Chapter 13
Community Mobilization

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13.1 Introduction

The military of today faces unique challenges, challenges which other generations did not encounter. Stark numbers support this claim. The military of the twenty-first century is all-volunteer, with less than 0.5% of the US population currently serving. This is in stark contrast to World War II, when more than 12% of the population served. Post-Vietnam, 70% of Congress had military service. Today, that number is only 20% (Eikenberry & Kennedy, 2013). These statistics will have a strong impact on the recruitment and retention of the future all-volunteer force, and the implications behind these statistics will be devastating to our national security if not addressed now. This has been referenced by many senior leaders in the community as the "civil/military divide," or more recently, "the civil/military drift" (Institute for Veterans and Military Families, 2013; Pew Research Center, 2011).

With the population of America hovering near 320 million, 0.5% is still 1.6 million people (United States Census Bureau, 2015). This means that approximately 1.6 million Americans are currently serving in some capacity in our armed forces and alongside those service members are spouses, children, parents, and other loved ones. While the percentage of those in the military is small, the number of those affected grows exponentially and in recent conflicts, it has become better understood that the family not only serves, but also suffers.

There is little argument that on September 11, 2001, the United States was not prepared for the extended conflict that we have now experienced. Our last major deployment of troops was in 1990–1991, with Operation Desert Storm (ODS). Unlike the conflicts in Iraq and Afghanistan, which meandered on for years, ODS was over in less than a year. Prior to ODS, the United States had not participated in

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L. Hughes-Kirchubel et al. (eds.), *A Battle Plan for Supporting Military Families*, Risk and Resilience in Military and Veteran Families,
https://doi.org/10.1007/978-3-319-68984-5_13

a major, multi-year conflict since Vietnam, which ended in 1975. When the Twin Towers fell, it had been over a quarter of a century since America had participated in a conflict that involved a large commitment of ground troops, air support, and an international coalition of joint forces.

Since September 2001, approximately 2.5 million members of the active duty services as well as the related Reserve and National Guard units have deployed to the Afghanistan and Iraq theaters. More than a third—over 833,000—have deployed more than once (Adams, 2013). Bilmes (2007) noted that their experience was also unique in that they had a much higher battlefield survival rate than twentieth century wars. In Iraq and Afghanistan, the ratio of wounded service members to those killed was 16 to 1. In Vietnam and Korea, there were 2.6 to 2.8 injuries for each fatality and World Wars I and II had even lower ratios (p. 2).

Other changes have also made these twenty-first century conflicts different from preceding wars. The multiple deployments have created a tail impact on family members and children and the increased number of women serving has also impacted families. Traditionally, women stayed home and took care of the "homefront" while their husbands went to war. In today's conflicts, women also deploy or both parents deploy, sometimes simultaneously. During the Gulf War, 41,000 women served. Over the course of the post-9/11 conflicts, that number rose to over 155,000 (Holder, 2010, p. 2). When these service members come home, they face a system that has not yet been developed sufficiently to provide the kind of caregiver and traumatic injury benefits specialized to these conflicts. By the Department of Veterans Affairs' (VA) own admission, they were ill-equipped and poorly prepared to serve not only our women veterans but also our veterans suffering from PTSD and TBI (Daly, 2014; Kashdan, 2014). Returning service members also face the long-lasting challenge of the lack of interoperability between military medical records and the civilian care provider network. The issues stemming from this are far-reaching, particularly when service members leave the service or, as activated Guardsmen and Reservists, deactivate. The gulf of disconnect between the civilian population and the military continues to be a growing issue, despite those larger numbers of citizen soldiers deploying to theaters of combat where "there are no front-lines anymore" (Woolf, 2015).

13.2 Key Landmark Events

When we look at Community Service Provider Mobilization, there are many issues that this sector was unprepared to meet in 2001. After more than 20 years of not having hundreds of thousands of deployed troops serving extended tours of duty over the course of a decade, no one really knew what to expect. And, of course, no one knew at that time that Operation Enduring Freedom would continue for more than a decade, unabated, and unfortunately, no one had a crystal ball that told them Operation Iraqi Freedom would begin 2 years later and last another 8 years. Here in 2015, we now have the luxury—and the ability—to look back and determine what key events and situations over the past 14-plus years inform our current model.

In 2002, however, then-Secretary of State Colin Powell came the closest to honestly foretelling of the scope of the commitment, arguing that, “US troops should join the small international peacekeeping force patrolling Kabul […] and help Hamid Karzai extend his influence beyond just the capital of Kabul” (“Context of “February 2002: Powell’s Proposal,” 2002). His proposal was rejected. Four years later, even our inactive ready reserves would be activated at never-before-seen rates, throwing men and women—individuals with careers and lives completely separated and disconnected from their obligatory reserve status—into the conflict. These men and women did not even have an obligation to drill or train with a military reserve unit and during those years, most had not received any military training. This so-called inactive ready reserve activation was perhaps the most telling aspect of just how unready we really were (“U.S. Military Calling Back Troops,” 2006).

According to a U.S. Government Accountability Office (GAO) report (2004), “with the high pace of operations since September 11, more than 51 percent of Army Guard members and 31 percent of Air Guard members have been activated to meet new homeland and overseas demands” (“Reserve Forces”). In 2005, we reached our peak of Guardsmen and Reservists in combat-deployed roles. At this time, they represented nearly 50% of the deployed force in Iraq (Tyson, 2006). This is unlike previous conflicts—those citizen soldiers had always deployed, but never in such high numbers. With the US military being an all-volunteer force, there were simply not enough active duty service members to support the needs of two simultaneous wars. Also, unlike their active duty brethren, these citizen soldiers did not come back to military-knowledgeable communities. Their families, by and large, did not have a frame of reference for their service members’ experiences.

Particularly in the early years of OEF and OIF, the community resources and support for Reserve and Guard families were insufficient and even if some existed, the families did not necessarily know to seek them out. In a GAO report on the Federal Recovery Coordination Program (2011), one of the key issues identified was the limitations on information sharing between programs. Eighty-four percent of recovering service members and veterans were enrolled in more than one program, but because there was no coordination between programs, there was duplication of service and difficulties were created for the very people the program was created to help (“Federal Recovery Coordination Program,” p. 6). Despite the support provided by these mass deployments of Guardsmen and Reservists, the force faced a dwell-time peak of 18–24 months. Service members had two or fewer years at home before deploying again, which in turn put more pressure on community resources. The families left behind still needed support and the service members needed support not only when they were deployed, but when they came home again.

Enter the “Sea of Goodwill” of American support—as Admiral Michael Mullen, the then-Chairman of the Joint Chiefs of Staff said, “The challenge… is how do you connect the sea of goodwill to the need?” (Copeland & Sutherland, 2010, p. 1). The issue was not a lack of organizations to provide services to these service members, veterans, and their family members. Instead, it was determining how to best connect those organizations and services to the people who needed them. That “Sea of Goodwill” can be overwhelming, particularly for those who are already facing other

difficulties—personally, professionally, emotionally, mentally, physically—and many people give up because navigating those waters can seem like such an insurmountable task.

One of the most significant challenges for these service members, veterans, and family members was the lack of caregiver assistance for the catastrophically wounded, ill, or injured until 8 years into the conflict. This is one of the areas in which Community Mobilization stepped in. Organizations observed the lack of officially funded and provided caregiver assistance and many began to provide that assistance themselves. Because of the higher rate of survival due to better technology and faster medical care, many of those who would have perished in previous conflicts from their injuries instead survived. Some of those who survived were so severely injured that they need intensive care—often at home—for the rest of their lives.

13.3 Innovations and Key Strategies

An important step in strategically responding to the issue of military disconnectedness is identifying training for the caregiver outside of the support net of DoD and VA funding. While there is now DoD and VA support for caregivers, more is needed. Organizations need to invest in veteran and military family case management training—while the major conflicts are over, the needs of families and veterans will continue to increase as the effects of decades at war continue to ripple across those communities. Initial steps to "wrangle" this "Sea of Goodwill" were undertaken by the DoD and the VA with the creation of an online resource aggregator—the National Resource Directory. In 2014, the Government Accountability Office (GAO) identified publicly available sources containing lists of relevant programs, e.g., the National Resource Directory or the Catalog of Federal Domestic Assistance and highlighted them as a best practice, stating:

> The NRD is a partnership among DoD, VA and the Department of Labor that seeks to connect wounded and other servicemembers, veterans, their families and caregivers to programs and services that support them. Information contained within the NRD website is from federal, state and local government agencies; veteran and military service organizations; non-profit and community-based organizations; academic institutions and professional associations that provide assistance to wounded warriors and their families ("Military and Veteran Support").

By being caught unaware on that long-ago September day, we failed to create a clear and easy network of access to community resources and we are still trying to correct this problem. The "Sea of Goodwill" is vast, but in its vastness it is easy to get lost and overwhelmed. By focusing on direct services, such as caregiver training, complementary and alternative therapies, and volunteer management and engagement on military installations and VA facilities, as well as investing significant resources in integrated case management training, we will ensure that we continue to meet the changing needs of those communities and also remain prepared to face the realities of the next conflict.

Investing in behavioral health support services for military spouses and children is another key innovation. When the conflict began, there was no thought as to the psychological and emotional impact on family members. In 2001, we had no idea that we would be sending service members out on multiple deployments with minimal dwell time. This goes hand-in-hand with the importance of expanding National Guard and Reserve engagement efforts and support as those service members and families do not have the same level of support as do active duty service members and families stationed on regular military installations.

Currently, as defined by the GAO, there are over 50 mental health programs run by the DoD and the military service branches ("Military and Veteran Support," 2014). However, the Substance Abuse and Mental Health Services Administration (SAMHSA) found that approximately 50% of returning service members in need of mental health treatment sought it, but of that 50%, only half received adequate care. In 2014, it was noted that a significant number of active duty troops and their families opt to not access these services provided by the DoD and military services branches because they fear discrimination or harm to their military career for seeking treatment for behavioral health issues. Additionally, National Guardsmen and Reservists who served in Iraq and Afghanistan are also eligible for behavioral health care services from the VA, but many of them are also unable or unwilling to utilize those services ("Veterans and Military Families," 2014).

The issue of mental health services for military families will continue to be a legacy impact of military service. Cultural biases often run counter to command's intentional desire to have a healthy and deployable force, general biases and stigma related to mental health issues in general, and the inherent conflict of mental health care providers who value and understand the importance of confidentiality in treatment and a commander's right to know about the health and welfare of their troops.Many commanders I have spoken to state that mental health challenges are not conducive to military service. Right or wrong, too many of our military leaders hold steadfast to this belief, which in turn drives many service members and their families to seek care (if they seek it at all) outside of the military medical health system and into the community.

Organizations like the American Red Cross, with thousands of volunteers—including mental health care professionals—were not prepared to re-deploy those volunteers to serve the military family community until nearly 5 years into the conflict. Other nonprofit organizations, such as Give an Hour, saw the need very early on and began recruiting mental health professionals to provide free mental health services as early as 2007. Today, they have thousands of registered mental health professionals providing free counseling services to military families and still turn many away due to the demand.

13.4 Needs and Lessons Learned

With the benefit of hindsight, it is easy to see how we could have done things better, how we could have anticipated the needs more successfully. But we did not have that hindsight and as we were plunged into a faraway conflict in Afghanistan, we had to react instead of preparing. So we, just as the DoD and the VA did, reacted.

We reacted to those unexpectedly high numbers of citizen soldiers being deployed. Not just deployed, but deployed multiple times. Organizations saw that the DoD and the VA did not have the ability to meet those needs at that time, so they stepped in. The "Sea of Goodwill" went into overdrive.

We did not anticipate the effect on family members. Without intervention, multiple deployments can negatively affect a marriage and a child's relationship with their constantly deployed parent can become fraught with misunderstanding, resentment, and confusion. A study by James and Countryman (2012) finds that these children have problems with sleeping, have higher levels of stress and anxiety, declining grades and increased behavioral issues (p. 17).

Furthermore, we did not anticipate the increased medical needs. With more severely injured service members surviving, the existing medical facilities and caregiver support were insufficient. The VA was not prepared for an influx of veterans with such a wide range of physical, mental, and emotional injuries. Even now, we do not comprehend the full extent or cost of these conflicts. The demand for volunteer clinical and non-clinical volunteers at military treatment facilities and VA hospitals rose dramatically, increasing the demand on non-profit organizations to recruit, place, manage, and supervise a large number of volunteers in hundreds of military installations and VA hospitals around the globe. As an example, at its height, the Red Cross at Landstuhl Regional Medical Center had more than 400 volunteers contributing more than 40,000 h in a year. To volunteer, these individuals went through a rigorous screening process to include a Red Cross background check, a health and wellness clearance, HIPAA training, and a DoD security clearance. Managing that volunteer workforce was a tremendous endeavor and the voluntary contributions of those hundreds of volunteers contributed hugely to the care and treatment of the wounded, ill, and injured at Landstuhl.

13.5 Responses and Strategies

The Red Cross' response to the conflicts can be categorized into four main areas: the expansion of volunteer recruitment, placement, and management capabilities; the expansion of direct services that aligned with our organizational core competencies; the expansion of our presence on military installations overseas and in theaters of combat; and the expansion of our emergency communication capabilities.

The success of the American Red Cross has always been dependent on its volunteers. Even today, volunteers constitute roughly 90% of the organization's workforce ("Be a Disaster Volunteer," 2015). The expansion of our volunteer program in response to the conflicts in Iraq and Afghanistan was twofold: first, expand our volunteer presence on military installations and military treatment facilities. Second, expand that presence at VA facilities to ensure that Red Cross volunteers were alongside our service members every step of the way.

To maintain the integrity and viability of these volunteer programs within military and veteran treatment facilities, the organization focused on recruitment, placement,

and onboarding. To volunteer in a military treatment facility is not just a matter of walking in 1 day and walking out again with a name tag. It is a process, a process created and developed to ensure not only the safety of the volunteer, but the safety and health of those they are there to help.

The expansion of direct services that are aligned with our organizational core competencies was another vital response to the conflicts in Iraq and Afghanistan. We were caught unawares in 2001, which meant that to be more effective, we needed to build upon our current strengths and develop what already existed into something that could meet the needs of a new fighting force.

So we focused on behavioral health support, creating programs such as Reconnection Workshops and Coping With Deployments. These two trainings were natural outgrowths of our current programs and focused on the needs of the population; what was needed were programs to help service members reconnect with their loved ones after a deployment and there needed to be more tools at the disposal of those left on the homefront to help them cope with their loved one being gone. We also focused on volunteer-supported morale and welfare support services, increasing our visits to the wounded, ill, and injured and distributing more comfort items to aid in recovery. Along with this, in several locations we created rest and recovery rooms to provide an oasis of peace not only for patients, but also for their caregivers. Finally, we expanded our financial assistance, reengineering emergency loans, and expanding our casualty assistance grants.

Next, the expansion of our presence on military installations overseas and in combat theaters was accomplished in several ways. First, we activated Red Cross reserve staff. Like reservists in the military, these were individuals who had normal lives and jobs, but signed up to deploy to a combat zone as a Red Cross staff member. By utilizing this reserve system, the organization was able to stabilize the deployments of its full-time staff and ensure continuity at Red Cross offices across the country and around the world.

The Red Cross continues to change and expand in response to the changing needs of the military. A significant part of this has been working with the DoD to ensure the success and integration of the organization on installations both in the United States and overseas. In recent years, an office has been opened in Djibouti and a second office opened in Kuwait, while at the same time an office in Afghanistan was closed due to troop drawdown in that theater. By placing Red Cross staff members in Kuwait, we are better able to meet the needs of a deployed military that is spread out geographically.

Finally, the expansion of clinical and non-clinical volunteers in military treatment facilities has played a significant role in expanding our presence. As stated previously, volunteers make up at least 90% of the Red Cross workforce. They are a force multiplier—from trauma surgeons to medical assistants, volunteer programs around the world have expanded our reach and ability to meet the needs of service members, veterans, and their families.

Lastly, the organization has made a huge push to expand our emergency communication capabilities. We have expanded the workforce, upgraded IT and telephony capabilities, and have redesigned the system to improve quality, timeliness,

and consistency in service. Emergency communications are at the core of our service to the military and to do that job well in the twenty-first century, we need to ensure that our technology and workforce keeps up with the needs of the population we are here to serve.

13.6 Results/Evaluations

By being unprepared for the consequences of the conflicts in Iraq and Afghanistan, we were late to the game of providing appropriate and timely support to our service members, veterans, and their families. Most organizations and programs were in the same boat, but as everyone rushed to fill the gaps, we unknowingly created that "Sea of Goodwill." Everyone had the best intentions and good programs, but no one was communicating effectively. All that information was overwhelming, not just for those individuals and organizations in that space, but confusing for the very people we were there to help.

We are still continuing the process of having an information and referral process for all service members, veterans, and family members that is easy to use, up-to-date, and not overwhelming. With thousands of organizations to choose from, this confusion is not surprising. The result of the chaos post-9/11 was that all these organizations realized that they needed to improve and increase their programs and services. In evaluating the subsequent "Sea of Goodwill" today, in 2015, the main issue is not quality or quantity or a lack of assistance. It is simply getting the right assistance to the right person at the right time. As we move forward into 2016 and beyond, that needs to be the focus. We need to keep developing our programs and services to meet the ever-evolving needs of the population we serve, and we need to ensure that we provide a way to connect those in need with what is available.

13.7 Recommendations

I would make the following recommendations to ensure that we are prepared for whatever the next conflict may bring:

- We must expand to an integrated national case management network.
- Through volunteerism, we must bridge the civilian/military divide.
- We need to open our doors to the veteran community.
- We must leverage our global footprint.
- Wherever it is most needed, we have to provide measurable and impactful direct service.
- We need to publish data.
- We must communicate across multiple platforms and mediums.
- Finally, we need to anticipate needs for resources prior to the need dictating service delivery options.

13.8 Conclusion

The biggest challenge facing our nation in the next major armed conflict will be the reinvigoration and smart growth of the lean and tested strength of the all-volunteer force and their families. More specifically, the challenges will lie in the number of citizens who are willing to serve in uniform, our nation's temperament to fight and win a protracted conflict and our government's ability to meet the full long-tail costs of war. Community service organizations will play a critical role in helping to address these challenges. In some cases, we should be the de facto solution to what ails our national defense industrial complex. One of the most frequently cited contributor to all of these issues is the "civil/military drift" or the "civil/military divide." This well-known problem is ripe for a coordinated non-profit and community service organization-based strategy.

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