endeavor for their Service members to meet extremely high levels of resilience which may be difficult to achieve unit wide. Military organizations investing a lot of resources in resilience improvement efforts may expect immediate or significant outcomes. Service members and their families may also form unrealistic expectations for resilience, such as underestimating detrimental stressors or assuming that resilience issues will not affect their duty performance.

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5 The Australian Director General Mental Health for Psychology and Rehabilitation noted that this definition is similar to the version formulated by The Technical Cooperation Program (TTCP).
Some wounded, ill, and injured Service members are “not necessarily starting with a clean slate.” Many Service members have participated in a range of resilience programs, often required by their militaries and leadership, and consequently display characteristics of resilience prior to the stage of becoming wounded, ill, or injured. This makes measurement of resilience challenging, with underlying causes of resilience issues or strengths often difficult to trace back to specific sources.

Work exists in several countries on resilience measurement and reporting, with some nations recently applying newly developed techniques. For example, the Australian Navy has recently developed its resilience plan, which focuses on the mind, spirit, physical, and external factors, while the Australian Army is summarizing outcomes of an internal qualitative study on flourishing, with the intent of applying the findings to resilience program improvement efforts.

Objective: Identify practices that incorporate Service members’ families into resilience training

Work Group 1 recognizes the need for a holistic approach to addressing resilience, to include all factors, even beyond designations of medical and non-medical. It is important to look “beyond the individual” by determining the levels for resilience among other stakeholders, such as whole units, peers, and families.

As families are one of the critical influencers of a Service member’s general health and wellbeing, they must be included in resilience improvement efforts. Several family resilience programs were highlighted by Work Group 1. For example, The Netherlands has an adaptive parenting tools program for families experiencing reintegration difficulties post-deployment. Canada employs the Road to Mental Readiness, its mental health and awareness resilience training program for all Service members and their families. This program has evolved and adapted to changing training needs over time. Australia runs programs such as FamilySMART for Service members’ families and LifeSMART for Service members transitioning to civilian life.

Objective: Outline criteria for a longitudinal study to address post-traumatic stress

The work group determined that the issue of focusing on post-traumatic stress alone was too narrow. Research in Australia and other countries suggest that post-traumatic stress and deployment are not sole sources of mental health conditions for wounded, ill, and injured Service members. The work group discussed broadening the language of the objective from referencing solely post-traumatic stress to also include post-traumatic mental health and a range of other mental health conditions.

The Work Group 1 Lead encouraged WC21 coalition members to capitalize upon existing knowledge and focus new efforts on filling apparent gaps in the understanding of mental health conditions related to resilience. He noted there are several existing longitudinal studies evaluating resilience, such as one currently being conducted by the Australian Defence Force to evaluate coping styles, entry behaviors, and entry attitudes beginning with training and over five-point periods over a span of three to four years. The study covers enlisted Service members and officers, and has provided information regarding the impacts of pre-enlistment traumas, alcohol use and smoking, and their relationship, if any, to the eventual appearance of mental health issues.

The Australian Department of Veterans’ Affairs, Department of Defence, and a consortium of universities are collaborating on the Transition and Wellbeing Research Programme, which evaluates the transitions of current and former Service members, reservists, and their families. This study seeks to determine the prevalence of
issues, and how individuals access services. The use of services includes whether Service members continue using the same services after transition as they did during military service, their use of technology, and whether they are exercising self-management above other provided services.

Mr. Morton suggested attendees need to appreciate the differences of their Service members’ experiences and needs, especially in determining treatment programs. He displayed an example framework (Figure 3) that Work Group 1 will update to support development and implementation of resilience programs.

![Figure 3](image)

Figure 3. A framework to guide practice in strengthening resilience in wounded, ill, and injured.

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<tr>
<th>Factors — Levels</th>
<th>Factors associated with resilience</th>
<th>Expectations, role and responsibilities</th>
<th>Resources they require</th>
<th>What success looks like – Outcomes</th>
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<td>Broader community stakeholders</td>
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Other areas determined to be important include: leadership/whole-organization, or “systems” approach; awareness of the benefits of individual readiness and self-management; realistic Service member and families expectations of resilience and recovery for various conditions; recovery orientation program integration; utilizing the deployment cycle to access unit members and help their transition to the workplace; integrated resilience training; engaging families in the process; and objective metrics that show individual and unit impact.

Work Group 1 believes there must be agreed common issues and standards of practice to inform, transition from care to return to duty, and transition from military to civilian life. These standards should apply to both Service members and their families.

Work Group 1 Breakout Session and Outbrief/Discussion

During each breakout session, attendees were divided into four “breakout groups” to focus, by means of smaller, open discussions, on questions related to the work group at hand. The following information summarizes the specific questions posed to each breakout group and the discussion findings that each group briefed to the WC21 coalition.
Discussion Question 1

What are some of the tangible characteristics, skills, and knowledge that individuals and families require if they are to transition effectively back into the military, back into the community, and ultimately into employment?

Common Themes

- Individuals, including Service members and family members, need to be knowledgeable about what resources are available to them and how to access those resources.
- Resilience programs should encompass a variety of focuses, such as training, financial planning/budgeting, psychology, problem solving, and self-awareness, among others.
- Both individuals and families require self-management, resourcefulness, and adaptability.

Characteristics

Several tangible characteristics necessary for individuals and families were identified during the breakout discussions. These tangible characteristics included the courage to seek help, motivation, self-confidence, realistic aspirations, a positive view of personal/family life, a flexible attitude, and a forgiving personality and team mentality (“team care”). Attendees recognized self-management as a tangible characteristic for individuals and families, including the ability to make one’s own choices and having the information required to make informed decisions. Despite unanimous agreement on the importance of self-management, attendees questioned whether evidence exists to prove that intervening with self-management training increases resilience levels.

Attendees also identified resilience characteristics that may be more heavily influenced by external factors, such as military role, family, and peer relationships. These characteristics included individual responsibility and accountability, physical and psychological readiness, a sense of purpose, a societal role, and toleration of hierarchical organizations.

The group suggested that research is needed to measure the ability of the individual or family to tolerate uncertainty and apply psychological skills, including the abilities to solve problems and break down large obstacles into a series of smaller, less daunting steps.

Skills

Breakout discussions resulted in several identified skills that Service members and families should learn to achieve resilience. Among them were emotional intelligence, adaptability, and flexibility. The ability to self-reflect was also highlighted, especially in the context of self-identifying symptoms related to resilience issues. Clear communication and the drive and ability to take initiative were also identified as important skills supporting resilience.
Knowledge

Compared to tangible characteristics and skills, knowledge is considered more difficult to instill. Efforts to truly impart resilience concepts into the beliefs and thought processes of Service members and families cannot be taught in a single class, but requires a more strategic and long-term investment. As discussed during the breakout sessions, Service members need to know they will not be “left behind” or forgotten. The belief that “resilience is the norm”, combined with the knowledge that resilience support programs and resources exist and are easily accessible, may encourage Service members and families to participate in resilience programs, seeking and accepting help when necessary.

Service members and their families should also understand logistical aspects that may affect resilience, such as the length of their deployment and leave times, the amount of time required to prepare to return home, and expectations on what life will look like during and after the process of transitioning to civilian life. Anticipating changes to one’s role in a family, military unit, and broader community will allow Service members to more easily adapt to and embrace these changes, whereas those who do not accept the likelihood of these scenarios may experience more shock and difficulty adjusting to these and future changes.

Discussion Question 2

Is there a shared responsibility between the military member, their family, command, the organization, and the broader community to achieve better health outcomes through improved resilience? If so, do our current approaches to building resilience and measuring effectiveness reflect this relationship, and what is the role and responsibility of leaders?

Common Themes

- Yes, there is a shared responsibility between all stakeholders to achieve better health outcomes through improved resilience.
- The chain of command assumes a greater share of this responsibility, and confidence is essential.
- Leadership must be educated to engage appropriately, as required. Leadership must also address the needs of family members.
- Family programs are important to the operational readiness and efficacy of each Service member.

Shared Responsibility

Attendees agreed unanimously that a shared responsibility exists to achieve better health outcomes, particularly because it generates accountability among all stakeholders. However, group participants questioned at what point the responsibilities need to be shared. Attendees agreed that there is a shared responsibility among all parties involved, but that there is unequal sharing. The group questioned whether primary responsibility falls to the individual, who must have a general level of culture and education.
One group formulated its response through categories of “internal” and “external” factors. External factors were Social, Technological, Economic, Environmental, Political, Legal, and Ethical (STEEPLE). Sub-factors were changing family dynamics; gender-based differences, especially with the increase in feminization in the combat role; the notion that technology could be an enabler, but could also undermine a deployed individual through accessibility from home; changing family dynamics. In addition, culture, ethnicity, and nationality (in a multinational setting) could all have an impact on requirements for tailored resilience development.

Internal factors were Training, Equipment, Personnel, Information Systems, Doctrine, Clinical, Organization, Infrastructure, Logistics (TEPID COIL). Training cannot be “one size fits all”: training must include generic awareness and education, “enrichment training,” and a form of screening. Canada’s “Road to Mental Readiness” is a good example that adapts the effort to the target audience. Selecting the right trainer is important, as is “training the trainer” and “training the leadership”. Service members must have trust in the process—this also reduces stigma. Training should be a life-long process, with touchpoints throughout Service member’s career. In terms of clinical sub-factors, the group noted the impact of comorbidity, both physical and psychological.

Military Member

At times, the family, command, and the broader community will need to make the decision to help the Service member if the Service member cannot or will not seek help. Group participants noted that 70% of Service members who do not seek help do so because they want to deal with conditions themselves. However, the group noted that Service members may be significantly underestimating the seriousness of their conditions.

One group listed better care, prevention, and a better support environment, which depends on the level of resources and whether resources are individually-based. They believe that early detection is paramount to achieving better health outcomes.

Family

Family programs are important for the operational readiness and efficacy of the Service member. Families can be fragile during a Service member’s deployment and an organization-based perspective on families might exclude non-standard, complex families. Family members need to know what to expect and how to identify issues, and leadership needs to realize that families may not know or see the hidden wounds of war. Finally, family members should know how to improve the resilience of the Service member as well as all their family members.

Command

Confidence in leadership is important because there is an expectation of reciprocity between leadership and staff. The chain of command instills confidence throughout the organization. Therefore, commanders need to

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6 Breakout Group B combined Discussion Questions 1 and 3 by listing tangible characteristics, skills, and knowledge within internal and external factors. Breakout Group B split into two separate groups during the Breakout Session—one group to focus on internal factors, the other to focus on the external. The facilitator for Breakout Group B presented participants with two anagrams, STEEPLE and TEPID COIL, through which to view various factors and characteristics related to resilience.
be educated on becoming engaged when they see Service members in need. Commanders must realize that the family may be affected as well. Commanders are responsible for training, education, and providing a climate that encourages use of available programs.

**The Organization**

One group asked, “Does building organizational resilience affect the individual’s resilience?” Military organizations should communicate the expectation to Service members that injuries and illnesses occur.

**The Broader Community**

Spiritual resilience is an area where members of civil society can take greater responsibility for Service member resilience. This includes trained chaplaincies and community support networks. Spirituality can also facilitate Service members’ acceptance of injuries. Attendees stressed that peer-to-peer support among former active duty Service members is critical to instilling resilience in younger Service members.

**Current Approaches and Recommendations for the Future**

Some attendees noted that current approaches do not reflect a shared responsibility. Group members noted that resilience efforts are “working too much at the individual level,” and that policymakers must broaden their approach.

Measuring the effectiveness of resilience training and current approaches to building resilience have made significant changes in program effectiveness. Military organizations and researchers should study populations identified as more resilient and populations identified as at-risk to determine characteristics that enhance resilience in Service members and their families.

Some people may not be aware of the realities of deployment. Building resilience varies based on each situation and individual involved. One group stressed the need to focus on raising awareness and coping skills.

Building resilience should be personalized to the individual and family.

**Discussion Question 3**

What are the factors associated with resilience at the levels of individuals, family, the Unit, the military organization, and the broader community?

**Common Themes**

- Strong leadership is an important factor of resilience.
- The individual should be able to withstand adversity and demonstrate psychological skills and flexibility.
- Community leaders are critical in pivoting the focus to Veterans.
- Community leaders must prepare the community and guide the community on how to help.

“Does building organizational resilience affect the individual’s resilience?”
• Community leaders dictate policy, compensation, the community’s view of the military, and the extent of community engagement.

Individuals
Attendees determined opposition to dependency; leadership, education, and confidence in themselves; their equipment; and tactics, techniques, and procedures (TTPs) as key factors for individuals’ resilience.

The resilient individual should be able to withstand adversity and tolerate uncertainty, as well as maintain a flexible attitude and psychological skills, including the ability to solve problems and break down large obstacles into a series of steps.

Service members must have the opportunity during training to practice these skills. These skills must be attained first-hand and through experience, rather than through presentations. Mental training may be helpful as well as debriefs to inform Service members of available tools.

The Family
At the family level, spouses are important. A spouse may reduce a Service member’s resilience if he or she leaves during the Service member’s service. Resilient families possess security; knowledge of resources; cohesion; and an understanding of military training, which provides peace of mind, family values, realistic expectations, and the ability to cope with a lack of communication. Leadership and education are important to the Service members and their family members.

The Unit
Performance optimization is a critical factor at the unit level. Resilient units possess leadership, security, reputation, accomplishment, mission, cohesion, welfare support, training, and resources.

The Military Organization
Command leadership confidence is critical in military organizations. The resilient military organization possesses solid senior leadership, strategic objectives, resources, and vision.

The Broader Community
Community leaders are critical in pivoting focus to Veterans. However, some communities are not immediately prepared to support Service members and Veterans and need guidance on how engage support networks, including spiritual organizations, to assist Service members and their families.

“How can and does the broader community contribute to resilience?”

One group asked, “How can and does the broader community contribute to resilience?” Lessons from the Vietnam War show how the community can affect outcomes. Members of the US Reserve Component might experience different reception from the broader community in contrast to experiences of active duty personnel.
Canada’s Soldier On allows Service members to see and learn from their former active duty peers’ successful transitions. This contributes to peer support in the community.

One group highlighted courage of convictions in military organizations, including a sense of purpose and a connection to the larger group, as a key component of resilience.

Discussion Question 4

Most research has focused on resilience in individuals but the concept is also being seen as related to systems of families, workplaces, organizations, and communities that the person is engaged with or a part of. What are the implications of this for the range of programs required and the impact of those?

Common Themes

The availability, distribution, and investment of resources has a strong effect on the degree of resilience across the military organization.

Implications of Multi-Factor Approach

Attendees determined that programs cannot only focus on the individual level, but must also be focused on family, leadership and community support with linkages and interplay between the various levels. Attendees noted that a “systems” approach has inherent complexities – in any complex system, the seams between the various components are where the greatest issues arise. As scope widens and components increase, so do the challenges. The distribution and investment of resources, particularly from one branch of the military to another, is one implication that affects resilience across a military organization.

Realistic expectations are necessary, as it is difficult to improve the resilience of systems for communities, families, and organizations. This challenge is compounded when military organizations must devote resources primarily to managing and building resilience of the individual. Still, it is important to acknowledge when and issue exists and that the organization is trying to address it. Resilient organizations are created through selecting resilient people or finding “ordinary” people and deriving excellence from these people (this is the more difficult option).

Questions Raised

“How does remoteness of deployment and access to technology, or lack thereof, impact deployed resilience?”

“How does the individual out of contact demonstrate a greater deployed resilience than one who can be easily contacted by his or her family?”

“How does the military deliver information to families?”

“Does the resilience of families (regular versus reserve; individual augmentee versus unit; different services) vary because of how they live?”

“Can we enhance family resilience by giving a formal ‘role’ for supporting resilience training with other families?”

“What are the metrics of success for resilience?”

“Are metrics such as reduced divorce rate, reduced suicide rate, sustained employment, etc. valid?”

“Do we understand how the
different target audiences for potential resilience training best want and optimally receive their training information?” “Is it possible to capture and measure ‘gut feel’ of the Stage 1 training instructor?”

**Research Implications**

Research is driven by the ease of measuring and testing. The ability to research and measure workplace resilience is difficult given the variant factors of mission, training, individual influences, level of confidence in one’s ability, and family situation. Some would offer that resilient people create resilient organizations.

**Focus Area: Recovery and Rehabilitation**

Recovery and rehabilitation is the second warrior care focus area, supported by WC21 Work Group 2. The goal of Work Group 2 is “to improve efforts to support Service members and their families for success during recovery and rehabilitation.” During the 2016 Symposium, several activities centered on recovery and rehabilitation, including a presentation by WC21 Work Group 2 (Recovery and Rehabilitation) and group breakout sessions and outbriefs.

**Work Group 2 Introductory Presentation**

**Brigadier Timothy Hodgetts**, Medical Director for Defence Medical Services, United Kingdom, and Lead, Work Group 2 (Recovery and Rehabilitation)

Brigadier Timothy Hodgetts delivered a presentation to review the four Work Group 2 objectives taken on by the group following the WC21 2015 Symposium. He stated there has been substantial output across all partnering nations with respect to all four objectives and provided evidence of the progress against each objective.

**Objective: Conduct a gap analysis to identify current deficiencies with family support**

The Families OverComing Under Stress (FOCUS) Project in the United States, which provides family resilience services, is an example of a gap analysis of family support. In the United Kingdom, an interim report from Scotland studies mental health outcomes in patients and their relatives.⁷

**Objective: Identify methods to make patient transitions and handoffs seamless**

On supporting seamless patient transition, the speaker referenced the Canadian Forces 2016 Ombudsman Report, which identified three key recommendations for how to improve the transition from service to the

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civilian setting: retaining the Service member until all benefits and services are in place; having a “Concierge Service” and single point of contact for Service members and their families; and having a singular web portal for multiple agencies. The Australian Defence Force has improved separation health examination during service, in terms of both access to health examinations and the content of the health examinations, with the addition of psychological stress indicators. Australia has also focused on facilities for health assessments after the Service member’s release to the Department of Veterans’ Affairs. In the United States, the Health Artifact and Imagery Management Solution (HAIMS) provides access to Service members’ records, including documents, images, radiographs, and files, after the completion of military service. The United Kingdom has introduced Osseo integration as an opportunity for amputees with high amputation (above knee) and low possibility of mobility.

**Objective:** Identify ways to improve stakeholder and civilian knowledge of military medicine and mental health injuries

Enforcing a “learning organization” approach throughout the military organization is key to improving stakeholder knowledge and intellectual capital. Learning organizations transmit information effectively throughout the organization and to audiences. The Department of Veterans Affairs plays an important role in physician training and implementation of learning organization methodology in the United States. Canada is an example of effective distribution of learning, specifically regarding psychological wellbeing and through the use of online materials. The United Kingdom is currently assessing how to codify findings, practices, and progress from Queen Elizabeth Hospital Birmingham, the United Kingdom’s primary hospital for Service members, and circulate data effectively to other hospitals in the United Kingdom.

Finally, the work group lead indicated that by participating in the WC21 2016 Symposium, attendees fulfill five critical criteria for qualifying as a “learning organization”: learning from others; learning from recent experience; showing evidence of transferring knowledge within individual organizations and between organizations; experimenting with new approaches regarding physical and mental rehabilitation and recovery; and trying to solve issues systematically. Using a quote from B. H. Liddell Hart: “The one thing harder than getting a new idea into the military mind is getting an old one out”, the Medical Director for Defence Medical Services, United Kingdom, indicated that the best way to continue our progress in recovery and rehabilitation is to remain open to new ways of exploiting technology for the betterment of our Service members and their families.

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8 “Simplifying the Service Delivery Model for Medically Releasing Members of the Canadian Armed Forces.” Ombudsman. National Defence and Canadian Forces, 2016. http://www.ombudsman.forces.gc.ca/assets/OMBUDSMAN_Internet/docs/en/nsdm_en.pdf. Brigadier-General Hugh Colin MacKay, Canada, cautioned attendees that the Ombudsman report should not necessarily have prescriptive implications, regarding retaining the Service member for a prolonged period. He noted that prolonged retention of a Service member after completion of service may not be applicable to all Service members, and moreover that some Service members benefit from earlier transition.
Objective: Develop a strategic communications plan to provide credible information regarding recovery and rehabilitation

Regarding strategic communications, the Medical Director for Defence Medical Services, United Kingdom, provided examples from the United Kingdom that help build the strategic message, including transferring knowledge and practices from the military to the civilian healthcare community. Paralympics has also served as an opportunity for many partnering nations to spread a positive message of the success that sports play in telling the story of our recovered Service members.

Challenges and Recent Developments

About half of military personnel with substantial mental health conditions are not seeking help. Stigma may contribute to this phenomenon. Perceptions of stigma have fallen over time during deployment, but are still high. Service members feel greater pressure against presenting with mental health symptoms during deployment compared to when not deployed. Two papers, published in 2015 and 2016, have affirmed prior assumptions of the importance of leadership and cohesion and the threat of a perception of weakness as a primary rationale for feeling stigma.9

According to a UK medical journal that detailed key recent developments in rehabilitation, of 65 seriously injured amputees, 95% of these amputees were independent in all activities of daily living upon discharge. Over 75% of triple amputees did not require a wheelchair. Findings also showed that the Injury Severity Score was not predictive of long-term outcomes for brain injury, contrary to current notions.10

Another recent study related to Service member rehabilitation measured the average gait, energy consumption, and walking speed of amputees compared to a healthy population. The study showed that a lower-limb amputee walked at a comparable speed to the control group, a healthy population.11 The Bespoke Offloading Brace, designed to treat patients suffering from complex hind foot injuries, shows improvements in functional daily living, quality of life, substantial improvement in ability to play sports and walking speed, and measurable improvement in stride length.12


11 In response to Colonel James Kile’s question regarding the reason for lower energy consumption than expected for lower-limb amputees, a representative from the United Kingdom clarified that state-of-the-art equipment, intense rehabilitation, and training help explain these results.

Alcohol use—the “hidden pandemic”

Regarding mental health, alcohol use is a “hidden pandemic” affecting military organizations of many partnering nations and has a strong connection to operational deployment. An observable separation exists between misuse of alcohol in the general population and misuse of alcohol in the military. Young males in the military demonstrate about twice the prevalence of hazardous use of alcohol than young males in the general population. Females in the military demonstrate twice the rate of hazardous use of alcohol than females in the general population up to the age of forty.13

Researchers have questioned the value of post-operational screenings. In a randomized study evaluating 434 United States platoons, there was no significant difference in outcome from receiving screening or tailored advice. This study contradicts the previously held belief of the benefit of post-operational screenings.14

The United Kingdom’s Trauma Risk Management (TRiM) is a structured risk assessment for Service members and their peers after exposure to a traumatic event. Recent indications show that TRiM does not lead to an improvement in mental health, but participation in TRiM does increase the likelihood that a Service member presents mental health symptoms to the clinical system following a traumatic event.

A study from King’s Centre for Medical Health Research evaluated factors affecting psychological wellbeing in non-deployment settings. The study found exercise to be one positive factor in affecting psychological wellbeing.15

Future Topics and Research Initiatives

One topic that Work Group 2 has not discussed is the possible differences in suicide rates that may be attributable to service and other mitigating factors.16 While this topic has been explored within some of the WC21 nations, including the United Kingdom and United States, among others, Brigadier Hodgetts stated that this topic deserves further investigation.

The Netherlands currently conducts research into the utility of virtual reality in rehabilitation. This shows the importance of the WC21 coalition, as partnering nations who have also experimented with the benefits of virtual reality, such as the United Kingdom and the United States, can share findings and collaborate with The Netherlands. The WC21 coalition is also instrumental in preventing duplication of research among nations.17

17 Brigadier-General Hugh Colin Mackay, Canada, noted that NATO has already conducted research related to suicide, and will present results during a symposium in Lithuania in April 2017.
Through a longitudinal cohort study, the United Kingdom expects to gain a greater understanding of long-term outcomes for physical, psychological, and social factors. Understanding long-term outcomes will also allow reinterpretation of short-term outcome conventions. In terms of mid-term outcomes, the United Kingdom has found success in optimizing employability and employment opportunities during the transition process.

Two different perspectives exist for approaching recovery and rehabilitation: the mental health and the physical health. Brigadier Hodgetts shared a quotation from the Mayo brothers: “The only victor in war is medicine.” Attendees can demonstrate victory through medicine in their recent campaigns, which have had extraordinary physical outcomes. Successes for military organizations in the acute phase, such as early survivors, have presented new challenges in physical and mental rehabilitation. Military organizations have risen to these challenges and heightened expectations of our Service members, commanders, public, and politicians for what can be achieved in the future.

**Work Group 2 Breakout Session and Outbrief/Discussion**

During each breakout session, attendees were divided into four “breakout groups” to focus, by means of smaller, open discussions, on questions related to the work group at hand. The following information summarizes the specific questions posed to each breakout group and the discussion findings that each group briefed to the WC21 coalition.

**Discussion Question 1**

How do we reduce the burden of alcohol misuse and its physical, psychological, and social aspects?

**Common themes**

Methods to reducing the burden of alcohol misuse include:

- Harm reduction, identifying at-risk users and causal factors
- Understanding the drivers that lead Service members to misuse alcohol
- Education and health promotion
- Regular health screenings
- Identifying the causes or correlations between military culture and alcohol misuse
- Identifying other contextual or circumstantial factors that lead to alcohol misuse

**Best Practices and Recommendations**

Military organizations must draw attention to programs, engage all Service members, implement standardized screenings for further studies, track Veterans and Veteran agencies’ engagement, and offer celebration alternatives.
Military organizations can reduce the burden of alcohol misuse through regulating supply, influencing demand, reducing intake, and controlling availability. Controlling alcohol on deployment (e.g., event planning) is good, but strong leadership is important for influencing non-deployment usage. Robust leadership includes being a good role model and setting values. Leadership and medical personnel must remain vigilant, and address and prevent issues up-stream prior to the occurrence of a condition.

Removing alcohol from base does not prevent the problem and may even have a negative effect on morale. Partnering with community alcohol vendors to “serve responsibly” could have positive results.

**Surveys and Assessments (Secondary Prevention, or Early Detection)**

For secondary prevention (or early detection) practices, the group recommended a physical health assessment (PHA)—a questionnaire followed by a one-on-one meeting to address issues that also includes routine medical examinations with a structured mental health assessment. The United Kingdom currently employs these examinations that are attached to yearly dental check-ups, as opposed to the typical 5-year medical check-up. Similar practices include the United States’ Force Preservation Council, the United Kingdom’s Unit Health Committee, a post-deployment questionnaire in The Netherlands and Denmark, and Australia’s annual mental health screen with audit. Denmark also uses a climate health survey—a questionnaire that’s administered every two years to ascertain the atmosphere of the work environment.

Several WC21 nations have studied and continue to examine the causal factors and impacts of Service member alcohol abuse. Combining recent and future findings from these studies will allow more robust and comprehensive conclusions to be drawn from the research, and ultimately help each nation better prevent and respond to alcohol abuse among their Service members and military families.

**Contextual Influences**

Attendees recommended acknowledging and researching cultural and social norms related to drinking. Areas deserving better attention for recovery and rehabilitation include families, natural sleep, pain management, use of alcohol in unit cohesion, and the entry point for substance abuse.

Military organizations should exercise harm reduction through identifying at-risk users and causal factors. These factors include social demands, such as loneliness and being part of a group; relationship, legal, and financial issues; and the role of alcohol related to other health issues. Researchers should study how to address comorbidity of Service members with a mental health condition and a substance abuse issue, such as the habitual use and abuse of energy drinks and tobacco products.

Attendees questioned whether a hidden pandemic exists. The group suggested studying the issue within the reservist, active duty, and wounded, ill, and injured populations. Representatives from Australia and Denmark stated that there is no statistical difference between military and civilian populations regarding alcohol-related
problems. However, the representative from Denmark noted that the Denmark Veteran community does face problems with tobacco, alcohol, and drugs. Representatives from the United States and Denmark noted that alcohol is not the focus of events because of a “culture shift” in the respective countries. They also noted that alcohol is more of a problem for the younger population, which the group generally agreed includes Service members younger than 25.

Attendees wondered whether there is causation between military service and alcohol abuse or merely correlation: “Does the military cause people to drink more? Or do the people that join the military have different characteristics that pre-dispose them to drink more?” The group noted that monitoring for mental health may help control this issue.

Attendees stated that the military creates an environment that allows for drinking by providing subsidized housing and salary. Because of this, young Service members can afford alcohol more easily. The group asked, “What are the circumstances that young people come from?” There is speculation that peer pressure in the early stages of the Service member’s tenure could have a significant effect.

Alternatives

Attendees proposed that military organizations provide alternative tools to cope, including better pain management, improved mental healthcare, reducing stressors, facilitating reintegration and transitions, and finding other outlets, such as sports and meditation.

Educational Initiatives

Military organizations must communicate the appropriate use of alcohol. Military organizations need to dispel the “binge drinking” cultural expectation; promote alternatives to coping; identify normative fallacies and point out to Service members that “not everyone is drinking”; and lead by example (e.g., mandating that instructors and superiors refrain from smoking in the presence of subordinates).

Attendees recommended education and health promotion; spiritual guidance; normalizing care for alcohol misuse to reduce stigma or perceptions of stigma; and treatment of patients with mental or behavioral health issues in primary care facilities. The group recommended engagement and accountability within the justice system to provide a deterrent. The group asked, “Are there secondary consequences?” Attendees also proposed educational initiatives in a three-phased approach of sleep, nutrition, and exercise.

Finally, Organizations must account for Service members with established alcohol issues (i.e., tertiary prevention). In these cases, an education component is necessary for reducing stigma to encourage individuals to present issues to leadership; to convey to Service members that help is available; to reduce fear or a perception of risk of losing one’s position; and to raise awareness of access to effective, safe, individualized, and resourced care. Attendees also recommend identifying avenues that allow a better interface between military and civilian providers.
Discussion Question 2
How do we reduce the burden of training related injury and its impact on continued military employment, with specific reference to the increasing number of women adopting training for combat roles?

Second-Order Questions
What is the burden? What are the common predictable injuries that lead to discharge? What is the future mitigation? What are the gender differences in training injuries? What will be the impact of women in ground close combat on the prevalence of those injuries? What is the future mitigation? What are the research questions? What is the impact of physical injury on psychological morbidity for those that continue to serve?

Strategic Messages
Attendees developed the following key strategic messages: The determinants of musculoskeletal health (alcohol, smoking, obesity, general health) versus injury prevention; strength and conditioning versus running; and improving injury management. One area for further research is studying the ergonomic differences in equipment required for female versus male Service members.

Precepts to Reducing Training Injury Burden
Attendees recommended the following precepts to reduce training injury burden: move away from the “one-size-fits-all” fitness testing towards occupational and gender-specific testing; developing infrastructure and the processes for prevention/early intervention with minor injuries; functional movement screen; “fleet maintenance model” for individuals; combining mindfulness with physical training to improve overall performance; rehabilitation requirements that are gender-specific; high-education physical therapy (educate clients so they understand the specific intent and process behind their physical training); and individualized physical therapy (mirroring the civilian sports club model). One suggested area of further research is the analysis of ergonomic differences in physical training and therapy equipment required for female versus male Service members.

Discussion Question 3
What is the role of regenerative medicine in shaping future recovery and rehabilitation from combat injury?

Second-Order Questions
Where does regenerative medicine start? Is there a role for techniques in the deployed space?

“Blue Sky Thinking”
Attendees recommended the following concepts under the category of “Blue Sky Thinking”: Tissue banking; 3-D imaging of the body before deployment; and the question, “Where does genetics and genomics cross over with regenerative medicine?”
Military organizations need to capitalize on existing work in this area. Group members mentioned NATO Human Factors & Medicine (HFM) Panel 272 on regenerative medicine and advanced rehabilitation as a resource for conclusions and recommendations.

Cellular-based intervention is an example of an opportunity more likely to be a “quick win,” as opposed to organ generation. However, skin “is the most accessible ‘organ’ for regeneration.” Attendees recommended considering the impact of sleep as a “regenerative” intervention.

Caveats included the recommendation to be aware of the pressure to innovate in regenerative medicine without the underpinning of sound basic science; the perception of regenerative medicine as the quick fix, political expedient, panacea, or replacement for conventional rehabilitation; and unintended consequences, such as whether a regenerated limb will still cause pain.

Focus Area: Reintegration

The third primary focus area of WC21 is reintegration. Supported by Work Group 3, their goal is “to improve efforts to support Service members during reintegration into military service or transition to civilian life.” During the 2016 Symposium, a guest speaker presentation on invisible wounds, work group presentations, and breakout sessions highlighted coalition progress and identified challenges, solutions, and best practices relating to the reintegration of wounded, ill, and injured Service members.

Guest Speaker Presentation: Invisible Wounds

Colonel (Retired) Miguel Howe, Director of the Military Service Initiative for the George W. Bush Institute

The George W. Bush Institute aims to foster the successful transition to civilian life for warriors and families. The Bush Institute focuses on wounded, ill, and injured Service members who have suffered less conspicuous trauma during Service, such as Traumatic Brain Injury (TBI).

In a video shown to attendees, interviewed Service members explained the difficulty of telling Service members, who often identify with military culture, that they have problems. Service members also discussed adjusting to their personal “new normal.”

Both the public and military Veterans believe it is difficult to find and afford quality care for military wounds.

When thinking about military wounds, the public thinks of physical wounds before “invisible wounds”, which include conditions such as traumatic brain injury and post-traumatic stress. Furthermore, it is important to distinguish “invisible wounds” from other wounds, as they require vastly different courses of treatment.

The Bush Institute’s initiative on “invisible wounds” is called “Recognize, Connect, Deliver.” The initiative strives to foster outcomes of high-quality care, and is focused primarily within the private sector. Programs include research, policy initiatives, as well as a Wounded Warrior golf tournament and bike ride.
In 2016, the Bush Institute conducted a survey of 3,000 members of the public and a parallel survey of post-9/11 wounded, ill, and injured Service members in the United States. Of the Service members who responded to the survey, 23% reported that they were wounded while deployed; 66% of post-9/11 confirmed that they had been exposed to either indirect or direct fire, or an Improvised Explosive Device (IED) attack. The survey suggested that a disconnect between the civilian and military population still exists. Civilians still have difficulty understanding problems related to the military, and a significant portion of the public overestimates the number of post-9/11 who suffer or have suffered from post-traumatic stress or traumatic brain injury. The public and military Veterans believe that Veterans with post-traumatic stress or traumatic brain injury are perceived negatively.

Military Veteran survey respondents said that employment, reconnecting with friends, and continuing education were extremely or very challenging. Veterans also said that shame and embarrassment were barriers to seeking treatment—69% of Veterans who seek, find, and sustain treatment have found the treatment effective. However, the wounded, ill, and injured Service member cannot recover if he or she cannot seek, find, and afford quality care. Both the public and military Veterans believe that it is difficult to find and afford quality care for military wounds.

The Bush Institute stresses the importance of collaboration among the public, private, and non-profit sectors. They have worked with partners at the Department of Defense, USSOCOM, and the Invictus Games, and intend to stay connected with WC21 2016 Symposium attendees to include offering online resources that the Bush Institute has developed on “invisible wounds.”

Introductory Presentation: Work Group 3 – Reintegration

Mr. Paata Patiashvili, Head of the Wounded and Injured Warrior Support Department for the Ministry of Defense, Georgia, and Lead, Work Group 3 (Reintegration)

Mr. Paata Patiashvili delivered the Work Group 3 presentation, beginning with emphasizing the importance of the WC21 coalition for Georgia. He described the tasks facing Work Group 3 since the WC21 2015 Symposium, including identifying the challenges, best practices, and innovative concepts to improve the reintegration process for Service members for entry into both military service and civilian life, and focusing on four key objectives:

- Define reintegration touch points for employment, education, financial support, family counseling, medical treatment, and social support;
- Define criteria for holistically assessing fit for duty and/or return to duty;
- Identify transition functions that incorporate peer-to-peer and community support; and
- Identify tools and resources for service members and families to build skills and live independently.

Case Study: Warrior Care in Georgia

Georgia has participated in conflicts in the 1990s and peacekeeping missions in 2008. Since the 1990s, it has been difficult to track and determine the number of wounded, ill, and injured Service members. Processes
existed, but there were no means to identify the needs of wounded, ill, and injured Service members. Consequently, the Wounded and Injured Warrior Support Department was created in 2015, and has released a questionnaire to identify needs for active duty wounded, ill, and injured Service members working in the Ministry of Defense. Georgia has identified about 500 wounded, ill, and injured Service members and meets personally with these Service members and their families to complete the questionnaire and determine any social, medical, or other issues related to the reintegration process.

Further developments in Georgia include a conditional reassessment of Service members’ health and ongoing medical needs, based on questionnaire results, and a hotline, through which Georgia seeks to replace its current, less formal mode of communication between Service member and the Ministry of Defense. Ministry of Defense personnel are required to address issues raised through the hotline in no more than 48 hours from the initial call. The Ministry of Defense has also endorsed and implemented an “open door policy” which facilitates communication between Service members and the civilian sector, including families. A Ministry of Defense working group addresses wounded, ill, and injured Service member issues on a weekly basis and includes wounded, ill, and injured Service members as members of the working group because of their firsthand understanding of their needs and the Ministry of Defense’s effort to include wounded, ill, and injured Service members as key stakeholders in formation of policy. The Ministry of Defense founded the Wounded Warrior Foundation that will function as a charity and operate under the government, offering financial assistance and services to wounded, ill, and injured Service members that are unavailable under the state budget. The Ministry of Defense also provides free legal consultations for Service members and Veterans.

**Objective:** Define reintegration touch points for employment, education, financial support, family counseling, medical treatment, and social support

The Education and Employment Initiative (E2I), a United States Department of Defense program for the United States Military Services, provides employment and education counselors to assist wounded, ill, and injured Service members in their transitions to civilian life. The program helps Service members determine suitable types of education, qualifications, fields of study, possible vocations, and includes resume-writing assistance. In addition to E2I, the United States Air Force conducts regional care programs that include, adaptive sports, a mentorship program, and in-house Air Force resume-writing and counseling workshops. The Air Force employs these in-house programs because it has found that Service members within the Air Force may be more comfortable approaching the Air Force for these services than utilizing the Department of Defense’s E2I. The Air Force helps acclimate Air Force Service members to Department of Defense services, and utilizes Department of Defense, industry, and non-profit representatives to ease this transition. The Air Force has structured financial counseling into its transition assistance programs. Wounded, ill, and injured Service members can receive one-on-one financial counseling upon request. Implementation of a financial literacy program is forthcoming, which will provide financial counseling from training through a Service member’s career.
The Netherlands employs a Veterans’ office, a single touchpoint for active-duty or former Service members. Other organizations offering programs in The Netherlands include the Ministry of Defence; Veterans Institute, the National Health System for Veterans in The Netherlands; and civilian entities.

Programs implemented in Canada include the Second Career Assistance Network (SCAN), Enhanced Transition Services, Transition Interviews, Assistance Service Hotline, and Operational Stress Injury Clinics. The Veterans Affairs Canada’s Life After Service Studies found that nearly 75% of Canadian Veterans “transitioned well.” Veterans Affairs Canada examined the subgroups of the population of Veterans that did not transition well to determine target areas and effective approaches to support. Veterans Affairs Canada found that individuals in lower ranks without transferable occupations from military to civilian life, individuals in the army, and individuals with mental health conditions are the populations facing the most difficult transitions. Interagency cooperation was key to progress in the Canadian military system.\textsuperscript{18}

Canada’s Public Service Commission extends preferential appointment to Veterans of the Canadian Armed Forces in applications to externally-advertised jobs in the federal public service. This benefit represents implied recognition by the government that Veterans have important skillsets to offer.

The Canadian Armed Forces works closely with the Military Family Resource Center (MFRC), which undertakes care and education for military families to help understand the transition of the family’s Service member.

Georgia has begun to find employment for family members of wounded, ill, and injured Service members in the private sector. This initiative is meant to counteract, in part, certain legislative difficulties that pose challenges for adequate compensation of wounded, ill, and injured Service members. The Georgian Ministry of Defense also employs two wounded, ill, and injured Service members in its cybersecurity department, who in turn train their peers. This form of employment allows wounded, ill, and injured Service members in Georgia to circumvent legal difficulties and work for pay promptly instead of waiting for legal and policy-related issues to resolve for wounded, ill, and injured Service members. Other programs in Georgia include a behavioral health counseling center that holds ten-day sessions for Service members and families.

**Objective:** Define criteria for holistically assessing fit for duty and/or return to duty

Regarding Canada’s Transition Interviews and Enhanced Transition Services, “transition interviews” are either required or recommended for every Service member, and provide useful data. Veterans Affairs Canada conducts Enhanced Transition Services to medically releasing individuals, allowing Veterans Affairs Canada to intervene earlier in the Service member’s reintegration. The representative from Veterans Affairs Canada notes that this early intervention has been shown to produce greater outcomes of successful reintegration. Enhanced

Transition Services also includes pre-adjudication of benefits for Service members and ensures that the family is engaged in the process.\footnote{The representative from Veterans Affairs Canada noted that the family is normally involved through Transition Interviews, but that additionally engaging the family through Enhanced Transition Services takes a more proactive approach to ensuring the family’s engagement.}

The representative from Canadian Armed Forces described the assessment process, in which personnel assess Service members for medical or non-medical release. The Joint Personnel Support Unit supports Service members transitioning out of the Canadian Armed Forces or into the Joint Personnel Support Unit and subsequently back to duty. The Joint Personnel Support Unit comprises personnel from Veterans Affairs Canada, mental health personnel, and other relevant organizations to fulfill all needs of the Service member. Each Service member is handled as a case until ready to return to duty or transition into civilian life. Currently, Canadian Armed Forces only requires this program for wounded, ill, and injured Service members, but hopes to expand the program to include all Service members in the future.

Assessing Service members’ fitness for returning to duty has posed challenges for Georgia, due to existing legal decrees. An internal decree of Soviet origin, translated from Russian into Georgian, places restrictions on Service members wishing to return to active duty and has not been modified since its original institution.

**Objective:** Identify transition functions that incorporate peer-to-peer and community support

In the United States Army, the Soldier for Life program is designed to help Service members transition out of the military. The Army partners with industry to give Service members marketable skills before leaving the military. The Soldier for Life program also works with communities, education partners, and civic leaders. Regional coordinators for the Army meet with civic leaders, employers, and others to express the benefits of hiring Veterans across The United States Military Services by conveying skills that Veterans bring to the workplace.

**Objective:** Identify tools and resources for service members and families to build skills and live independently

In Canada, the Navigated Guided Support Role uses “journey mapping” to examine the experiences of clients as they work their way through Veterans Affairs Canada. Veterans Affairs Canada identified a group requiring intensive case management, a group able to self-manage, and a “gap group” that did not need intensive case management but were unable to manage their way through the system independently. Veterans Affairs Canada instituted the Guided Support program to address this “gap group” so individuals will have points of contact and support for several months or years to move successfully through the Veterans Affairs Canada process, but will not receive intensive involvement by a case manager.
Work Group 3 Breakout Session and Outbrief/Discussion

During each breakout session, attendees were divided into four “breakout groups” to focus, by means of smaller, open discussions, on questions related to the work group at hand. The following information summarizes the specific questions posed to each breakout group and the discussion findings that each group briefed to the WC21 coalition.

Discussion Question 1

Recognizing that transition is often unique to each individual/family, what are the primary focus areas to support the civilian and military reintegration process, including those relating to family, work, and society?

Common Themes

- Importance of managing stigma and addressing public misperceptions
- Financial security is also important. Service member might lose specialty pay, which will also impact his or her family

Domains of Transition

Attendees stated that meaningfulness and a sense of purpose are critical to reintegration. Purposeful activities, especially in the household, help Service members cope with transition. Attendees also included housing, family, physical health, mental health, and identity as fundamental domains of transition.

Military-To-Military

Some attendees focused specifically on factors related to military-to-military reintegration. Factors related to work included stigma, re-training, and career progression. Re-training for a different role may also imply the loss of specialty pay. Within career progression, the Service member may be affected by the ability (or inability) to deploy, as well as a security clearance change because of the Service member’s changed condition.

Family-related factors of military-to-military reintegration were inclusivity, managing expectations, and vulnerability if not categorized by the military as significant elements. The group also noted that, in terms of managing expectations, support for the family may be more robust while the Service member is actively serving. Participants also noted that loss of specialty pay will affect the Service member’s family as well as his or her career.

Societal factors in military-to-military reintegration were managing stigma and a reintegrated soldiers support network. Within managing stigma, participants made a distinction between “malingering” and morbidity.

Military-To-Civilian

Some attendees focused specifically on factors related to military-to-civilian reintegration. Work-related factors of military-to-civilian reintegration included connection, training, the resume and cover letter, skills translation, and mentorship. Connections may come from a civilian industry. In the United States, connections may come
from the community and within the Department of Veterans Affairs. Mentorship may come in the form of mentors from both the military and civilian sectors.

Family-related factors of military-to-civilian reintegration included inclusivity, employment, and managing expectations. Managing expectations also requires the family to adjust to the “new normal”: families must adjust to no longer living on a military base and its accompanying social support and network.

Societal factors of military-to-civilian reintegration included managing perceptions, the Veteran network, and raising awareness.

Recommendations

Attendees offered several recommended practices to support reintegration. Data management is a powerful, underrated tool. Counseling can provide a sense of self-worth. Employer awareness and addressing public misperceptions can improve employability. Financial security and support networks of friends and family are extremely critical to reintegration. Improving collective responsibility is important to dispel cultural misunderstandings about Veteran health and capability.

Discussion Question 2

What are best practices for tracking the progress of the reintegration process and beyond? What is the recommended length of time to track this progress? Are there best practices for identifying and filling the gaps during and after transition?

Common Themes

Tracking should continue after military service. However, Service members might be sensitive to intensive tracking after service.

Challenges and Best Practices

Some attendees expressed wariness of invasive tracking methods, noting that Service members want peace following the end of their service periods. Attendees described gaps in the tracking process, such as cases where relatively lower-risk Service members were not tracked. In the United States, tracking may be lost for reservists and National Guard Service members because of their intermittent exposure to service/non-service organizations. Attendees developed several solutions for filling the gaps during and after transition, including flexible non-liability insurance; following the Navy system, which allows a review for members being discharged with other than honorable conditions to assess their mental injuries; an “exit boot camp” to offer guidance; peer support services; and community engagement. Attendees also noted that Military organizations can benefit the next cohort of Service members by learning best practices now.

In the United States, lifetime tracking exists for seriously injured Service members if they choose to enroll. USSOCOM employs through-service tracking. All Wounded Warrior programs in the United States track Service members while they are on active duty. Representatives from the United States said that it is easier to track “garrisoned” personnel in United States Wounded Warrior battalions, such as in the Army or the Marines, but that cohesion is better when Service members are retained in their units, such as in the Navy and Air Force.
Second-Order Questions

Questions raised included “How do we think about the path to transitioning?” and “Do we look at it as a linear chronology or as a milestone path?” Linear thinking may lead to over-prescription.

Additional questions included “How long do we track?” and “What is the end state of reintegration?” Possible answers posed were “Until no services are needed” and “Until effective in a job.”

**Discussion Question 3**

What medical, social, and employment benefits are available to wounded, ill, and injured Service members and their families during transition? What are the eligibility factors? Who covers the costs?

Common Themes

Various medical, social, educational, and overall reintegration-related benefits should be ensured for Service members.

Communication of Benefits

Attendees described a “Defined Transition Process” as a best practice for Service member and family reintegration. Aspects of this process include the availability of seminars and trainings for Service members and their families and a point of contact. The Service member must be engaged in this process.

Medical Benefits

Medical benefits for Service members included caregiver support; medical care; disability benefits, such as Social Security Disability Insurance (United States); and enhanced prosthetic services, such as Murrison Centres (United Kingdom).

For families, medical benefits included caregiver benefits, medical care for spouse and children under retirement, and Social Security Disability Insurance for children up to 18 years (United States).

Social Benefits

Social benefits for Service members included housing; independent living assistance; tax benefits; low-cost housing loans; reduced insurance (e.g., car or house insurance), private sector benefits (e.g., discounts), and overall state-dependent benefits. Attendees voiced concern for Service members that separate from the military and later present training- or Service-related mental or behavioral health issues and noted that these occurrences should be addressed.

Attendees said that Service members should be able to network. This includes connecting with other Veterans in society, yet also requires Service members and Veterans to be willing to help each other. Maintaining connections and maintaining ties to the military eases transition. The sentiment that a Service member is a “soldier for life” may offer reassurance. Transitioning from the military does not imply cutting all ties from the
military. In fact, a Service member may want to maintain ties to the military because of the role that the military may play in his or her identity.

Social services should also include fostering connections between Service members and related associations (such as Non-Governmental Organizations and Veterans Service Organizations). University culture should foster and sustain mutual understanding between Veterans and academic institutions. Attendees believe that families share the same social benefits as Service members.

**Employment Benefits**

Employment benefits included occupational health-based workers’ compensation (e.g., National Accident Concession Corporation, New Zealand); wage replacement; retraining or cross-training for retention of service and during transition out of service; and employment preparation and support, including support for education and housing costs (such as the Department of Veterans Affairs Vocational Rehabilitation & Employment program, United States). Employment support should also include liaisons to coordinate between Service members and employers, as well as community leader programs to build mutual understanding between civilian and military personnel.

Service members should have access to vocational rehabilitation, including resume-writing assistance. Service members should be trained to use relevant professional services and resources, such as professional networking websites.

Educational benefits also play an important role. Attendees referenced the Post-9/11 GI Bill (United States) as an example. Educational benefits exist in the form of scholarships (e.g., Folds of Honor and the Special Operations Warrior Foundation, both United States) and internships. Attendees noted the transferability of educational benefits to spouse and children as a best practice.

**Discussion Question 4**

What are best practices for implementing a “community approach” to supporting reintegration and transition? What areas should the government, non-profits, and other stakeholders contribute to?

**Common Themes**

- Non-governmental organizations should play a role in supporting the transition of Service members.
- Positive public relations and partnership with the media are key to successful transitions for Service members.

**Best Practices in Government**

Best practices identified include portability of resources; agility in adapting innovative practices; interagency fellowships, such as the Canadian Institute for Military and Veterans Health Research (CIMVHR); and identifying and reducing redundancy in transition processes.
Military organizations should provide sufficient opportunities for Service members to discover and develop skills. This requires time which is a similarly important resource when compared to money.

Military organizations should educate employers about the benefit of hiring a Veteran; highlight the strengths and characteristics of Veterans that would be beneficial in the workplace; ensure that Veterans have realistic expectations about the workforce; and, engage with hiring managers, rather than just the top levels at companies.

Incorporating Non-Governmental Organizations and Military-Civilian Cooperation

The group also stressed the role of the private sector in supporting transitioning Service members, including employment, vocational training, and similar benefits.

Charitable organizations should be actively engaged to assist in the transition process. Often, charitable organizations require guidance and coordination with Service processes, which brings legal and political implications. Thus, the group recommends implementation of coordinating bodies in the government to bring non-profits and government agencies together (e.g., Netzwerk der Hilfe, Germany).

In Denmark, a Civilian Veteran coordinator is assigned to a community to facilitate the reintegration process. Veteran for Veteran programs operate in Australia. These are not government- or community-driven, but volunteer organizations that offer services to help Service members’ reintegration into society. Other examples include Soldier On and Mates for Mates.

Attendees specified training government and non-profit programs that hire Veterans as best practices for implementing a “community approach.” These programs should be ready and willing to hire Veterans immediately after transition from the military.

Public Relations

Attendees identified media engagement and public affairs as important factors to supporting reintegration and transition. Attendees noted that the media tends to focus on negative stories instead of highlighting positive ones. Military organizations must work with media to spread a message of success stories.
Focus Area: International and Interagency Collaboration

Day 3 of the WC21 Symposium was held at the James A. Haley Veterans’ Hospital, and began with presentations and a moderated panel discussion on international and interagency collaboration.

Panel Moderator Remarks

Ms. Lida Citroën, International Branding Specialist for Executives and Veterans, LIDA360

Ms. Lida Citroën, panel moderator, began with introductory remarks. She described the importance of image, reputation, and networking in the modern workforce, and the gap between military and civilian culture that can impede Service members from transitioning from the military successfully. She stated that Service members are not trained to market themselves or demonstrate their distinguishing features. Rather, Service members are trained to place service before self. However, Service members may benefit from personal branding training, which helps individuals define themselves and their role in the workplace. Once the individual is aware of his or her own skills, strengths, and weaknesses, he or she can take the next step.

Panelist Presentation: Challenges and Solutions in Rehabilitation of Ukrainian War Casualties

Colonel Professor Vsevolod Stebliuk, Deputy Head of the Ukrainian Military Medical Academy and Chair of Guardian Angels Ukraine

Col Prof. Stebliuk delivered a presentation on the challenges the Ukrainian military has faced and the international and interagency partnerships that have helped alleviate these challenges. He serves as the Ukraine Coordinator for the Guardian Angels Ukraine Project, an international partnership between Ukraine and Canada that focuses on medical rehabilitation programs for Ukrainian wounded, ill, and injured Service members.

Ukraine has experienced recent and ongoing foreign conflicts, and now has 25,000 wounded, ill, and injured Service members and civilians. Ukraine has struggled improving its treatment systems for wounded, ill, and injured Service members. Thus, rehabilitation efforts are not ideal. Before its most recent conflict in 2014, Ukraine had no systematic approach to rehabilitation. The country used the antiquated post-Soviet system of sanatorium treatment and recreation, and had no experience in psychological care for wounded, ill, and injured Service members.

In 2014, Ukraine reached out to Canada to establish the Guardian Angels Ukraine Project that began. The first step was an exchange of knowledge between the two nations. Next was organizing psycho-physical rehabilitation, a program that employs several different rehabilitative practices, such as animal therapy.

The Ukrainian military also conducts scientific and technological exchange programs, inviting specialists from the Ukrainian military hospital to hold classes on physical therapy and psychological support.
The Ukrainian military hosted an international conference, in collaboration with Queen’s University, Canada, and maintains partnerships with Ukrainian universities, rehabilitation centers, foundations, and other organizations.

**Panelist Presentation: NATO Trust Fund Project to Support Practical Cooperation with Ukraine**

Mrs. Nataliia Melnychenko, Medical Rehabilitation North Atlantic Treaty Organization (NATO) Trust Fund Project Supervisor for the NATO Support and Procurement Agency, Ukraine

Mrs. Nataliia Melnychenko explained that NATO’s assistance of Ukraine focuses on two main aspects: the patients and the system. Activity supporting patients includes medical rehabilitation services and assistive devices; vocational rehabilitation services; and sport rehabilitation services for community and elite. Activity supporting systems includes equipment to appropriate medical rehabilitation facilities; equipment and facilitation of technology transfer and best practices to appropriate prostheses centers and Research Scientific Institutes; and, competency development of professional staff involved in physical and psychological rehabilitation and in the provision of prostheses.

The project requires facilitation between Ukraine and twelve other nations, as well as one Non-governmental organization. The project has faced difficult situations, and still faces challenges garnering adequate interest and financial support. So far, the project has provided prostheses to eight patients and medical rehabilitation to 127 patients. The project also runs vocational rehabilitation programs and trained thirteen employees to date. These trainers are integrated into Ukrainian society after two to three months of training. Ukraine plans on training thirty vocational trainees total. To date, this project has provided sport rehabilitation to sixty patients (30 military/30 civilian) with a desired goal of 340 patients. Finally, the NATO project and the Ukrainian military are interested in sending wounded, ill, and injured Service members to the Invictus Games, and are working on obtaining financial support.

**Panelist Presentation: Canadian Forces Health Services Group**

Colonel James Kile, Command Surgeon, Canadian Army

Colonel James Kile is the senior clinical advisor for the Canadian Army and advises the Army Commander on various health concerns, supports base surgeons and patients, and coordinates between the Canadian Forces Health Services (CFHS) and the Canadian Army Surgeon General on domestic and international health issues.

Col Kile began his presentation by noting that some Service members can transition seamlessly from the military to civilian life. Additionally, policymakers often forget another type of Veteran—one who never deployed, but has spent twenty to thirty years in the military. This Veteran does not identify as a “Warrior,” but counts the military as a fundamental part of his or her identity.

A challenge for Canada is the sheer size of the country in contrast to the about 82,000 Veterans that use the Veterans Affairs Services. Canada also faces challenges with public relations: a recent example is a report
released in June 2016 on homeless Veterans. The Canadian Armed Forces collects information from surveys, though it recognizes that results may not always be actionable.

The Canadian Armed Forces recognizes a gap in Service member transition between discharge from the Canadian Armed Forces and the start of Veteran care. However, Canadian Armed Forces places confidence in Veterans Affairs Canada to identify and address challenges jointly with care, compassion, and respect. Communication between the two agencies is essential.

Col Kile described the “paper trail” and migration of documents from Canadian Armed Forces to Veterans Affairs Canada. Past inefficiencies have been improved, and the process is now more streamlined.

Panelist Presentation: ISAF Medical Collaboration Dealing With Deployment-Related Physical and Mental Disorders in the DEU Bundeswehr

Brigadier General (BGen) Dr. Bernd Mattiesen, Commissioner for Members of the Armed Forces Suffering from Post-Traumatic Stress Disorder and Those Wounded in Action, German Ministry of Defense

BGen Dr. Mattiesen’s presentation focused on International Security Assistance Force (ISAF) collaboration and dealing with deployment-related physical and mental disorders in the Bundeswehr (the German armed forces). In Afghanistan, ISAF is tasked with implementing an anticipative, adaptive, comprehensive, and integrated healthcare system that provides a medical capability as close as possible to peacetime standards; developing the Afghan National Security Forces (ANSF) health system; influencing civil-sector health capabilities through the Afghanistan Ministry of Public Health, the donor community, international organizations (IOs), and non-governmental organizations (NGOs); and, promoting mutual support between the Ministry of Public Health and the ANSF to optimize limited health resources.

BGen Dr. Mattiesen described ISAF support and development of the ANSF health care system. ISAF supported the ANSF throughout the patient flow: point of injury, treatment in medical clinics, treatment of regional hospitals, and treatment in the National Military Hospital (NMH). All activities were Afghan-led and executed.

BGen Dr. Mattiesen then shifted the presentation to the status of wounded, ill, and injured Service member care in Germany. Germany’s “Commissioner for Post-Traumatic Stress Disorder” coordinates between the German Bundestag (the lower house of the German parliament), the Bundeswehr, the media, a post-traumatic stress disorder working group, and wounded, ill, and injured Service members. The Bundeswehr conducts psychiatric care treatment in four hospitals, with a ratio of 4.9 beds per 10,000 soldiers. The Bundeswehr engages in preventative measures, focusing on detecting mental fitness, mental fitness training, peer-to-peer psychological crisis intervention, and debriefing seminars.

Legislative history related to wounded, ill, and injured Service member care can be traced to 2004, with passage of the Special Foreign Assignments Benefits and Pensions Act. The most recent piece of legislation was an act related to German Armed Forces retention and recruitment in 2015. Due in part to difficulties passing legislation, Germany also pursues other means to address deployment-related injuries.

BGen Dr. Mattiesen closed with positive news regarding German Service members’ morale and general welfare. The Bundeswehr invests substantially in support for Service members and their families through a variety of
treatments and programs. The Bundeswehr offers guides for personnel injured on operations; specialist advice seminars; sports therapy for personnel injured on operations; a family support organization; a “PTBS Coach” application for personnel with post-traumatic stress disorder concerns; and an interagency psycho-social network.

Panelist Presentation: U.S. Department of Veterans Affairs International and Interagency Relationships

Dr. Linda Schwartz, Assistant Secretary for Policy and Planning for the Department of Veterans Affairs, United States, delivers a presentation on Veterans Affairs international and interagency relationships.

As to the status of Veterans, the United States has nearly 22 million living Veterans. About 20% of these Veterans receive compensation for injuries or illnesses. Nearly 9 million Veterans are enrolled in Veterans Affairs health care.

It is the Department of Veterans’ Affairs mission to care for Veterans through all stages of life – even death. 45.8% of Veterans are elderly. The Department operates thirty-three national cemeteries.

The Department of Veterans Affairs builds its relationship with the Department of Defense, with whom it coordinates for Service members transitioning from the Service to Veteran status, through trust, teamwork, adaptability, and accountability.

Moderated Panel Discussion on International and Interagency Relationships

As moderator, Ms. Citroën asked panelists about the media perception of wounded, ill, and injured Service members in their respective countries. In Germany, there is a two-fold relationship: the media holds government accountable for care of wounded, ill, and injured Service members, particularly those suffering from post-traumatic stress, but they also depict to the public possibly damaging reports. Col Kile (Canada) said that a discussion about media must also include social media, which has gained dominance in recent years and is accessible to anyone. Media coverage in Canada, like Germany, is a “double-edged sword.” Media coverage can bring both positive and negative attention, as well as real, unfortunate consequences for Veterans. In one case, media had to stop reporting on Veteran suicides because the increased Veteran suicide rates correlated with the media coverage.
Dr. Linda Schwartz (United States) said that recent media coverage has helped normalize and de-stigmatize certain medical conditions. It is now normal in the United States for sufferers of post-traumatic stress to work in the civilian sector. In Ukraine, the media helps the military by channeling the military’s needs to the public. Through media coverage, Ukrainian NGOs have become interested in wounded, ill, and injured Service member issues and the image for Veterans has improved.

In response to whether the military can thrive independently, Dr. Schwartz explained that neither the military nor the private sector can “fill all the gaps.” At times, it is necessary for military organizations to voice their needs publicly. However, we do see many instances of the power of military networks and communities. One example is a Service member who had no furniture in his family’s home. The military community came together to furnish his house.

An attendee from Jordan asked how military organizations can ensure that the Service member’s dignity is intact during this process. He also asked what percentage of soldiers are self-employed, wish to continue their education, are seeking employment, or prefer not to work. In Ukraine, Veterans’ organizations run programs and distribute documents to empower Veterans and help organize small businesses for Veterans. NGOs that offer special courses, universities, and employers help motivate Veterans. However, Veterans also have the option of independence. After rehabilitation is completed, a Veteran may wish to start his or her own business independently. In Germany, the Bundeswehr helps staff and support Veterans who had a difficult or unsuccessful transition.

Canada strives to ensure dignity through its “Departure with Dignity” program. In this program, the chain of command acknowledges the Service member for his or her service and career in various ways before departure. Furthermore, the representative from Canada stated that the military organization can instill dignity throughout the Service member’s career by demonstrating good leadership behaviors. The representative from the United States said that across the United States, Veterans are special people in their communities. The GI Bill sends Service members back to school, includes stipends for housing, books, and tuition, and the benefits are also transferable to the Service member’s family. In this way, a Service member unable to continue his or her education because of injury can transfer the benefits to his or her family in dignity so that his or her service may be honored. In certain instances of national economic woes, the executive branch has provided added benefits for Veterans to return to school to find a new career.

An Australian audience member asked whether there are commonalities among nations regarding the percentage of Service members that have difficulties during transition. BGen Dr. Mattiesen (Germany) stated that perhaps a Service member will have a difficult transition if he or she is not accepted as disabled, or is just under the threshold of the evaluation criteria. In Canada, the disability eligibility process may impact the Service member’s dignity and success in transition. Canada is focusing on reducing the time that a Service member must wait for an eligibility decision. Dr. Schwartz said that part of the problem is that the military is precise and disciplined, but civilian life might lack structure and direction. Younger Veterans, especially those without
families or a support system, might face problems at a higher rate. The military also provided a sense of purpose and satisfaction with one’s work, which may be difficult for some individuals to find in civilian life.

Dr. Schwartz ended the panel discussion by offering a personal account of resilience. She was on a mission in an aircraft and the door blew off mid-air, sending her flying through the cabin. She suffered physical trauma and was told she could not return to nursing or return to school to continue her education. She refused to leave the workforce and began her career at the Department of Veterans Affairs. Her story serves as an archetype for the resilient Service member, and underscores the personal stake many Veterans Affairs employees have in delivering care and benefits to Veterans.

Veterans Affairs Presentations and Demonstrations

The remainder of day 3 consisted of a guest speaker presentation on recovery, rehabilitation, and resilience through the lens of Veteran organizations, a tour of the Polytrauma and Spinal Cord Injury Center, and a demonstration of the Department of Veterans Affairs’ telehealth capability. Key takeaways include the importance of private-public partnerships, innovation in technology, and public support for warrior care.

Lunch Presentation

Dr. Richard Stone, Principal Deputy Under Secretary for Health, Veterans Health Administration, United States

Dr. Richard Stone delivered a presentation on Veteran recovery and rehabilitation. He began with the historical context of Veterans in the United States, referencing Abraham Lincoln’s second inaugural address and the scientific breakthroughs and studies on infectious diseases in the early 20th century. The Department of Veterans Affairs health care delivery system was essential to medical progress in the United States throughout history.

The media poses challenges for the Department of Veterans Affairs and Warrior Care in general. Veterans Affairs has made innovative developments in the accessibility of health care, but the media is unlikely to cover these developments. United States has a high incidence of mental illness. The problems that military populations are facing reflect the problems in American society.
Dr. Stone mentioned the impending institution of the Electronic Health Platform, which will consolidate medical records and increase electronic mobility of information.

Dr. Stone also stressed the complexity of the care that patients receive in the five polytrauma centers. These five facilities are supported by dozens of additional teams on smaller systems.

**Polytrauma and Spinal Cord Injury Center and Telehealth Demonstration**

**Mr. Joe Battle**, Director, Polytrauma Medicine and Rehabilitation, James A. Haley Veterans’ Hospital

As part of the WC21 2016 Symposium activities at the James A. Haley Veterans’ Hospital, attendees were given a tour of the Polytrauma and Spinal Cord Injury Center, one of five such centers in the Department of Veterans Affairs. Mr. Joe Battle and his staff led attendees on a tour of the Polytrauma and Spinal Cord Injury Center, demonstrating the latest technology in spinal cord injury rehabilitation, including the Hand Glove, which helps stimulate nerve endings to bring sensation and eventually movement back to limbs. The tour also included a stop at the Aquatic Therapy Pool, where a patient with a spinal cord injury demonstrated his progress improving his gait with the help of the underwater treadmill that decreases body weight and stress on limbs.

Mr. Battle’s staff demonstrated Assisted Technology therapy, which is helping patients with traumatic brain injury learn how to drive again, as well as Vestibular Balance and Virtual Reality treatments. These therapies help patients with TBI regain balance and sensory function. Patients climbed the rock climbing wall, a show of accomplishment after a long and arduous treatment program.

The afternoon ended with a demonstration of the Department of Veterans Affairs’ telehealth capability, which has been implemented successfully to improve patients’ access to care. Care providers can “see” patients with non-urgent health issues the same day with the use of videoconferencing.

Telehealth makes care possible in rural areas. Mental health is also an included treatment. The Telehealth service satisfies Veterans’ desire to speak to their health care providers face-to-face, and can adapt to having these conversations virtually. There are about 677,000 people in the system. The satisfaction rate stands at over 90%.
The Road Ahead: Canada 2017

Brigadier General (BG) Hugh Colin MacKay, Surgeon General, Canadian Armed Forces

The WC21 2016 Symposium identified, as intended, several more challenges, solutions, and innovative concepts related to warrior care resilience, recovery and rehabilitation, and reintegration. The three WC21 work groups will refine their objectives for 2017 based on discussions and lessons learned from the Symposium, and will continue to meet monthly to identify best practices and solutions to address the objectives. Work group leads will communicate findings to the WC21 co-chairs and other stakeholders as appropriate, and will prepare to brief updates and findings at the 2017 Symposium.

The figure below provides an overview of past progress and future developments (Figure 4).

As a precursor to the WC21 2017 Symposium, BG Hugh Colin MacKay delivered remarks during dinner on day 2 of the 2016 Symposium. The Surgeon General praised the Symposium’s in-depth conversations and the progress attendees have made on behalf of Service members worldwide. He cited Canadian Prime Minister Justin Trudeau’s mandate letters, which proclaim the need to care for those who serve. The mandate letters validate the importance of the Symposium and related efforts. BG MacKay stressed that it is the responsibility of all attendees to ensure Service members’ readiness, resilience, rehabilitation, recovery, and reintegration.

Noting that warrior care is multi-disciplinary, integrated, complicated, and varies by country, BG MacKay pointed out that the WC21 coalition exemplifies warrior care collaboration by making possible a formal collaboration venue and solidifying plans for international collaboration. He commended the work that has already occurred, and implored work groups to continue their dedication and efforts.

Canada invites WC21 members to Toronto, Ontario, in September 2017 for the WC21 2017 Symposium. The event will coincide with the Invictus Games – an opportunity for WC21 members to witness the amazing mental and physical resilience that can be achieved through a Service member’s passion combined with family and community support.
Conclusion

The WC21 2016 Symposium expanded upon progress that resulted from the inaugural WC21 2015 Symposium; solidified Work Group planning, discussions, and meetings; introduced innovative recommendations; and formalized a commitment among all attending nations to collectively improve care for wounded, ill, and injured Service members and their families.

The WC21 coalition supports participating nations’ efforts to improve warrior care policies and programs by sharing best practices and collaborating on new and innovative ideas. It also supports the 2014 NATO Armed Forces Declaration, a commitment among 27 nations dedicated to, “…enhancing the sharing of best practices and lessons learned in support of our Armed Forces personnel and their families, including on our national approaches to providing medical care to the injured personnel and support to their families.”

Through the annual symposiums, work group meetings, establishment of the International Warrior Care Portal to share warrior care policies, operations, and research, and a declaration symbolizing the commitment among participating nations to achieve better care for wounded, ill, and injured Service members and their families, the WC21 coalition represents a recognized and robust institution in the global warrior care domain. Moving forward, participants recommend continued communication among WC21 coalition nations, including the work group leads, work group members, and other WC21 stakeholders. WC21 encourages the participation of new attendees and nations to support increased expertise, depth, and scope.

The United States Department of Defense is grateful for the contributions of all participating nations, and looks forward to future opportunities to work together to identify challenges, solutions, best practices, and innovative concepts that will continue to benefit our wounded, ill, and injured Service members, their families, and their caregivers.

From one participant: “We all have the same problems and together we can find the solutions.”
Appendix

Appendix A: WC21 2016 Symposium Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>0730 – 0830</td>
<td>Registration&lt;br&gt;&lt;em&gt;Davis Conference Center&lt;/em&gt;</td>
<td>Mr. James Rodriguez, Co-Chair, WC21 (United States)</td>
</tr>
<tr>
<td>0830 – 0835</td>
<td>Welcome</td>
<td>Mr. Ken James, Office of Warrior Care Policy (United States)</td>
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<tr>
<td>0835 – 0845</td>
<td>Administrative Remarks</td>
<td>Senior Representatives, Invited Nations</td>
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<tr>
<td>0845 – 0855</td>
<td>Nation Introductions</td>
<td>Colonel Cary Harbaugh, Special Operations Command (United States)</td>
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<tr>
<td>0855 – 0915</td>
<td>Group Picture</td>
<td>All</td>
</tr>
<tr>
<td>0915 – 0930</td>
<td>Host Remarks</td>
<td>Dr. Karen Guice, Office of the Assistant Secretary of Defense for Health Affairs (United States)</td>
</tr>
<tr>
<td>0930 – 1000</td>
<td>Warrior Care in the 21&lt;sup&gt;st&lt;/sup&gt; Century Opening Remarks</td>
<td>Dr. Ray Nason, Office of Warrior Care Policy (United States)</td>
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<tr>
<td>1000 – 1015</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>1015 – 1030</td>
<td>Warrior Care in the 21&lt;sup&gt;st&lt;/sup&gt; Century Review&lt;br&gt;(October 2015 Symposium, standup of work groups, recently joined nations)</td>
<td>Brigadier Timothy Hodgetts, Co-Chair, WC21 (United Kingdom) and Mr. James Rodriguez, Co-Chair, WC21 (United States)</td>
</tr>
<tr>
<td>1030 – 1100</td>
<td>Modeling Force Readiness</td>
<td>Dr. Amy Adler, Walter Reed Army Institute of Research (United States)</td>
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<tr>
<td>1100 – 1130</td>
<td>Break</td>
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</tr>
<tr>
<td>1130 – 1215</td>
<td>Breakout Session – Work Group 1 Focus Area</td>
<td>Mr. David Morton, Lead, WC21 Work Group 1 (Australia)</td>
</tr>
<tr>
<td>1245 – 1300</td>
<td>Work Group 1 – Resilience&lt;br&gt;(Work group objectives provided on page 6)</td>
<td>Supporting Nations; Australia, Canada, Denmark, Netherlands, New Zealand, United Kingdom, United States</td>
</tr>
<tr>
<td>1300 – 1345</td>
<td>Break</td>
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<tr>
<td>1345 – 1445</td>
<td>Breakout Session Outbrief/Discussion</td>
<td>Mr. James Rodriguez, Co-Chair, WC21 (United States)</td>
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<tr>
<td>1445 – 1500</td>
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<tr>
<td>1500 – 1600</td>
<td>Breakout Session Outbrief/Discussion</td>
<td>Mr. James Rodriguez, Co-Chair, WC21 (United States)</td>
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<tr>
<td>1600 – 1615</td>
<td>Day 1 Summary, Day 2 Look Ahead</td>
<td>Mr. James Rodriguez, Co-Chair, WC21 (United States)</td>
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<tr>
<td>Evening</td>
<td>Free</td>
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## Day 2 – Wednesday, October 26, 2016 | MacDill Air Force Base, Tampa, FL

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<tr>
<td>0800 – 0815</td>
<td>Opening Remarks</td>
<td>Mr. Ken James, Office of Warrior Care Policy (United States)</td>
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| 0815 – 0900| **Work Group 2 – Recovery and Rehabilitation** | Brigadier Timothy Hodgetts, Lead, WC21 Work Group 2 (United Kingdom)  
Supporting Nations: Australia, Canada, Netherlands, New Zealand, United Kingdom, United States |
| 0900 – 0915| Break                                 |                                                                           |
| 0915 – 1015| Breakout Session – Work Group 2 Focus Area | All (Designated Breakout Groups)                                           |
| 1015 – 1030| Break                                 |                                                                           |
| 1030 – 1130| Breakout Session Outbrief/Discussion  | Breakout Group Representatives                                            |
| 1130 – 1145| Break                                 |                                                                           |
| 1145 – 1230| Guest Speaker Lunch (Pay As You Go)   | Colonel (Ret.) Miguel Howe, Bush Institute (United States)                |
| 1230 – 1245| Break                                 |                                                                           |
| 1245 – 1330| **Work Group 3 – Reintegration**      | Mr. Paata Patashvili, Lead, WC21 Work Group 3 (Georgia)                  
Supporting Nations: Australia, Canada, Denmark, Georgia, Netherlands, United States |
<p>| 1330 – 1345| Break                                 |                                                                           |
| 1345 – 1445| Breakout Session – Work Group 3 Focus Area | All (Designated Breakout Groups)                                           |
| 1445 – 1500| Break                                 |                                                                           |
| 1500 – 1600| Breakout Session Outbrief/Discussion  | Breakout Group Representatives                                            |
| 1600 – 1615| Day 2 Summary, Day 3 Look Ahead       | Mr. James Rodriguez, Co-Chair, WC21 (United States)                       |
| 1830 – 1900| Networking Reception                  |                                                                           |
| 1900 – 2030| Guest Speaker Dinner                 | Brigadier-General Hugh Colin MacKay, Canadian Armed Forces (Canada)       |</p>
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<tr>
<td>0700 – 0800</td>
<td>Transportation from MacDill Inn to James A. Haley Veterans' Hospital</td>
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<tr>
<td>0800 – 0830</td>
<td>Guest Arrival at James A. Haley Veterans' Hospital</td>
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</tr>
<tr>
<td>0830 – 0835</td>
<td>Welcome</td>
<td>Mr. James Rodriguez, Co-Chair, WC21 (United States)</td>
</tr>
<tr>
<td>0835 – 0845</td>
<td>Host Remarks</td>
<td>Mr. Joe Battle, James A. Haley Veterans' Hospital (United States)</td>
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<tr>
<td>0845 – 0900</td>
<td>Panel Moderator Remarks</td>
<td>Ms. Lida Citroën, LIDA360 (United States)</td>
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<tr>
<td>0900 – 1030</td>
<td>Panelist Remarks on International and Interagency Relationships</td>
<td>Colonel James G. Kile, Canadian Army (Canada)</td>
</tr>
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<td></td>
<td>Brigadier General Dr. Bernd Mattiesen, Ministry of Defense (Germany)</td>
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<td></td>
<td></td>
<td>Mrs. Nataliia Melnychenko, NATO Support and Procurement Agency (Ukraine)</td>
</tr>
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<td></td>
<td>Dr. Linda Spoonster Schwartz, Department of Veterans Affairs (United States)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colonel Professor Vsevolod Stebliuk, Ukrainian Military Medical Academy (Ukraine)</td>
</tr>
<tr>
<td>1030 – 1100</td>
<td>Break</td>
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<tr>
<td>1100 – 1200</td>
<td>Moderated Panel Discussion on International and Interagency Relationships</td>
<td>Ms. Lida Citroën, LIDA360 (United States)</td>
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<td>Colonel James G. Kile, Canadian Army (Canada)</td>
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<td>Brigadier General Dr. Bernd Mattiesen, Ministry of Defense (Germany)</td>
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<td>Dr. Linda Spoonster Schwartz, Department of Veterans Affairs (United States)</td>
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<td>Colonel Professor Vsevolod Stebliuk, Ukrainian Military Medical Academy (Ukraine)</td>
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<tr>
<td>1200 – 1230</td>
<td>Break</td>
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<tr>
<td>1230 – 1330</td>
<td>Guest Speaker Lunch (Pay As You Go)</td>
<td>Dr. Richard Stone, Veterans Health Administration (United States)</td>
</tr>
<tr>
<td>1330 – 1400</td>
<td>Break</td>
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<tr>
<td>1400 – 1445</td>
<td>Tour of Tampa Polytrauma Rehabilitation Center</td>
<td>Department of Veterans Affairs (United States)</td>
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<tr>
<td>1445 – 1530</td>
<td>Telehealth Demonstration</td>
<td>Department of Veterans Affairs (United States)</td>
</tr>
<tr>
<td>1530 – 1600</td>
<td>Symposium Summary, WC21 Look Ahead</td>
<td>Brigadier Timothy Hodgetts, Co-Chair, WC21 (United Kingdom) and Mr. James Rodriguez, Co-Chair, WC21 (United States)</td>
</tr>
<tr>
<td>1600 – 1700</td>
<td>Transportation from James A. Haley Veterans' Hospital to MacDill Inn</td>
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**Appendix B: Registration List**

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<tr>
<th>#</th>
<th>Last Name</th>
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<th>Organization</th>
<th>Title</th>
<th>Nation</th>
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<tbody>
<tr>
<td>1</td>
<td>Adler</td>
<td>Amy</td>
<td>Walter Reed Army Institute of Research</td>
<td>Research Psychologist</td>
<td>United States</td>
</tr>
<tr>
<td>2</td>
<td>Al Masarweh</td>
<td>Jadallah</td>
<td>The Hashemite Commission for Disabled Soldiers</td>
<td>Brg.Gen. (Rtd)/General Director</td>
<td>Jordan</td>
</tr>
<tr>
<td>3</td>
<td>Al-Hussein</td>
<td>Mired</td>
<td>Hashemite Commission for Disabled Soldiers</td>
<td>His Royal Highness/President</td>
<td>Jordan</td>
</tr>
<tr>
<td>4</td>
<td>AlJa'arat</td>
<td>Khalaf</td>
<td>The Hashemite Commission for Disabled Soldiers</td>
<td>Maj./Royal Guard to HRH Prince Mired Raad Zeid Al-Hussein</td>
<td>Jordan</td>
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<tr>
<td>5</td>
<td>Allen</td>
<td>Edward</td>
<td>USCENTCOM</td>
<td>Chief, Personnel Division</td>
<td>United States</td>
</tr>
<tr>
<td>6</td>
<td>Amidon</td>
<td>Matthew</td>
<td>George W. Bush Institute</td>
<td>Deputy Director - Military Service Initiative</td>
<td>United States</td>
</tr>
<tr>
<td>7</td>
<td>Ammerman</td>
<td>Howard</td>
<td>USSOCOM Warrior Care Program (Care Coalition)</td>
<td>Sergeant Major/Senior Enlisted Advisor</td>
<td>United States</td>
</tr>
<tr>
<td>8</td>
<td>Back</td>
<td>Matthew</td>
<td>UK Defence Medical Services</td>
<td>Flt Lt</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>9</td>
<td>Bailey</td>
<td>Suzanne</td>
<td>Canadian Armed Forces</td>
<td>Senior Social Work Officer</td>
<td>Canada</td>
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<tr>
<td>10</td>
<td>Baines</td>
<td>Lynne (Lyndsay)</td>
<td>Ministry of Defense &amp; Anglia Ruskin University</td>
<td>Academic</td>
<td>United Kingdom</td>
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<tr>
<td>11</td>
<td>Barkaia</td>
<td>Khatuna</td>
<td>Ministry of Defense</td>
<td>Acting Head of Administrative Division; Wounded and Injured Warrior Support Department</td>
<td>Georgia</td>
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<tr>
<td>12</td>
<td>Battle</td>
<td>Joe</td>
<td>James A. Haley Veterans’ Hospital and Clinics</td>
<td>Director</td>
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<td>Iain</td>
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<td>Medical Officer Primary Care Division</td>
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<td>Junior Writer</td>
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<tr>
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<td>Markus</td>
<td>Canadian Forces Health Services</td>
<td>Head of Rehabilitation Medicine</td>
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<tr>
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<td>Besterman-Dahan</td>
<td>Karen</td>
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<td>Medical Anthropologist</td>
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<tr>
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<td>Bruner</td>
<td>Al</td>
<td>Office of Warrior Care Policy</td>
<td>Director, DoD DES Policy</td>
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<td>Resolute Support HQ Medical</td>
<td>Advisor</td>
<td>Afghanistan</td>
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<td>Discipio</td>
<td>Iryna</td>
<td>Revived Soldiers Ukraine</td>
<td>President/Development</td>
<td>Ukraine</td>
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<td>Department of Veterans Affairs, Research</td>
<td>Research Assistant</td>
<td>United States</td>
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<tr>
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<td>Dursun</td>
<td>Sanelia</td>
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<td>Director Research Personnel &amp; Family Support</td>
<td>Canada</td>
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<tr>
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<td>Edgecomb</td>
<td>Anne</td>
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<td>Chief, Internal Communications</td>
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<td>Elie</td>
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<td>French Military Health Service</td>
<td>COL, M.D. Medical Liaison Officer to the OTSG - US Army</td>
<td>France</td>
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<td>Director Defence Rehabilitation</td>
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<td>Finley</td>
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<td>Outreach Vocational Rehabilitation Counselor/IDES National Program Lead</td>
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<td>Arlene</td>
<td>International Institute of Orthotics and Prosthetics</td>
<td>Founder/CEO</td>
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<td>Tessa</td>
<td>British Embassy</td>
<td>Policy Advisor</td>
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<td>Acting Assistant Secretary of Defense for Health Affairs</td>
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<td>Harbaugh</td>
<td>Cary</td>
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<td>Hillier</td>
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<td>Navy Wounded Warrior-Safe Harbor</td>
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<td>Ministry of National Defense of the Republic of Lithuania</td>
<td>Advisor to the Minister of Defense of the Republic of Lithuania</td>
<td>Lithuania</td>
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<td>Jgarkava</td>
<td>Vasil</td>
<td>MoD</td>
<td>Colonel/GEO SNR to CENTCOM</td>
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<td>Natalie</td>
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<td>VISN 8 Director</td>
<td>United States</td>
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<tr>
<td>53</td>
<td>Lea</td>
<td>John</td>
<td>Ministry of Defence</td>
<td>SO1 Health and Wellbeing</td>
<td>United Kingdom</td>
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<td>Rich</td>
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<td>Karen</td>
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<td>Bernd</td>
<td>MOD Germany</td>
<td>Brigadier General (Med Corps)</td>
<td>Germany</td>
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<td>David</td>
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<td>Chief of Defence People (CDP)</td>
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<td>Chief of the Department of Veterans</td>
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<td>Veterans' Affairs, New Zealand Defence Force</td>
<td>Principal Advisor to the Head of Veterans' Affairs</td>
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<td>Dustin</td>
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<td>Regimental Surgeon</td>
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<td>Potvin</td>
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<td>Kenneth</td>
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<td>Director, Defense Health Agency (DHA), Defense Health Headquarters</td>
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<td>Ruth</td>
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<td>James A. Haley Veterans’ Hospital and Clinics</td>
<td>Tampa VA Polytrauma Director</td>
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<td>Sharpley</td>
<td>John</td>
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<td>Surgeon Captain/Defence Consultant Advisor in Psychiatry</td>
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<td>Matthew</td>
<td>MEDCOM, Warrior Care and Transition</td>
<td>Deputy Chief of Staff</td>
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<td>Stebliuk</td>
<td>Vsevolod</td>
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<td>Colonel, Professor, Vice-Chief</td>
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<td>Christina</td>
<td>Department of Veterans Affairs</td>
<td>VA WC21 POC</td>
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Appendix C: Speakers and Presenters

Amy B. Adler, Ph.D.
Clinical Research Psychologist, Walter Reed Army Institute of Research, United States

Dr. Adler obtained her undergraduate baccalaureate degree in economics from Brown University in Providence, Rhode Island, and her Masters and Doctorate (Ph.D.) degrees in psychology from the University of Kansas. After her internship and fellowship in Chicago-area medical centers, she served as a licensed clinical psychologist in military health clinics in Germany from 1993 to 1996; she served as an instructor in psychology with the University of Maryland-European Division from 1992 to 1999.

In 1992, Dr. Adler began working part-time at the U.S. Army Medical Research Unit-Europe, an overseas unit of the Walter Reed Army Institute of Research (WRAIR) located in Heidelberg, Germany; she then began working full-time in 2000. In 2014, she was relocated to WRAIR in Silver Spring, MD, where she is co-chair of the Army’s Psychological Health and Resilience Research Program and senior science advisor to the Center for Military Psychiatry and Neuroscience. She also serves as a scientist and has led randomized trials assessing early interventions and resilience training with operational units and units going through Basic Combat Training. Her current research interests include attitudes that influence treatment seeking, behavioral health leadership, and optimizing resilience training efficacy.

Besides being an invited speaker at international conferences, she has served on NATO committees and as the US representative on technical panels as part of a five-nation activity (The Technical Cooperation Program). Dr. Adler has also published more than 90 articles in peer-reviewed journals and has co-edited six books. Her book, “Deployment Psychology” (co-edited with Paul Bliese and Carl Castro), was published by the American Psychological Association in 2011. She is an associate editor of Military Psychology and serves on the editorial board of the Journal of Occupational Health Psychology. She received the Department of the Army Meritorious Civilian Service Award (2014) and is a Fellow of the American Psychological Association.

Ms. Khatuna Barkaia
Acting Head of Administrative Division, Wounded and Injured Warrior Support Department, Ministry of Defense, Georgia

Khatuna Barkaia has served as the Acting Head of the Administrative Division of the Wounded and Injured Warrior Support Department since 2015. Her main duties and responsibilities include working on wounded or injured warriors, their family members’ reintegration, resocialization-related issues and projects, as well as updating and maintaining the wounded or injured warrior database and supporting the department’s engagement in international projects. She began her career at the Ministry of Defense of Georgia in March, 2014. Khatuna Barkaia graduated from the Tbilisi Institute of Asia and Africa in 2007 and obtained her Bachelor’s Degree in Japanese Language, History and Culture. She obtained her Master’s Degree in Japanese History from Kobe University in Kobe, Japan, in 2013.
Mr. Joe D. Battle  
Medical Center Director, James A. Haley Veterans’ Hospital and Clinics, United States

Joe D. Battle was appointed Medical Center Director of the James A. Haley Veterans’ Hospital and Clinics in Tampa, Florida effective July 26, 2015.

Previously, Mr. Battle served as the director of the VA Medical Center in Jackson, Mississippi and prior to that, he served as the Associate Director of the VA Medical Centers in Orlando, Florida, and Dayton, Ohio. Mr. Battle began his VA career in 1983 as a general engineer at the VA Medical Center in Dublin, Georgia and also worked at the VA Medical Center in Indianapolis, Indiana as the Assistant Chief and later as the Chief of Engineering.

In 1997, he received VA’s Federal Engineer of the Year Award presented by the National Society of Professional Engineers. In that same year, he also received the VA Chief Engineer of the Year Award. Mr. Battle is a 2003 graduate of Leadership VA (LVA), the 2002 class of the Executive Career Field Training Program and the Healthcare Leadership Institute. He completed the UNC Kenan-Flagler Business School Senior Executive Strategic Leadership course in 2012. He is a certified mentor and has mentored Executive Career Field candidates and members, and Leadership Development Candidates.

Mr. Battle recently served on the Veterans Integrated Services Network (VISN) 16 Executive Leadership Board, and was the Lead Director for the VISN 16 Central Southern Planning Market. Previously his work included VA’s Office of Information and Technology Region 3 Governance Board, and Chaired the VISN 8 Information and Data Management Committee, Capital Asset Management Committee and Finance Committee. He has served on several national committees and task forces. Mr. Battle currently serves on the National Leadership Council, Capital and Logistics Sub-committee.

Mr. Battle is a current member of the American College of Healthcare Executives and the LVA Alumni Association. He is a 1981 graduate of the University of Alabama and married with two adult children.

Ms. Lida Citroën  
Principal, LIDA360, United States

Lida Citroën is an international reputation management and brand specialist who designs and enhances the identities of companies and executives globally. Her specialty is Personal Branding, the practice of promoting one’s value, managing reputation online and in person, building executive presence and creating measurable impact to a target audience. Citroën has worked with notable government and private sector executives and leaders in the United States, Canada, Spain, Switzerland, Japan, Holland, the United Kingdom, France, the United Arab Emirates, Australia, and other countries.

After a 20-year career in corporate branding, strategic marketing, and international communications for regional and national companies, in 2008 Citroën formed LIDA360, a Colorado-based consulting firm, to meet the demand of international
professionals seeking to differentiate themselves and their businesses in increasingly competitive and global markets.

Since 2009, Citroën has leveraged her expertise to help transitioning military service members build their civilian careers. Citroën is a member of the Board of Directors of the National Association of Veteran Serving Organizations (NAVSO), writes for Military.com, collaborates with LinkedIn on Veterans’ issues, and volunteers with the Employer Support of the Guard and Reserves (ESGR). Citroën teaches personal branding and online reputation management (specifically LinkedIn) in the transition program (TAP) at the United States Air Force Academy. She presents her program, “Personal Branding for the Military-to-Civilian Transition,” at conferences, on military installations, and in corporate settings where Veterans are employed. LIDA360 offers talent consulting services to companies seeking to hire, on board and retain Veteran employees across the organization.

Citroën makes regular media appearances to share her perspective and tools on Veteran reintegration and career transition. She was a TEDx speaker in 2016, and has been featured in The UK Guardian, Handelsblatt, Fortune Magazine, Huffington Post, Entrepreneur Magazine, Hiring America, Forbes.com, Harvard Business Review, and on MSNBC and CBS Moneywatch, among others.

In 2014, Citroën published her second book, Your Next Mission: A personal branding guide for the military-to-civilian transition offering personal branding, career and professional tools and guidance to transitioning military Veterans. She is also the author of Reputation 360: Creating power through personal branding, (Palisades Publishing, 2011,) a best-selling guide for reputation management.

Citroën collaborates with and provides personal branding services for military Veterans through: General Electric, the Institute for Veterans and Military Families (IVMF at Syracuse University), American Veterans (AMVETS), Raytheon, Veterans of Foreign Wars (VFW), Xcel Energy, the US Air Force Academy, the Marine Corps Base Quantico, the U.S. Department of Defense, Wounded Warrior Project, Student Veterans of America, Wall Street Warfighters, BAE Systems, the Department of Veterans Affairs, the Society of Human Resource Management (SHRM), the Office of the Chairman of the Joint Chiefs of Staff, Warrior & Family Support, and many other private and governmental organizations.

Karen S. Guice, MD, MPP
Acting Assistant Secretary of Defense for Health Affairs, United States

Karen S. Guice, M.D., M.P.P., is the Acting Assistant Secretary of Defense for Health Affairs. Dr. Guice assists in the development of strategies and priorities to achieve the health mission of the Military Health System, and participates fully in formulating, developing, overseeing and advocating the policies of the Secretary of Defense.

Dr. Guice also acts as a liaison for the ASD(HA), other offices within OSD, the Military Departments, Congress, and other Executive Branch agencies to develop, coordinate and integrate health care policies with departmental priorities and initiatives. Additionally, Dr. Guice oversees Congressional and legislative activities for the OASD(HA), as well as guides the office’s public affairs and communications programs. The Office of Health Affairs provides a cost effective, quality health benefit to 9.6
million active duty uniformed Service Members, retirees, survivors and their families. The MHS has a $50 billion annual budget and consists of a worldwide network of 59 military hospitals, 360 health clinics, private-sector health business partners, and the Uniformed Services University.

In addition, Dr. Guice serves as acting Military Health System Chief Information Officer. In this position, she supports the assistant Secretary of Defense (Health Affairs) and Department of Defense medical leaders on all matters related to information management and information technology.

Previously, Dr. Guice served as the Executive Director of the Federal Recovery Coordination Program, a joint program of the Departments of Defense and Veterans Affairs. Dr. Guice graduated from the University of New Mexico School of Medicine and completed her general surgery training at the University of Washington. She has been a member of the surgical faculties at the University of Texas Medical Branch at Galveston, the University of Michigan, Duke University, and the Medical College of Wisconsin. She was promoted to Professor of Surgery during her tenure at Duke University.

Dr. Guice received a master’s degree in Public Policy from Duke University and was selected as a 1997-1998 Robert Wood Johnson Health Policy Fellow. Dr. Guice served as a staff member of the Senate Committee on Labor from 1998-1999, and as the Director of Fellowship Services at the American College of Surgeons (1999-2001). She was the Deputy Director for the President’s Commission on Care for America’s Returning Wounded Warriors (Senator Bob Dole and Secretary Donna Shalala, co-chairs, 2007).

Dr. Guice has been a funded investigator for over 10 years, receiving grants from the NIH and the Emergency Medical Services for Children Program. Her basic science research included the scientific investigation of pancreatitis related respiratory failure and her health services research focused on the development of a national trauma registry for children and outcome evaluation of children’s trauma-related care. She has served on NIH Study Sections and EMSC grant review panels. She authored or coauthored over 60 peer reviewed publications and nine book chapters.

Dr. Guice is a member of several professional societies and was elected President of the Association of Academic Surgery in 1993. She received the Association of Women Surgeons Distinguished Member Award in 1999 and the W.W. Coon Surgical Residents Award for Teaching Excellence at the University of Michigan in 1988. In 1993, she received the Outstanding Alumna Award from the College of Arts and Sciences at New Mexico State University. She received an award for Outstanding Achievement from the office of the Secretary of Defense in 2007 for her work on the President’s Commission, and received a Commendation from the Department of Veterans Affairs in 2009.
Colonel Cary C. Harbaugh, U.S. Army
Director, Care Coalition, United States Special Operations Command, United States

Colonel Cary C. Harbaugh is a native of Pittsburgh, Pennsylvania. He first served as an enlisted soldier and noncommissioned officer in Airborne and Special Operations units from 1978-1987. He was commissioned as a Distinguished Military Graduate through the ROTC program at The Ohio State University in 1987.

His military education includes the Italian War College (Foreign Exchange); and the Army War College in Fellowship at the CIA, where he also completed the National Clandestine Service’s Graduate Studies Program.

Colonel Harbaugh’s service has included deployments from Operations Just Cause and Desert Shield/Storm to Iraqi Freedom and Enduring Freedom (Trans Sahel). From 2001-2004 he served as the Director of Intelligence (J2) at US Special Operations Command Europe. From 2007 to 2009 he assumed duties as the first Director/Commander of the Joint Intelligence Center, USSOCOM (JICSOC). After a NATO tour to Italy, he returned to USSOCOM in 2013 and now serves as the Director of USSOCOM’s Care Coalition supporting Special Operations wounded, ill, and injured Service members and their families.

Brigadier Timothy J. Hodgetts, CBE
Medical Director, Defence Medical Services, United Kingdom

Brigadier Tim Hodgetts is an emergency physician with over 20 years of operational experience, leading the UK specialty of military emergency medicine from infancy to maturity and treating the victims of conflict in Northern Ireland, Kosovo, Iraq and Afghanistan. He has published and lectured extensively in the fields of pre-hospital emergency care, disaster medicine, and resuscitation of the critically injured, and has designed and propagated national and international curricula in these subjects.

Brigadier Hodgetts’ academic career includes the positions of inaugural Defence Professor of Emergency Medicine at the Royal College of Emergency Medicine, Honorary Professor of Emergency Medicine at the University of Birmingham, Visiting Professor in the School of Health Sciences at City University London, and Penman Professor of Surgery at the University of Cape Town. In 1999 he was made Officer of the Order of St John for services to humanity in Kosovo; in 2006 he was the UK national ‘Hospital Doctor of the Year’; in 2009 he was made Commander of the British Empire for his contribution to combat casualty care; and in 2010 he received the Danish Defence Medal for Meritorious Service for his clinical leadership of the Danish-US-UK field hospital in Afghanistan. From 2004-2010 he served as the Queen’s Honorary Physician. From 2011-2013 he was the Medical Director with NATO’s Allied Rapid Reaction Corps. His current appointment is as Medical Director to the UK Defence Medical Services.
Colonel Miguel Howe, USA, Ret.
Director, Military Service Initiative, George W. Bush Institute, United States

Colonel Miguel Howe, USA, Ret. is the Director of the Military Service Initiative at the George W. Bush Institute. As the Director, Colonel Howe leads the Bush Institute’s work to honor the service and sacrifice of post-9/11 Veterans, service members and their families. The Military Service Initiative will work to unite the efforts of non-profits, businesses, universities, individual citizens and communities to empower all post-9/11 Veterans to continue to serve as national assets after they take off the uniform.

Colonel Howe retired from the United States Army where he served for over 24 years in a myriad of command and staff assignments to include in Iraq and Afghanistan. He deployed in support of Operation Enduring Freedom as the commander of the Afghan National Army Special Operations Advisory Group, Camp Morehead Afghanistan. He also deployed in support of Operation Iraqi Freedom as the Chief of Staff for the NATO Training Mission in Al Rustamiyah, Iraq. A Special Forces Officer, he has commanded special operations forces on numerous deployments throughout Latin America with the 7th Special Forces Group (Airborne). Colonel Howe served as the Special Assistant to the CEO of the Millennium Challenge Corporation (MCC) and commanded the U.S. Army Southern California Recruiting Battalion. He began his Army career in the 25th Infantry Division as a Rifle Platoon Leader.

Colonel Howe was selected in 2006 by President George W. Bush to serve as a White House Fellow. He is a graduate of the United States Military Academy and earned a Master of Arts in National Security Studies from Georgetown University. He is married with two children.

Harold K. “Ken” James, Colonel, USAF, Ret.
Lead Associate, Booz Allen Hamilton, United States

Mr. James is the Booz Allen Deputy Project Manager for the Warrior Care Performance Management Support Team, Department of Defense, Office of Warrior Care Policy. An accomplished, versatile, and results-driven senior executive, Mr. James offers a solid history of 40+ years of leading diverse organizations, human resource functions, and information management initiatives.


In 2006, Mr. James joined Booz Allen Hamilton as a defense consultant focusing on the Department of Defense and Joint Combatant Command markets. He was the Deputy Project Manager for developing a new air force base design concept for the Secretary and Chief of Staff of the U.S. Air Force. Shortly after completing this project, Mr. James joined Office of Warrior Care Policy. A recognized expert on disability issues, he worked with Department of Defense, Military Department, and Veterans Affairs representatives to redesign the disability
evaluation program—first major change in 60 years. Mr. James has used his expertise to conduct numerous Congressionally directed studies that addressed evaluation of the DES structure and resources.

Mr. James is a Distinguished Graduate of the U.S. Air Force Air Command and Staff College, holds a Master of Arts in Management from Webster University, Missouri, and a Master of Arts in National Security and Strategic Studies from the Naval War College, Newport, Rhode Island. Mr. James is the recipient of the Defense Superior Service Medal, Legion of Merit (1 oak leaf cluster), Defense Meritorious Service Medal, Meritorious Service Medal (4 oak leaf clusters), Air Force Commendation Medal, Air Force Volunteer Service Medal, and the Air Force Good Conduct Medal.

**Colonel James G. Kile, OMM, CD, MSC, MD**  
Command Surgeon, Canadian Army, Canada

Col Jim Kile enrolled in the Canadian Armed Forces (CAF) in 1989 through the Medical Officer Training Program (MOTP) and graduated from the University of Toronto Medical School. He holds both a Bachelors and Masters of Science degree from the University of Waterloo (U of W) specializing in muscle fatigue and exercise physiology through the Faculty of Applied Health Sciences. In 1995 Col Kile deployed on Op MANDARIN as the Battalion Medical Officer for the Canadian Logistics Battalion (CANLOGBAT) in support of United Nations Protection Force (UNPROFOR) in the Balkans.

Upon his return he was posted to the Canadian Forces Medical Services School (CFMSS) at CFB Borden as an instructor. In 1996, he graduated top candidate on the Canadian Forces flight surgeons’ course, receiving the prestigious Pagnutti Award. Col Kile was subsequently deployed for a brief period working as a flight surgeon aboard the aircraft carrier USS Enterprise.

Col Kile was promoted to the rank of Major in 1998 and posted to CFB Petawawa as Base Surgeon and was placed in charge of the Base’s main medical facility. Selected for special training in emergency medicine at the University of Ottawa he returned to Petawawa following graduation as the Officer Commanding a Medical Company in 2 Field Ambulance and was subsequently appointed Brigade Surgeon for 2 Canadian Mechanized Brigade Group (2 CMBG). During this period he deployed to Tanzania in support of a French led Humanitarian initiative, and was appointed Medical Platoon Commander of the Disaster Assistance Response Team (DART).

Promoted to LCol in 2003, Col Kile was posted to Ottawa to serve as Senior Staff Officer for the Military Doctor RECRUITMENT and RETENTION PROJECT. Concurrently, he was appointed CAF physician to the Honourable Adrienne Clarkson, Governor General of Canada, during her travels abroad. In 2004, Col Kile received the Faculty of Applied Health Science Alumni Achievement Award from the U of W as a distinguished alumnus and was recognized for his academic achievements, humanitarian work and community service. In the fall of 2004, Col Kile deployed to Kabul, Afghanistan as Commanding Officer of the Field Hospital and as Task Force Surgeon during Operation ATHENA. Upon his return, he was posted to Canadian Forces Health Services Support Unit (Ottawa) as the National Capital Region (NCR) Surgeon. In the fall of 2005, Col Kile was made a Fellow of the College of Family Physicians of Canada.
In July 2006, Col Kile assumed command of 2 Field Ambulance in Petawawa. At the same time, he was elected to the board of directors of the Pembroke Regional Hospital and held the 1st vice chair position. A member of the Upper Ottawa Valley Medical Recruitment committee, he was instrumental in fund raising and recruiting several new civilian doctors to the area.

In July 2009, Col Kile was posted to Toronto as the Joint Task Force Central / Land Forces Central Area (JTFC / LFCA) Surgeon, where he was the senior medical advisor to the Regional Army and 4 Health Services Group Commanders. Among his assignments was the command position for the military health services component of the G8/G20 summit and military post-mortem coverage for the soldiers killed in Afghanistan.

In July 2011, Col Kile began full time studies in French Language. In July 2013, Col Kile was promoted to his current rank beginning work as the Canadian Army Surgeon. After 3 years with the Army, Col Kile was appointed Director of Medical Policy and Clinical Services for Canadian Forces Health Services Group.

An avid hockey fan and player, he played varsity hockey for U of W and has coached and played competitive hockey at the Regional and National levels for the CAF. He is an ardent reader who enjoys nonfiction books dealing with war, political history, and leadership. Throughout his career he has represented the military on many speaking occasions including as the Keynote Speaker for the Canadian Association of Emergency Physicians. He has guest lectured at the Royal Military College, multiple Medical Conferences and several universities throughout the country. In 2010, Col Kile received a Graduate Certificate in Health Systems Leadership from Royal Roads University. In 2011, he received the Order of Military Merit from the Governor General of Canada.

Brigadier-General Hugh Colin MacKay, OMM, CD
Surgeon General, Canadian Armed Forces, Canada

Brigadier-General MacKay joined the Canadian Armed Forces in 1983 as a Signal Officer. He was first posted to 4 Canadian Mechanized Brigade Group Headquarters and Signal Squadron where he served as the Assistant Operations Officer and COMCEN Troop Commander. Following his tour in Germany he was posted to 1 Canadian Signal Regiment in 1987 where he served as the Telecommunication Maintenance Troop Commander, the Unit Adjutant and completed the Advanced Signal Officer Course. He then went to the Directorate of Electronics Engineering and Maintenance where he was a Project Manager for Army Electronic Warfare equipment. In 1989 Brigadier-General MacKay was selected for the Military Medical Training Program and went off to the University of Toronto to complete his Doctor of Medicine in 1993. After completing a Family Medicine Residency at Queen's University in 1995 he was posted to work as a General Duty Medical Officer at Canadian Forces Base Kingston. In 1996 he was able to rejoin his former unit, now named the 1st Canadian Divisional Headquarters and Signal Regiment, as the Unit Medical Officer. While there he participated in Op ASSURANCE and Op ASSISTANCE. This was followed by a promotion to the rank of Major in 1997 and a posting as the Base Surgeon at Canadian Forces Base Shilo. In 1999 he was posted to 2 Field Ambulance in Petawawa as the Officer Commanding Medical Company and the Brigade Surgeon. While there he led the medical component of the DART during the earthquake disaster relief effort in Turkey, Op TORRENT. He was selected in 2000 to do post-graduate training in Occupational Medicine and Public Health at the University of British Columbia which he completed in 2002.
Upon completion of his Masters in Health Science he was promoted to the rank of Lieutenant-Colonel and posted to the Director of Health Services Operations where he served as the Head of Operational Medicine and the Project Director of the Biological Warfare Medical Countermeasures Project. Brigadier-General MacKay also completed the Advanced Military Studies Course at the Canadian Forces College in 2004. He deployed on Op ATHENA in 2007 as the Commanding Officer of the NATO Role 3 Multi-national Medical Unit at Kandahar Airfield and as the Canadian Task Force Surgeon. Upon returning from Kandahar, Brigadier-General MacKay completed second language training at the Asticou Centre and then spent six months as the CEFCOM/Canada COM/CANOSCOM Surgeon before being promoted to Colonel and assuming responsibilities as Director Force Health Protection in July 2009.

In 2012 he assumed the position of Deputy Surgeon General. On 25 May 2015, he was promoted to his current rank and on 10 June 2015, Brigadier General MacKay was appointed Surgeon General, Commander Canadian Forces Health Services Group and the Head of the Royal Canadian Medical Service. Brigadier-General MacKay is an officer of the Order of Military Merit.

Brigadier General Dr. Bernd Mattiesen, MA
Commissioner of the German Minister of Defense for Members of the Armed Forces Suffering from PTSD and Those Wounded in Action, Germany

Brigadier General Dr. Bernd Mattiesen became Commissioner of the German Ministry of Defense (MoD) for Members of the Armed Forces suffering from PTSD and those wounded in action in July 2015. In this position he advises the MoD on the prevention, care, and treatment of PTSD and wounded warrior care policy.

Mrs. Nataliia Melnychenko
Medical Rehabilitation NATO Trust Fund Project Supervisor, NATO Support and Procurement Agency, Ukraine

Since 2015, Mrs. Nataliia Melnychenko has served for the NATO Support and Procurement Agency (NSPA) as Project Supervisor for the Medical Rehabilitation NATO Trust Fund.

Prior to her current role, Mrs. Melnychenko served for ten years at PULS – MEDIUM LLC in Kyiv, Ukraine, from 2011 to 2015 as Manager of Pharmacy and from 2006 to 2011 as Pharmacist.

Mrs. Melnychenko obtained the degree of Specialist in Pharmacy in 2008 from Bogomolets National Medical University, in Kyiv, Ukraine. She underwent three months of practical work in the Therapy Unit of Kyiv City Clinical Hospital No. 3 in 2006 and three months of practical work in Kyiv City Psychoneurological Clinical Hospital No. 1 in 2007. She completed a ten-month internship in State Pharmacy, “Pharmacia,” Ukraine in 2009. Mrs. Melnychenko has also completed an Occupational Health and Safety Awareness Course in Luxembourg, in 2015, and Ukraine’s Compulsory Professional Development Course, administered every three years.

Mr. David Morton
Director General Mental Health, Psychology and Rehabilitation, Australia

David Morton joined the Australian Government Department of Defence in 2010 in the position of Director General Mental Health, Psychology and Rehabilitation within the newly formed Joint Health Command.

He has 28 years experience working in community health and mental health across clinical service provision, service delivery management and policy positions. Much of his career has involved working with Veterans, their families and defence members. He has a Bachelor of Social Work and has completed post graduate studies in Public Sector Management.

Since 1989 David has undertaken a variety of roles and tasks within the Department of Defence and Department of Veterans’ Affairs. These include: Regional Director for the Australian Defence Families and Information Liaison in the Northern Territory and Senior Social Worker for Air Force in South Australia; Director of the Veterans and Veterans Families Counselling Service in South Australia; Director of Mental Health Policy for DVA and Development of the DVA Mental Health Strategy – Towards Better Mental Health for the Veteran Community in 2001; Development of the DVA national alcohol project – The Right Mix – Your health and Alcohol which continues to be a fundamental program for reducing alcohol related harm in both DVA and defence communities; and National Manager of the Veterans and Veterans Families Counselling Service (VVCS) between 2005 and 2010.

As Director General Mental Health, Psychology and Rehabilitation in Joint Health Command, David’s primary role and responsibility is to establish the policy and program framework to improve mental health and rehabilitation services through Garrison Health Services and the Surgeon General, and provide technical advice on these matters for the ADF.
E. Ray Nason, Ph.D., Lieutenant Colonel, USAF, Ret.
Senior Associate, Booz Allen Hamilton, United States

Dr. Ray Nason is a Booz Allen Hamilton business leader and social scientist with extensive experience in human capital management, social science research and consulting and military operations, including multiple program manager and military command and staff assignments. He is widely recognized as an expert in Department of Defense and Department of Veterans Affairs disability and benefits issues.

Dr. Nason leads a cross-functional team of scientists, engineers, analysts, programmers, and communicators advising executive-level clients on the U.S. Secretary of Defense’s staff delivering a wide array of consulting services.

Dr. Nason’s areas of expertise and featured services include: quantitative descriptive, inferential, and predictive analytics and simulation modeling; research study design, execution, and documentation; organizational planning and strategy (plans, scorecards, measurement models); legislative and policy analyses, development, and integration; IT system delivery (strategy, requirements, architecture, development, acquisition); communications and outreach strategy and execution; and training strategy, design, development, and delivery, including platform and digital media.

Prior to joining Booz Allen Hamilton, Dr. Nason founded and operated Analytic Data Consulting to provide management and analytics consulting services in the commercial space. Dr. Nason also served a career on active duty in the U.S. Air Force including assignments as the Air Force Deputy Commander and Chief, Personnel Programs for U.S. Transportation Command; Director, Manpower and Personnel, Joint Task Force Southwest Asia; Commander, 5th Mission Support Squadron; Director of Research at the U.S. Air Force Academy; and Human Systems Research Manager at the U.S. Air Force Armstrong Laboratory. Dr. Nason has also held appointments as Assistant or Adjunct Professor at multiple academic institutions.

Dr. Nason has a Ph.D. in Industrial and Organizational Psychology from Michigan State University, an M.A. in Industrial and Organizational Psychology from St. Mary’s University, an M.S. in Business System Administration from St. Mary’s University, and a B.S. in Behavioral Sciences from the U.S. Air Force Academy.

Mr. Paata Patiashvili
Head of the Wounded and Injured Warrior Support Department, Ministry of Defense, Georgia

Paata Patiashvili has served as Head of the Wounded and Injured Warrior Support Department at the Ministry of Defense of Georgia since 2015 and works on wounded/injured warriors, their family members’ reintegration, and re-socialization-related issues and projects.

His career in the Ministry of Defense of Georgia started in 2012, when he served as the Head of International Protocol Department. Later in 2013, he was promoted to the position of Advisor to the Minister of Defense. His work concentrated on issues related to wounded warriors. In 2015, the Wounded and Injured Warrior Support Department was established and Patiashvili was assigned as Head of the department.
Prior to his work in the Ministry of Defense, Patiashvili worked at the Ministry of Foreign Affairs of Georgia, the Parliament of Georgia, the National Security Council of Georgia, and the Georgian International Oil Corporation. He graduated from Tbilisi Ivane Javakhishvili State University in 2002 and earned a master’s degree in international relations.

**Mr. James Rodriguez**

Deputy Assistant Secretary of Defense, Office of Warrior Care Policy, Office of the Secretary of Defense, United States

Mr. James Rodriguez is the Deputy Assistant Secretary of Defense, Office of Warrior Care Policy (WCP), Office of the Secretary of Defense. In this role, Mr. Rodriguez serves as the principal advisor on the coordination of recovery, rehabilitation, and reintegration for wounded, ill, and injured Service members across the military departments. WCP provides DoD policy development, oversight, and performance management to support what remains a highest priority for the Department: ensuring the Nation’s wounded, ill, and injured Service members, their families, and caregivers receive the support they need for recovery, rehabilitation, and reintegration. He holds leadership or membership positions on several DoD and interagency workgroups, including the DoD Council on Homelessness, DoD/VA Wounded warrior Interagency Care Coordination Committee, the Joint Executive Committee – and its Wounded, Ill, and Injured Committee – the Health Executive Committee, and the Benefits Executive Committee.

Prior to his selection as Deputy Assistant Secretary of Defense, Mr. Rodriguez was the Director for Veteran and Wounded Warrior programs at BAE Systems. In that capacity, he acted as the Corporate Liaison for the White House Joining Forces initiative, to senior military leaders, government officials, and nonprofit organizations, increasing the footprint of our nation’s wounded, ill, and injured across all spectrums of support and employment.

Mr. Rodriguez served twenty-one years in the United States Marine Corps in numerous leadership and management positions. He deployed to over 11 countries around the world and served in Operations Desert Shield/Desert Storm, Operation Eastern Exit – Somalia, and Operation Enduring Freedom. During his final duty assignment at Balboa Naval Hospital, he was the Senior Enlisted Advisor to the Officer in Charge of the Wounded Warrior Battalion, where he was responsible for the transition, education, recover, and rehabilitation of Service members with service-connected disabilities.

Mr. Rodriguez holds a Bachelor’s Degree in Political Science from the University of Maryland, University College and a Masters of Arts Degree in International Commerce and Policy from the George Mason University School of Public Policy. He is a frequently cited source on wounded, ill, and injured issues in such publications as: Your Next Mission: A Personal Branding Guide for the Military-to-Civilian Transition, by Lida Citroën, the Center for a New American Security’s Employing America’s Veterans: Perspectives from Business, and the Institute for Veterans and Military Families’ Guide to Leading Policies, Practices & Resources: Supporting the Employment of Veterans & Military Families. Mr. Rodriguez has appeared in numerous magazines including “Military Times EDGE,” “Insight Into Diversity,” and “G.I. Jobs.”

He is married to Mrs. Vanessa Rodriguez. They have two college-age daughters: Courtney and Casey.
Dr. Linda Spoonster Schwartz
Assistant Secretary for Policy and Planning, Department of Veterans Affairs, United States

Dr. Linda Spoonster Schwartz was confirmed as Assistant Secretary for Policy and Planning by the Senate on September 16, 2014. Prior to her confirmation, she served as State Veterans Affairs Commissioner of Connecticut since 2003 and was known for her strong advocacy for Homeless Veterans, Veteran Suicide Prevention, and Women Veteran issues. Dr. Schwartz served during the Vietnam War, was a member of the United States Air Force (1967-1986) and served on Active Duty and as a Reservist.

She retired in 1986 after sustaining injuries in an aircraft accident while serving as a USAF Flight Nurse. After her military service she earned a Masters in Nursing from Yale and went on to achieve a Doctorate in Public Health from the Yale School of Medicine through the VA Vocational Education Program.

She led several major research initiatives and served seven years on the VA Scientific Advisory Committee Vietnam Veterans Longitudinal Study. From 1989 to 1998 Dr. Schwartz served in an advisory capacity to the Secretary of Veterans Affairs on several subjects including Veterans Mental Health and Women Veterans issues. She has been elected to the National Board of Directors of the American Nurses Association, Vietnam Veterans of America and the Vietnam Women’s Memorial. She was also elected to the American Academy of Nursing in 2001.

Dr. Schwartz was instrumental in the construction and 2008 opening of the John L. Levitow Health Center in Rocky Hill, Connecticut, which provides care to Veterans with chronic diseases. Her many honors include the National Commendation medal of Vietnam Veterans of America for Justice, Integrity, and Meaningful Achievement; the Legion of Honor Bronze Medallion from the Chapel of the Four Chaplains; and induction into the Ohio Veterans Hall of Fame.

Colonel Professor Vsevolod Stebliuk
Deputy Head, Ukrainian Military Medical Academy, Ukraine

Col. Prof. Vsevolod Stebliuk is the current Deputy Head of the Ukrainian Military Medical Academy for clinical work – a post he gained in April 2016. He also serves as the Ukraine Coordinator for the Guardian Angels Ukraine Project, which focuses on medical rehabilitation programs for Ukrainian Veterans, and as Special Advisor to Ukraine’s Minister of Defence for Medical Issues.

Prior to his current position at the Ukrainian Military Medical Academy, Col. Prof. Stebliuk served as Assistant Minister of Defence from 2015-2016 and periodically taught at several different academic institutions prior to the Russian-Ukrainian War. He began his career in the Ukrainian military in the mid-1980s, but he would rise to leadership roles from 1993-1994 and 2004-2010 in various posts throughout the Ministry of Internal Affairs’ hospital network. Throughout his career, Col. Prof. Stebliuk has taught multiple subjects at various Ukrainian academic institutions, including Medicine and Aerospace Biocybernetics at the National Aviation University; Physical Rehabilitation at the Institute of Biomedical Engineering at Sikorsky
Technical University KPI; and Criminology, Forensic Medicine, and Psychiatry at the National Academy of Internal Affairs. Col. Prof. Stebliuk has generated over 100 publications and 12 patents in his 20 years of research experience, and is credited with founding a new direction in medical science and practices relating to psychophysical rehabilitation.

Col. Prof. Stebliuk possesses significant field experience. He assisted with the aftermath of the Chernobyl incident from 1986-1987 early in his career and served as Head of the Medical Service Battalion patrol special policy “Peacemaker” from July-September 2014 early in the Russian-Ukrainian war. While in the Medical Service Battalion, Col Prof. Stebliuk participated in the partial liberation of the Donbass region and was a defender in the siege of Illovaysk where he negotiated for the release of more than 80 Ukrainian wounded soldiers. He would later return to inspect the warzone in eastern Ukraine as part of his duties as Assistant Minister of Defence from 2015-2016.

Col. Prof. Stebliuk earned four degrees including a medical doctorate from the Kyiv Bogomolets Medical Institute (1992), a Ph.D. in Anesthesiology from the National Academy of Internal Affairs (1999), a degree in Management and Administration of Health Services from the Ukrainian Military Medical Academy (2004), and a doctorate in Medical Sciences (2007). He has been recognized as an Honored Medical Doctor of Ukraine (2008) and as a National Hero of Ukraine (2015) for his actions during the siege of Illovaysk before being awarded the Ukrainian Order of Freedom (2016).

Richard A. Stone, MD
Principal Deputy Under Secretary for Health, Veterans Health Administration, United States

Richard A. Stone, MD, was appointed as Principal Deputy Under Secretary for Health in the Department of Veterans Affairs on February 29, 2016, where he leads clinical policies and programs for the Veterans Health Administration (VHA), the United States’ largest integrated health care system. Almost nine million Veterans are enrolled in VA’s health care system, which provides a broad range of primary care, specialized care, and related medical and social support services that are uniquely related to Veterans’ health or special needs. In addition, VHA is the nation’s largest provider of graduate medical education and a major contributor to medical research.

Prior to this appointment, Dr. Stone was a Principal at Booz Allen Hamilton, and was widely recognized for his expertise in civilian and Department of Defense health and health care business reengineering. He provided strategic input across the Federal and civilian Health portfolio and supported programs to enhance the overall health of service members, Veterans, and military families.

Dr. Stone is retired from the US Army where he served as the Army’s Deputy Surgeon General and the Deputy Commanding General of Support for US Army MEDCOM. His final assignment was leading the operations cell of the Defense Health Agency Transition Team that developed business case analysis and business process reengineering for the 10 “shared services” assigned to the new Defense Health Agency.

With extensive experience in civilian health care, Dr. Stone served multiple non-profit regional health care systems and has owned multiple businesses over his career. Currently a practicing dermatologist, he obtained
his training from Wayne State Affiliated programs in Detroit and the VA Health system, and is a Board Certified fellow in the American Academy of Dermatology.

Dr. Stone holds a BS in biology and chemistry from Western Michigan University, a MD from Wayne State University and a MA from the Army War College in Strategic Studies. He has a number of awards and honors to his credit including Distinguished Alumnus of Western Michigan University College of Arts and Sciences; the Legion of Merit, Bronze Star, and Combat Action Badge; and was a member of the Department of Defense Recovering Warrior Task Force from 2011 – 2015.
Appendix D: Breakout Session Outbrief Slides

Breakout Session 1 – Group A

**WORK GROUP 1 GOAL**
Improve efforts to build and maintain resiliency levels in Service members and their families

**DISCUSSION QUESTION #1**
What are some of the tangible characteristics, skills, and knowledge that individuals and families require if they are to transition effectively back into the military, back into the community, and ultimately into employment?

- Skills
  - Emotional Intelligence
  - Adaptability/Flexibility
- Knowledge
  - “Service member will not be left behind”
  - “Resilience is the norm” and support programs exist
- Characteristics
  - Positive view of personal/family life, sense of purpose, and societal role
  - Forgiving personality
  - Team mentality, “team care”

**Breakout Session 1 – Group A**

**WORK GROUP 1 GOAL**
Improve efforts to build and maintain resiliency levels in Service members and their families

**DISCUSSION QUESTION #2**
Is there a shared responsibility between the military member, their family, command, the organization, and the broader community to achieve better health outcomes through improved resiliency? If there is, do our current approaches to building resilience and measuring effectiveness reflect this relationship and what is the role and responsibility of leaders?

- Yes, generates accountability among all stakeholders
- Chain of command is immensely responsible and confidence is needed
  - Confidence in leadership important because of expectation of reciprocity
- Family programs are important to operational readiness/efficacy of Service member
- Family can be fragile in terms of deployment
- Organization perspective on families leaves out non-standard, complex families
- Spiritual resilience is an area the community can take greater responsibility in Service member resiliency (chaplaincies, community support)
- Spirituality can lead to easier acceptance
- P2P Support critical to resilience for younger
Breakout Session 1 – Group A

WORK GROUP 1 GOAL
Improve efforts to build and maintain resiliency levels in Service members and their families

DISCUSSION QUESTION #3
What are the factors associated with resilience at the level of individuals, family, the Unit, the military organization, and the broader community?

- Individual
  - Opposition to dependency
- Family
  - Spouses are important and can reduce Service member resilience if they leave their spouse in the service
- Unit
  - Performance optimization
- Military organization
  - Command leadership confidence critical
- Community
  - Community leaders are critical in pivoting focus to veterans; however, community not prepared, needs guidance on how to help
  - Spiritual organizations

Resilience • Recovery & Rehabilitation • Reintegration

Breakout Session 1 – Group B

WORK GROUP 1 GOAL
Improve efforts to build and maintain resiliency levels in Service members and their families

DISCUSSION QUESTIONS #1 + #3
What are the factors associated with resilience at the level of individuals, family, the Unit, the military organization, and the broader community?

What are some of the tangible characteristics, skills, and knowledge that individuals and families require if they are to transition effectively back into the military, back into the community, and ultimately into employment?

- Can analyse factors systematically:
  - External Factors (STEEPLE):
    - Social, Technological, Economic, Environmental, Political, Legal, Ethical
  - Internal Factors (TEPID COIL):
    - Training, Equipment, Personnel, Information systems, Doctrine, Clinical, Organisation, Infrastructure, Logistics

Resilience • Recovery & Rehabilitation • Reintegration
Breakout Session 1 – Group B

**Discussion Questions #1 + #3**

- **External factors:**
  - Changing family dynamics
  - Gender-based differences, especially with increase in feminization in combat role
  - Technology could be an enabler, but could also undermine deployed individual through accessibility from home
  - Culture, ethnicity, nationality (in multinational setting) could all have impact on requirements for tailored resilience development
- **Internal Factors:**
  - Training
    - Not “one size fits all”
    - Generic awareness and education
    - “Enrichment training” and a form of screening
  - Canada “Road to Mental Readiness”: adopt trg to target audience
  - Remote training, e-learning, local support, counseling, possibly screening
  - Selecting right trainer—“train the trainer”, “train the leadership”
  - Trust in the process, helps de-stigmatize
  - Through-life process, touch points throughout whole career
- **Clinical**
  - Impact of comorbidity (physical or psychological)
  - We need to do the full factor analysis to support the answers to questions 1 & 3!

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**Breakout Session 1 – Group B**

**Work Group 1 Goal**

Improve efforts to build and maintain resiliency levels in Service members and their families

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**Discussion Question #2**

Is there a shared responsibility between the military member, their family, command, the organization, and the broader community to achieve better health outcomes through improved resilience? If there is, do our current approaches to building resilience and measuring effectiveness reflect this relationship and what is the role and responsibility of leaders?

- Shared responsibility? Yes.
- Do our current approaches reflect this shared responsibility? No.

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Resilience • Recovery & Rehabilitation • Reintegration
Breakout Session 1 – Group B

WORK GROUP 1 GOAL
Improve efforts to build and maintain resiliency levels in Service members and their families

DISCUSSION QUESTION #4
Most research has focused on resilience in individuals but the concept is also being seen as related to systems of families, workplaces, organisations, and communities that the person is engaged with or a part of. What are the implications of this for the range of programs required and the impact of those?

- How does remoteness of deployment and access (or not) to technology impact on deployed resilience? Does the individual out of contact demonstrate a greater deployed resilience than one who can be easily contacted by his/her family?
- How do you deliver information to families? Does the resilience of families (regular vs. reserve; individual augmentee vs. unit; different services) vary because of how they live?
- Can we enhance family resilience by giving a formal “role” for supporting resilience training with other families?
- What are the metrics of success for resilience? Are metrics such as reduced divorce rate, reduced suicide rate, sustained employment, etc. valid?
- Do we understand how the different target audiences for potential resilience training best want and optimally receive their training information?

Breakout Session 1 – Group C

WORK GROUP 1 GOAL
Improve efforts to build and maintain resiliency levels in Service members and their families

DISCUSSION QUESTION #1
What are some of the tangible characteristics, skills, and knowledge that individuals and families require if they are to transition effectively back into the military, back into the community, and ultimately into employment?

Individuals:
- Characteristics:
  - Courage to seek help, motivation, self-confidence, responsibility, accountability, realistic aspirations
  - Physical and psychological readiness
- Skills:
  - Communication, initiative, self-reflective skills
- Knowledge:
  - Knowledgeable of their own strengths and weaknesses
  - Know the resources available and how to access them – training, financial, support
- How long do you prepare to deploy versus time to return? Do the Service members need more time to prepare to return home? Gain the knowledge necessary to transition back to civilian life

Families:
- Characteristics:
  - Realistic aspirations
- Skills:
  - Communication
  - Advocacy skills
- Knowledge:
  - Know the resources available
  - Understand the military context – How do you provide the family with knowledge of these experiences? Understand what may have changed, what to look for?
Breakout Session 1 – Group C

WORK GROUP 1 GOAL
Improve efforts to build and maintain resiliency levels in Service members and their families

DISCUSSION QUESTION #2
Is there a shared responsibility between the military member, their family, command, the organization, and the broader community to achieve better health outcomes through improved resilience? If there is, do our current approaches to building resilience and measuring effectiveness reflect this relationship and what is the role and responsibility of leaders?

- Yes, there is a shared responsibility. At times the family, command, and the broader community will need to make the call to help the Service member if they cannot or will not seek help themselves.
- Why do they not seek help? 70% do not seek help because they want to deal with it themselves.
- The Service member may be significantly underestimating the seriousness of their condition.
- Commanders need to be educated to become engaged when they see Service members in need. Leadership should address not only the needs of the Service member but the needs of the family member.
- Family members also need to know what to expect and how to identify issues. Families may not know or see the wounds. Family members should know how to help the resiliency of the Service member but also improve the resiliency of the family members.
- At what point do the responsibilities need to be shared?
- Working too much at the individual level – broaden the approach
- Does building organizational resilience affect the individual’s resilience?
- Deliver expectations that injury, illnesses occur
- At the same time, resilience can be affected in an instant. Building resilience is often very personalized to the individual and family.
- Measuring effectiveness of resilience training and current approaches to resiliency building has had significant challenges.
- Begin looking at identified more resilient populations and more at-risk populations. Can be considered using the characteristics that identify resiliency.

Breakout Session 1 – Group C

WORK GROUP 1 GOAL
Improve efforts to build and maintain resiliency levels in Service members and their families

DISCUSSION QUESTION #3
What are the factors associated with resilience at the level of individuals, family, the Unit, the military organization, and the broader community?

- Leadership
- Education of the individual and family member
- At the individual level, confidence in themselves, their equipment and their TTPs, as well as their leadership contribute to resilience
- How can and does the broader community contribute to resilience? Lessons learned from Vietnam show how community can affect outcomes. In the U.S., members in the Reserve Component might experience different reception from the broader community.
- Success story – Soldier On (Canada), Service members can see fellow members successful transitions. Contribution of peer-support in the community.
- Courage of convictions in military organizations – sense of purpose and connection to the larger group

Resilience • Recovery & Rehabilitation • Reintegration
Breakout Session 1 – Group C

WORK GROUP 1 GOAL
Improve efforts to build and maintain resiliency levels in Service members and their families

DISCUSSION QUESTION #4
Most research has focused on resilience in individuals, but the concept is also being seen as related to systems of families, workplaces, organisations, and communities that the person is engaged with or a part of. What are the implications of this for the range of programs required and the impact of those?

- Programs cannot only focus on the individual level but must be focused on family, leadership and community support and the linkages and interplay between the various levels.
- A systems approach has inherent complexities – in any complex system, the seams between the various components are the areas where the greatest issues arise. The higher level view, and the more components, the more challenges.
- Implications: The distribution and investment of resources

Breakout Session 1 – Group D

WORK GROUP 1 GOAL
Improve efforts to build and maintain resiliency levels in Service members and their families

DISCUSSION QUESTION #1
What are some of the tangible characteristics, skills, and knowledge that individuals and families require if they are to transition effectively back into the military, back into the community, and ultimately into employment?

- Self-management (personnel and families): being able to make your own choices, have the information required
- Is there evidence that intervening with self-management training is going to increase level of resilience?
  - Need intervention research to support—measure ability to tolerate uncertainty, flexible attitude, psychological skills—problem solve, break down large obstacle into a series of steps
- Military characteristics: put group needs first, ability to be self-disciplined, tolerate hierarchal organizations
Breakout Session 1 – Group D

WORK GROUP 1 GOAL
Improve efforts to build and maintain resiliency levels in Service members and their families

DISCUSSION QUESTION #2
Is there a shared responsibility between the military member, their family, command, the organization, and the broader community to achieve better health outcomes through improved resilience? If there is, do our current approaches to building resilience and measuring effectiveness reflect this relationship and what is the role and responsibility of leaders?

- Better health outcomes: better care, prevention, better support environment (level of resources, individually based), early detection
- Shared responsibility? Yes – all have a shared responsibility, but unequal sharing
  - Primary responsibility from the person? (must have general level of culture and education)
  - Command is in charge of training, education, etc.
  - Some people may not be aware of the realities of deployment
  - Varies based on each situation and individual involved
- Focus on raising awareness, coping skills

Breakout Session 1 – Group D

WORK GROUP 1 GOAL
Improve efforts to build and maintain resiliency levels in Service members and their families

DISCUSSION QUESTION #3
What are the factors associated with resilience at the level of individuals, family, the Unit, the military organization, and the broader community?

- Psychological, biological, environmental factors
- Individual: Ability to withstand adversity, measure ability to tolerate uncertainty, flexible attitude, psychological skills – problem solve, break down large obstacle into a series of steps
  - Need to give them opportunity during training so that they can practice these skills
  - Can’t teach skills through presentations—need first hand during training
  - Mental training may be helpful (after tested, debrief to fully understand and discuss the tools that you used? Debrief after stress test
- Family: security, knowledge about resources, cohesion, need to have an understanding of military training- provide peace of mind, family values, realistic expectations, lack of communication
  - Unit: leadership, security, reputation, accomplishment, mission, cohesion, welfare support, training, resources
  - Military organization: Solid senior leadership, strategic objectives, resources, vision
  - Broader community: socializing the military experience, agreeing on the expectations, what is the responsibility, attitude and commitment of politicians- dictates policies, compensation, stigma, community view of military, social guarantees, community covenant, honoring Service, community engagement
Breakout Session 1 – Group D

WORK GROUP 1 GOAL
Improve efforts to build and maintain resiliency levels in Service members and their families

DISCUSSION QUESTION #4
Most research has focused on resilience in individuals but the concept is also being seen as related to systems of families, workplaces, organisations, and communities that the person is engaged with or a part of. What are the implications of this for the range of programs required and the impact of those?

- Research is driven by the ease of measuring and testing
- Ability to research and measure workplace resiliency is difficult
- Resilient people create resilient organizations
- How necessary is it to research this? Is it understood and we don’t need to invest the resource for the research?
- Realistic expectations - it is difficult to improve the resilience of systems of communities, families, and organizations (it is difficult enough when you have an individual in front of you)
- Acknowledging that there is an issue and you are making an effort to address it is important
- If you want to create a resilient organization, you can:
  1. Select resilient people OR
  2. Find “ordinary” people and bring excellence of these people (more difficult option)
- Research question: is it possible to capture and measure “gut feel” of stage 1 training instructor?

Breakout Session 2 – Group B

How do we reduce the burden of training related injury and its impact on continued military employment, with specific reference to the increasing number of women adopting training for combat roles?

Second order questions
- What is the burden?
- What are the common predictable injuries that lead to discharge? What is the future mitigation?
- What are the gender differences in training injuries? What will be the impact of women in ground close combat on prevalence of those injuries? What is the future mitigation?
- What are the research questions?
- What is the impact of physical injury on psychological morbidity for those that continue to serve?

Key strategic messages
- The determinants of musculoskeletal health (alcohol, smoking, obesity, general health) vs injury prevention
- Strength and conditioning vs. running
- Improving injury management

Research questions
- What are the ergonomic differences in equipment required for female vs. male?

Precepts to reduce training injury burden
- Move away from “one-size-fits-all” fitness testing to occupational and gender-specific testing
- Infrastructure and process for prevention/early intervention with minor injuries
- Functional movement screen
- “Fleet maintenance model” for people
- Combining mindfulness with physical training to improve overall performance
- Rehabilitation requirements must be gender-specific
- High-educative PT—audience to better understand why they are doing the physical training
- Individualized PT (mirroring the civilian sports club model)
Breakout Session 2 – Group B

WORK GROUP 2 GOAL
Improve efforts to prepare Service members & their families for success during recovery & rehabilitation

What is the role of regenerative medicine in shaping future recovery and rehabilitation from combat injury?

Second order question
- Where does regenerative medicine start?
- Is there a role for techniques in the deployed space?

“Blue sky thinking”
- Tissue banking
- 3-D image of body before deployment
- Where does genetics and genomics cross over with regenerative medicine?

Capitalise on existing work—NATO HPM 272: series of conclusions & recommendations

Opportunities
- Cellular-based interventions vs. generating organs are more likely to be the quick wins
- ...but skin is the most accessible "organ"

for regeneration
- Concepts
  - Consider the impact of sleep as a "regenerative" intervention
- Caveats
  - Beware the pressure to innovate in regenerative medicine without the underpinning sound basic science
  - Beware regen. med. being seen as the quick fix/political expedient/panacea/ replacement for conventional rehabilitation
  - Beware unintended consequences—will a regenerated limb still be painful?

Breakout Session 2 – Group A

WORK GROUP 2 GOAL
Improve efforts to prepare Service members & their families for success during recovery & rehabilitation

DISCUSSION QUESTION #1

How do we reduce the burden of alcohol misuse and its physical, psychological, and social aspects?

General approaches that were recommended include drawing attention to programs, engaging all Service members, screenings for further studies, and offering celebration alternatives.
- Great importance in cultural and social norms around drinking as well as taking individual and organizational responsibility
- Supply, controlling availability
  - Controlling alcohol on deployment (e.g. event planning) is good, but strong leadership is important for influencing non-deployment usage
  - Removing alcohol from base does not halt problem and may have a negative morale effect
  - Partnering with community alcohol vendors to "serve responsibly" could have positive results
- Demand, reducing intake
  - Bystander can have an influential role, and programs focusing on bystanders can target larger populations of at-risk users

- We need to dispel the "binge drinking" cultural expectation.
- We need to promote alternatives to coping.
- We need to identify normative fallacies and point out to Service members that "not everyone is drinking."
- We need to lead by example (e.g. having instructors, superiors not smoke in front of subordinates)
- Harm Reduction, identifying at-risk users and causal factors
  - Social demands: loneliness, being part of the group
  - Relationship, legal, and financial issues
  - Recognizing role of alcohol related to other health issues
  - Other topics addressed: included energy drink/tobacco smoking abuse

Areas deserving better attention for recovery/rehabilitation: families, natural sleep, pain management, use of alcohol in unit cohesion, entry point for substance abuse.
Breakout Session 2 – Group C

WORK GROUP 2 GOAL
Improve efforts to prepare Service members & their families for success during recovery & rehabilitation

DISCUSSION QUESTION #1

How do we reduce the burden of alcohol misuse and its physical, psychological, and social aspects?

- Comprehensive approach:
  - Address cultural norms within the military and civilian context
  - Understanding the drivers that lead Service members to misuse alcohol
    - High risk groups – young Service members, divorced individuals, remote individuals, etc.
  - Address and prevent issues upstream, prior to when a Service member becomes wounded, ill or injured
  - Ensure leadership and medical personnel are aware and vigilant
  - Education and health promotion
  - Normalize care to reduce stigma or perceptions of stigma, treat patients with mental/behavioral health issues in primary care facilities
  - Justice system engagement and accountability – provide a deterrent, are there secondary consequences?
  - Spiritual guidance
  - Provide tools to cope other than alcohol: better pain management, improved mental healthcare, reducing stressors, facilitating reintegration and transitions, finding other outlets e.g. sport activities
  - Standardized approach to screening for alcohol misuse
  - Research in how to address comorbidity of Service members with a mental health condition and substance abuse issue
  - Improved veteran tracking and veterans’ administration engagement

Breakout Session 2 – Group D

How do we reduce the burden of alcohol and its physical, psychological, and social aspects?

- Primary prevention
  - Education: Three phased approach (Sleep, nutrition, exercise)
  - Offer healthier alternatives: meditation, sports
  - Leadership: being a good role model, training, education, support, discipline, command, set values
  - Climate health survey: questionnaire every two years to get a pulse on the work environment (Denmark)

- Secondary prevention (early detection)
  - Physical health assessment (PHA): questionnaire and then sit down and go over issues
  - UK: Routine medicals include structured mental health assessment
    - Attached to dental check-up because it happens every year instead of every 5 years at medical check-ups

- US: Force preservation council
- UK: Unit health committee
- Netherlands & Denmark: post deployment questionnaire
- AUS: annual mental health screen with audit

- Tertiary prevention (recovery of people with established alcohol issues)
  - Reduce stigma to encourage individuals to come forward if they have an issue
  - Education component (help available)
  - Fear/ risk of losing position
  - Access to effective, safe, individualized, resourced care
    - Mental health care providers are limited
  - Interface between military and civilian providers
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Breakout Session 2 – Group D

DISCUSSION QUESTION #1
How do we reduce the burden of alcohol misuse and its physical, psychological, and social aspects?

- Hidden pandemic?
  - Reservists, active duty, wounded population
  - AUS & Denmark- military alcohol population isn’t higher than civilian population
  - Denmark- not a problem among active duty but Veteran society (smoke, alcohol, drugs)
  - U.S & Denmark- Culture shift so alcohol isn’t the focus of events
  - U.S- more of a problem for the younger population, <25 yrs old
- Cause and effect OR correlation?
  - Does the military cause people to drink more? OR Do the people that join the military have a different characteristic that pre-disposes them to drink more?

- Monitoring for mental health may help control for this issue.
  - Physical, psychological, social (government, price control)
  - Military creates an environment that allows for drinking- provide subsidized housing, provide salary, so affordability of alcohol for young folks is easy
  - Price control is effective
  - What is the circumstance that young people come from? Peer pressure when starting out in the military

Resilience • Recovery & Rehabilitation • Reintegration

Breakout Session 3 – Group A

WORK GROUP 3 GOAL
Improve efforts to support Service members during reintegration into military service or transition to civilian life

DISCUSSION QUESTION #1
Recognizing that transition is often unique to each individual / family, what are the primary focus areas to support the civilian and military reintegration process, including those relating to family, work, and society?

- Meaningfulness/Sense of Purpose is critical to reintegration and purposeful activities, especially in the household, help cope with transition.
- Data management is a powerful, underrated tool.
- Counseling can provide a sense of self-worth.
- Employer awareness and addressing public misperceptions can improve attractiveness.
- Is there a sense of entitlement upon exiting the service or is it a mismatch of authority?
- We need to improve collective responsibility to dispel cultural misunderstandings about veteran health and capability.
- Financial security and support networks of friends and family are extremely critical to reintegration.

Resilience • Recovery & Rehabilitation • Reintegration
Breakout Session 3 – Group A

WORK GROUP 3 GOAL
Improve efforts to support Service members during reintegration into military service or transition to civilian life

DISCUSSION QUESTION #2
What are best practices for tracking the progress of the reintegration process and beyond? What is the recommended length of time to track this progress? Are there best practices for identifying and filling the gaps during and after transition?

- Challenge of tracking reintegration process: Invasive vs. learning successes
  - We can benefit the next cohort by learning best practices now.
  - Service members want peace following the end of their service period.

- Gaps
  - Individuals unaware of their own injuries or relatively less worrisome are left out.
  - Reserves/National Guard are lost track of because of intermittent exposure to organization.

- Solutions
  - Flexible non-liability insurance
  - Navy system allows for a review for members being discharged below honorable conditions to have their mental injuries reviewed
  - "Exit boot camp" offers guidance
  - Peer support services/community engagement

- We still want to measure post-deployment transitions (switching to a "normal" role).

- How do we think about the path to transitioning?
  - Do we look at it as a linear chronology or as a milestone path?
  - Linear thinking could lead to over-prescription.

Breakout Session 3 – Group B

DISCUSSION QUESTION #1

- MIl → MIl
  - Ability to deploy?
  - Loss of security
  - Role in family
  - Career progression

- MIl → CV
  - Resume/ CV
  - Skills/ Transitions
  - Training
  - Industry

- FAMILY
  - Managing
  - Experiences
  - Education
  - Employment
  - Diversity
  - Community
  - Resilience

- MIl → MIl
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  - Resilience
Breakout Session 3 – Group B

DISCUSSION QUESTION #2

- NAIL REINTEGRATION
  - NATIONAL BEST PRACTICES/TEACHING
  - BEST MANUFACTURER (YAMA) LIFETIME REPAIRS IF THEY WORK
  - SOCOM SEMA REASSESSMENT TRACK THROUGHOUT SERVICE
  - ALL AS REGARDED WARRIOR PROGRAMS TRACK WHILE ON ACTIVE DUTY
  - EASIER TO TRACK 'GARRISONERS' PERSONNEL
  - NO WARS BATTLEDOGS (ARMY/MARINES) BEST BETTER...
  - COMMUNICATION WHEN REMOVED FROM UNITS (NAVY/USAF)

How long to track? What is endpoint of reintegation?
- Until no services are needed
- Until effective in a job

Resilience • Recovery & Rehabilitation • Reintegration

Breakout Session 3 – Group B

DISCUSSION QUESTION #3

- MEDICAL
  - Disability benefits (related to VS)
  - Social Security Disability Insurance (SSDI)
  - Workers’ Compensation (WC)
  - VA Health Care (VHA/VA)

- SEXUAL
  - Low-cost housing
  - Extended Hospital Care (EHC)
  - Priority Section
  - Employment

- EMPLOYMENT
  - Employment (VETS) TO VETS REGISTRATION (0-3, 21 WEEK)
  - Vocational, Counseling (VISHA)
  - Mentoring (VCS)
  - Paid travel
  - Employers: How to... (Attention, Mental Health,Employment benefits)
  - Transition Planning
  - Benefits on Transition

Families

- Caregiver benefits
  - Housing, Education, Medical, Care, Home Retirement
  - SET IN FAMILY UP TO $100K

Benefits on Transition

A-35
Breakout Session 3 – Group C

WORK GROUP 3 GOAL
Improve efforts to support Service members during reintegration into military service or transition to civilian life.

DISCUSSION QUESTION #3
What medical, social, and employment benefits are available to wounded, ill, and injured Service members and their families during transition? What are the eligibility factors? Who covers the costs?

- Caregiver support for wounded, ill and injured Service members
- Occupational health based workers compensation (e.g. National Accident Concession Corporation, New Zealand)
- Wage replacement, housing
- Medical care
- Concern for Service members that separate from the military and years later present mental or behavioral health issues as a result of service, as well as Service members wounded, ill or injured during training
- Retraining or cross-training for retention of service and during transition out of service
- Independent living assistance

DISCUSSION QUESTION #4
What are best practices for implementing a “community approach” to supporting reintegration and transition? What areas should the government, non-profits, and other stakeholders contribute to?

- Portability of resources
- Role of the private sector in supporting transitioning Service members: employment, vocational training, etc.
- Identify and reduce redundancy in transition processes
- Active engagement of charitable organizations to assist in transition process
  - Often charitable organizations require guidance and coordination with Service processes, Legal and political implications
  - Implementation of coordinating bodies to government structure to bring non-profits and government agencies together (< Netzwerk der Hilfe>, Germany)
- Agility in adapting innovative practices.
- Interagency fellowships
- Canadian Institute for Military and Veterans Health Research
- Media engagement and public affairs
Breakout Session 3 – Group D

DISCUSSION QUESTION #3

What medical, social, and employment benefits are available to wounded, ill, and injured Service members and their families during transition? What are the eligibility factors? Who covers the costs?

- Defined Transition Process:
  - E.g., availability of a seminar/trainings for Service member and their families; point of contact

- Benefits:
  - U.K. provides tax benefits for wounded, ill, and injured Service members

- Employment Preparation & Support:
  - Resume-writing, vocational rehabilitation and employment supports (VAVR&E), including for education and housing costs
  - Mediators or coordinators acting as liaisons between Service members and employers

- Social
  - Fostering connections between Service members and related associations (NGOs, VSOs)

- University culture- Mutual understanding between Veteran and academic institution

- Networking
  - Connect with other Veterans in society-willing to help each other

- Maintaining connections, keep ties back to military to help transition- you’re a “soldier for life”

- Utilize technology correctly- LinkedIn

- Community leader programs- build mutual understanding between civilian and military personnel

Resilience • Recovery & Rehabilitation • Reintegration

Breakout Session 3 – Group D

WORK GROUP 3 GOAL

Improve efforts to support Service members during reintegration into military service or transition to civilian life

DISCUSSION QUESTION #4

What are best practices for implementing a “community approach” to supporting reintegration and transition? What areas should the government, non-profits, and other stakeholders contribute to?

- Training
  - Government and non-profit programs that hire Veterans
  - Provide sufficient opportunity for member to discover, develop skills - requires time (money is often focus, but not the only important resource)
  - Denmark: Civilian Veteran coordinator assigned to a community
  - Australia: Veteran for Veteran programs- not government or community driven, but volunteer organization that offer services (Soldier On, Mates for Mates)

- Positive public relations- media tends to focus on negative stories instead of highlighting positive

- Area for improvement
  - Educate employers and about the benefit of hiring a Veteran
  - Highlight the strengths and characteristics of Veterans that would be beneficial in the work place
  - Veterans must have realistic expectations about work force
  - Engage with hiring manager, not just top level at corporations

Resilience • Recovery & Rehabilitation • Reintegration

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Appendix E: Symposium Presentations

Presentations from the WC21 2016 Symposium are available on the International Warrior Care Portal via the following link: https://iwcp.usuhs.edu/conference/2016-symposium/presentations. Individual presentations may also be accessed by clicking on the below hyperlinks.

Day 1 Presentations

**Force Readiness Modeling & Simulation** - Presented by Dr. Ray Nason, Booz Allen / Department of Defense Office of Warrior Care Policy (United States)

**Work Group 1 (Resilience)** - Presented by Mr. David Morton, Mental Health, Psychology and Rehabilitation, Joint Health Command (Australia)

**Resilience and Early Interventions: A Military Occupational-Health Perspective** - Presented by Dr. Amy Adler, Center for Military Psychiatry and Neuroscience, Walter Reed Army Institute of Research (United States)

Day 2 Presentations

**Work Group 2 (Recovery & Rehabilitation)** - Presented by Brigadier General Timothy Hodgetts, Defense Medical Services (United Kingdom)

**George W Bush Institute** - Presented by Colonel (Ret.) Miguel Howe, George W. Bush Institute (United States)

**Work Group 3 (Reintegration)** - Presented by Mr. Paata Patiashvili, Wounded and Injured Warrior Support Department, Ministry of Defense (Georgia)

Day 3 Presentations

**Challenges and Solutions in Rehabilitation of Ukrainian War Casualties** - Presented by Colonel Professor Vsevolod Stebliuk, Ukrainian Military Medical Academy / Guardian Angels Ukraine (Ukraine)

**NATO Trust Fund Project to Support Practical Cooperation with Ukraine in the Area of Medical Rehabilitation** - Presented by Mrs. Nataliia Melnychenko, NATO Support and Procurement Agency Office in Ukraine (NATO)

**Germany ISAF Medical Collaboration** - Presented by Brigadier General Dr. Berndt Mattiesen, PTSD and Mission Related Health Problems, Ministry of Defense (Germany)

**Canadian Forces Health Services Group** - Presented by Colonel Jim Kile, Medical Policy and Clinical Care, Canadian Forces Health Services Group (Canada)

**United States Department of Veterans Affairs** - Presented by Dr. Linda Schwartz, Policy and Planning, Department of Veterans Affairs (United States)