The Unspoken Casualties

THE FIGHT TO SAVE OUR SERVICE PEOPLE WITHIN THE RECOVERY COMMUNITY

A Word of Caution

The objective of this presentation is to educate about the history of substance abuse and mental health within the veteran and first responder community, illustrate the impact of the symptoms, trauma and disorders that have been directly influenced by the strain of their service, shine a light on what is being done, highlight the obstacles that still remain, and finally, to inspire others to either join or enhance the fight against substance use and mental health disorders among our veteran and first responder community. It would be irresponsible of me however, not to mention that some of the topics that I plan to discuss may be triggering to those who suffer from Acute Stress or Post Traumatic Stress disorders, mental health or substance use disorders or emotional or physical traumatic symptoms. If at any time during this presentation, you feel uncomfortable or triggered in anyway, please feel free to leave immediately and seek your respective support networks for assistance or call a Crisis Hotline for immediate help.

The Bond in Honor & Suffering

There is no question in anyone's mind, that our persons in uniform are the sword and shield of our society. Cultures all over the world turn to the brave and the willing who serve their nations, to protect their very way of life.

But what of their needs? What happens when are heroes are suffering? What happens when the very people we 'thank for their service' , succumb to the physical and mental wounds of their duties? We ask so much of the individuals who volunteer to put their lives on the line for us, yet despite the efforts of many, our response to their struggle is still greatly lacking.

The scars that Veterans & First Responders carry with them from their tours of duty, have led countless numbers towards substance use disorder, criminal behavior and suicide. Many service people go undiagnosed for a myriad of reasons. Whether it's a lack of health care, the fear of being ostracized by their peers, or the stigmas placed upon them by society, many in uniform will fall prey to addiction, trauma, and suicide. This is NOT because they are weak. This is NOT because they have a socialistic disorder or lack of will to survive. This IS because the pain is left unchecked. This IS because they believe the nightmares will never end. This IS because they believe WE have abandoned them. Today, we have an opportunity to change this terrible cycle, for the better.

During this presentation, we will explore the history of substance use disorder among the military, the impact PTSD and SUD has on the Veteran & First Responder population, the services that are available, and the obstacles standing in the way of our heroes to receive them.

By the end of this discussion, let us find a way to lessen the distance between what is being done to what can be done for our veterans and first responders within the recovery community.

A Mirror Image

The connection between Veteran & First Responder comes from an understanding of duty to something greater than oneself. The core values of the services that uphold the safety, stability, infrastructure, health and welfare of society, transcend all boundaries. It is no wonder that many who begin their careers in one uniform, often find their way into another after their tours are complete.

For instance, a survey conducted by The Marshal Project in 2020 indicated that while only 7 percent of the U.S. population had served in the military by that year, 19% of police officers around the country are veterans.

Firefighters and emergency medicine also made the list of the top 10 professions chosen by veterans, after retirement from military service.

There is an underlining vestige of respect within these professions, that make transition between them, natural. With this, however, comes the shared burden of withstanding the difficulties these commitments demand, sometimes far beyond what any average human being should have to endure. It is not without some understanding, that many would turn to nearly anything, to help alleviate the pain often accompanied by these hardships.

This trend of self medication did not begin at random. The culture of addiction was introduced to the military community, perhaps even earlier than many of you would think.

The Cost of Service - Civil War

It may not be known to many, but addiction within our military are almost as old as our nation itself. Brittany Tackett, an author for American Addiction Centers published an article containing some of the history of recorded use of narcotics within historical military events.

- **The first recorded use of drug addiction in the United States, was during the American Civil War. Morphine was the drug of this war. One of the Union officers supposedly made his command members drink opium daily as a preventative for dysentery.**

- **Soldiers left the war addicted to morphine and continued to use it at home, where it was readily available. An estimated 400,000 soldiers returned home addicted to morphine. For this reason, morphine addiction was known then as “Soldier’s Disease.”**

The Cost of Service - World War I

According to Lukasz Kamienski, a political science professor at the Institute of American Studies and Polish Diaspora, and author of Shooting Up: A Short History of Drugs and War, cocaine also became a drug of abuse on the frontlines of World War 1. People turned to the drug to boost energy, combat fatigue, and reduce wartime anxiety. It gained popularity when the British army created a drug known as “Forced March,” a combination of cocaine and a cola nut extract. People then began to self-prescribe the drug as a wartime aid.

The Cost of Service – World War II

- **Amphetamines were the most popular drugs used in World War II. In fact, soldiers accounted for the largest number of amphetamine users between 1939 and 1945.**
- **The Nazis started the trend. Their drug of choice was Pervitin, an early version of crystal meth in a pill form that they patented in 1937. The drug was marketed for military use to foster confidence, boost physical energy, enhance performance, and combat fatigue. The Germans also made a cocaine chewing gum that helped the pilots of one-man U-boats stay awake and alert. However, many of these men suffered breakdowns from using the drug and being in a small enclosed space alone for extended periods.**
- **Historians estimate that the German military consumed roughly 200 million methamphetamine pills during WW2. They also produced chocolates that contained 13mg of the drug, far more than the regular 3mg pills. With the help of Pervitin, German soldiers could march for days on end without stopping, going without sleep for up to 50 hours.**
- **Pervitin had many adverse effects, however. These included dizziness, sweating, depression, hallucinations, and addiction. Some soldiers died of heart failure, while others shot themselves during drug-induced psychoses.**
- **The United States, Japan, and Britain followed Germany's lead and administered amphetamines to their troops as well. The British army consumed an estimated 72 million Benzedrine (amphetamine) tablets during the war. The British allegedly defeated the Germans in the Second Battle of El Alamein while high on speed after Gen. Bernard Montgomery gave away roughly 100,000 amphetamine tablets.**
- **The American army used even more amphetamines than the British. The Pentagon issued between 250–500 million Benzedrine tablets to U.S. troops during the war. Benzedrine was added to American emergency bomber kits in 1942, and in 1943, they extended this practice to the infantry. Approximately**

The Cost of Service - Korean War

- Often referred to as The Forgotten War, The Korean Conflict was not without its uses of now illicit narcotics to supposedly enhance our Marines and soldiers' capabilities. Newly synthesized amphetamines were widely distributed to military personnel as pep pills . According to We Are The Mighty Veteran's Publishing, American servicemen stationed in Korea and Japan concocting the speedball: an injectable mixture of amphetamine and heroin. Many became dependent while in the service and continued use after the war.

The Cost of Service – Vietnam War

- Speed was a popular drug for American soldiers in the Vietnam War as well. The American military issued 225 million tablets of dextroamphetamine between 1966 and 1969. Dextroamphetamine was twice as strong as the Benzedrine tablets given during World War II. These so-called "Pep Pills" were given out like candy with no attention paid to dosing or frequency.
- Speed was far from the only drug used during this war, however. Drug use in Vietnam was quite common. At least half of the soldiers used marijuana, and a third of them used heroin or opium.
- According to Kamienski, the level of drug use among American military personnel in the Vietnam War was unprecedented. For example, soldiers going on special missions were administered steroid injections as well as given medical kits containing 6 dextroamphetamine pills, 12 Darvon tablets (a mild opioid painkiller), and 24 tablets of codeine (another opioid analgesic).
- The Department of Defense provided sedatives and neuroleptics to soldiers to help combat the intense stress and mental breakdowns associated with war. For the first time in history, antipsychotics such as chlorpromazine were given to soldiers. And even though these drugs drastically reduced the number of mental breakdowns in the short term, they were given without psychotherapy.
- The use of dextroamphetamine also caused long-term problems for soldiers. Speed increases aggression as well as alertness. When the drug wore off, the soldiers were often irritable, leading to incidents of insubordination with fellow soldiers and superiors alike. Unfortunately, soldiers were not able to detox from the drugs before being sent back home. Instead, they reportedly suffered serious withdrawals on the flight home. Those that arrived home were offered little to no support and many battled addiction and PTSD.

The Cost of Service - Iraq War

- **This trend of introduced narcotics for both heightened performance, mood-stabilizers and stress relief will continue through every major conflict to this very day.**
- **It's recorded that alcohol use is more prevalent among military men and women than among civilians. Almost half of the active-duty members reported binge drinking in a 2008 survey, an increase of 35% in a decade. Research indicates that binge drinking rates are even higher among those exposed to high combat.**
- **Illicit drug use is less common in military personnel than in the public, but prescription drug use is on the rise. Data from the Department of Defense reveals a significant increase in prescription narcotics for active-duty troops during the Iraq war, from 33,000 a month in October 2003 to 50,000 a month in September 2007.**
- **Research indicates that prescription opioids such as Percocet, OxyContin, and Vicodin are commonly abused. Energy drinks, NoDoz, and Dexedrine pills are also widely used to help maintain energy and alertness. When it’s time to come down, prescriptions drugs such as Ambien, Restoril, and other benzodiazepines are taken to help soldiers fall asleep and relieve anxiety.**

The Cost of Service - First Responsders

- **First responders are by no means alienated from the struggles of job-induced stress, leading to addiction disorders.**
- **The American Nurses Association has indicated that up to 10% of working RNs may be dependent on drugs or alcohol. However, the most worrisome statistic suggests thatbetween 14% and 20% of all RNs in the U.S. may have a problem with drug or alcohol dependence or abuse.**
- **This speaks to the suspected prevalence of unreported cases. By this estimate,1 out of every 5 to 7 RNs may be affected by an addictive disorder.**
- **According to a 2010 study by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), 16% of female police officers and 11% of male officers showed at-risk alcohol use.**
- **According to the Fire Service Joint Labor Management Wellness-Fitness Initiative, alcohol is the most commonly abused substance among fire fighters. Surveys by the Center for Fire Rescue and EMS Health Research (CFREHR) revealed that Eighty-five percent of career fire fighters reported past-month drinking. Most reported at least 10 days a month, or about half of their off-duty days.**

Behind the Causality, Lies "The Why"

Not to diminish the obvious reasons why our service people fall prey to addiction, one of the most prominent causes for substance abuse and suicide for our veterans and first responders is the struggle with post traumatic stress disorder or PTSD. This disorder is not exclusive to people of service but for the sake of our topic today, we will focus on the direct effects PTSD has on the veteran & first responder community, regarding mental health and addiction.

As we will discover in the following slides, the types of PTSD and the origins of their development in an individual will be largely dependent on the individual themselves, let it be said that there is no one greater form of suffering over another.

Behind the Causality, Lies "The Why"

All who experience trauma, experience their own personal form of Hell. Rather than judge the severity or the cause, let us remain focused on understanding and treating this disorder as the life-threatening mental health crisis it is. It has been the lack of respect and disregard of this disorder in the past, that has caused so many to befall the ultimate symptoms of its' burden. With furthering education in events such as this and keeping the topic fresh on the minds of those in a position to make progressive differences in treatment options, we stand a better chance to minimize the damage caused by PTSD.

Behind the Causality, Lies "The Why"

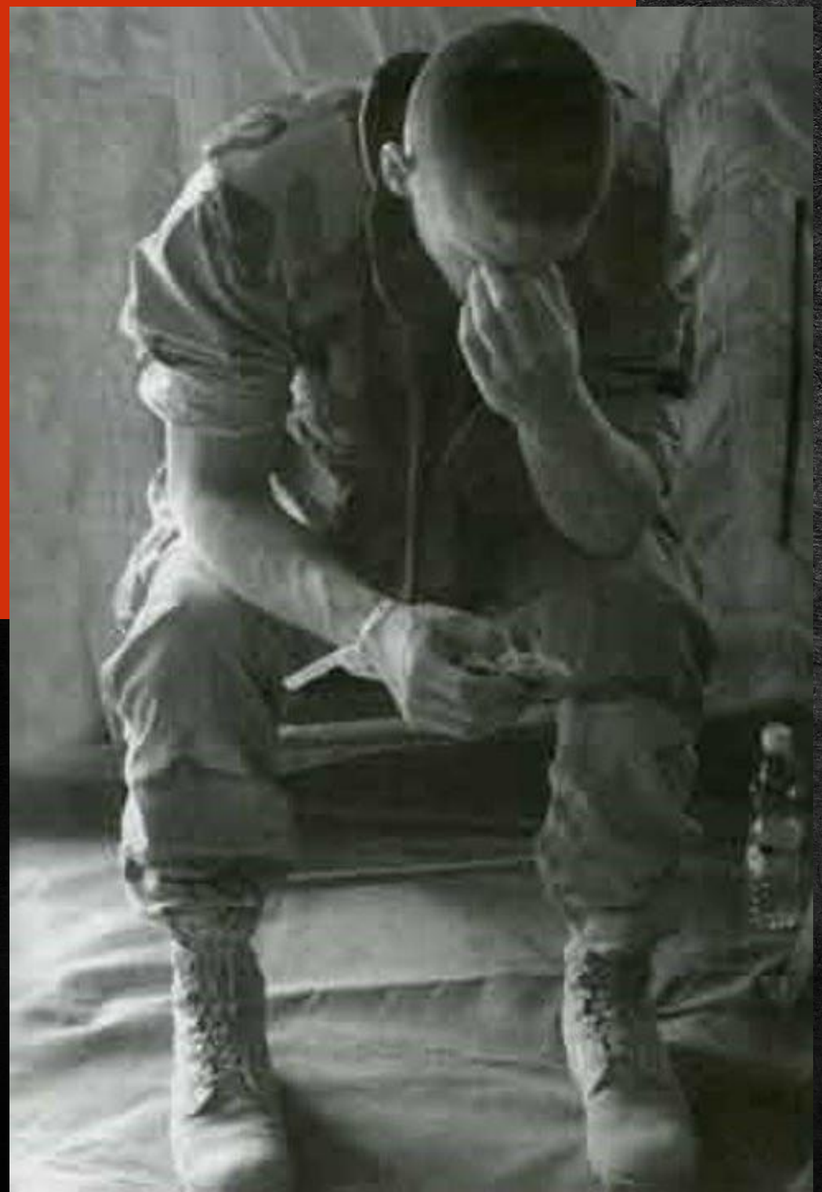
Although now a household common acronym, few people can properly describe this disorder. This is of no personal fault, only that the details are rarely discussed beyond the damage it causes. To fully understand why this is one of the leading causes of addiction and untimely death among our service persons, let us take a few moments to understand what it is and the dark relationship it shares with these professions.

What is PTSD?

- According to The American Psychiatric Association, Post Traumatic Stress Disorder (PTSD) is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or who have been threatened with death, sexual violence or serious injury.

- PTSD has been known by many names in the past, such as “shell shock” during the years of World War I and “combat fatigue” after World War II, but PTSD does not just happen to combat veterans. PTSD can be brought on by life-changing events such as dishonorable discharge, difficulties adjusting to civilian life, deployment-related separation anxiety, extended deployments overseas, learning about the violent death of a close family or friend, or repeated exposure to horrible details of trauma such as police officers exposed to details of child abuse cases, or medical personnel losing patients.

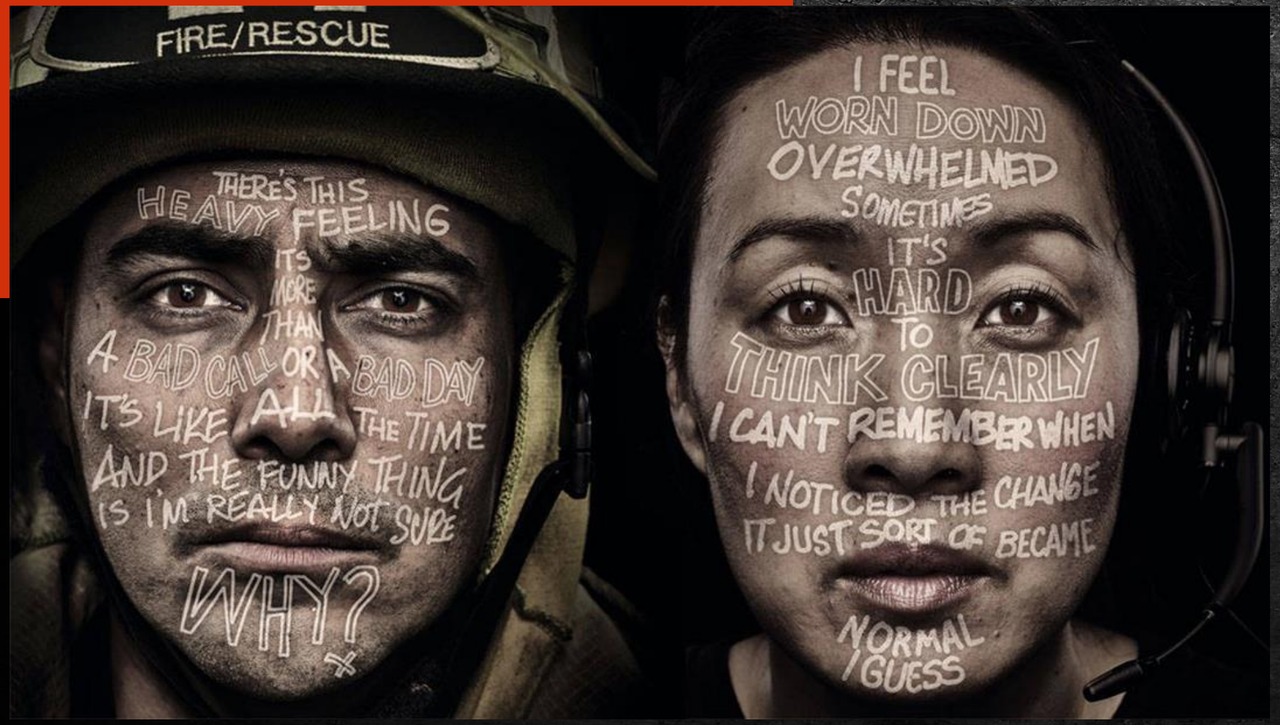
The Difference Between ASD & PTSD



- For those who have experienced a traumatic event, it is typical for the symptoms of the stressful experience to linger well after the event has passed. The U.S. Dept. of Veteran's Affairs defines **ACUTE STRESS DISORDER** as a mental health problem that can occur in the first month after a traumatic event. These symptoms of extreme stress effect daily life.

- **POST TRAUMAIC STRESS DISORDER** is a mental health condition where the symptoms of extreme stress have affected the person's daily life for a period over a month after the original event took place. So, the major differentiator of ASD and PTSD is the time of suffering for the individual.

What is PTSD?



- People with PTSD have intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares; they may feel sadness, fear or anger; and they may feel detached or estranged from other people. People with PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch.

What is PTSD?

- PTSD can be accompanied by a wide array of cooccurring disorders. Seizures, liver disease, HIV, schizophrenia, anxiety disorders, and bipolar disorder are among the many those who suffer from PTSD will live with in conjunction to their struggle with the trauma.

- Left untreated or undiagnosed, PTSD can be an obvious cause to substance abuse. Many turn to self medication, rather than bring their problems up to their chain of command of their families. This is largely due to the fear of judgement, repercussions or stigma they may face when revealing they are dealing with a mental health disorder. Another common outcome, not as commonly spoken of in public circles, is the heightened rate of suicide among veterans and first responders. Many of these cases can be linked directly to PTSD and substance use disorders.

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- When speaking of suicide among our service personnel, the facts are alarming and outright horrifying. Although some of the statistical numbers have indeed lessened over the past few years, they remain alarmingly high.

Loss & Neglect

- According to 2021 Annual Veteran Suicide Prevention report, published by the Veterans' Association's Office of Mental Health and suicide prevention, there were 6,261 veteran suicides reported in 2019, which, by comparison, represented 13.7% of suicides among U.S. adults in that year. That's approximately 17 veterans a day, took their own lives.

- USA Today reported that 103 firefighters and 140 police officers were reported to have died by suicide in 2017, compared to 93 firefighter and 129 officer line-of-duty deaths, according to the Ruderman Family Foundation.

- In 2019, a first of its kind study was conducted in Fairfax County Virginia, among 911 and emergency dispatchers. It was reported that found 911 dispatchers experience suicidal thoughts at a rate more than double the general population. This was contributed to the trauma received from fielding emergency calls from the public.

Loss & Neglect

- The pandemic has added enormous strain to health care workers, particularly nurses, who provide most of the bedside care. A study was conducted under the supervision of Matthew Davis, an associate professor in the Department of Systems, Population and Leadership at the University of Michigan.

- In the study, Davis and his team pored over suicide risk information -- for adults 30 and older -- drawn from the National Violent Death Reporting System.

- More than 159,000 suicides occurred during the study time frame -- 2007 to 2018. Of those, nearly 2,400 involved nurses, roughly 8 in 10 of whom were women. The study authors noted, this information correlates with estimates indicating that 80% to 85% of nurses are women, placing the female health care worker population at high risk to work related suicide.

What is Being Done?

- With such tragedy and hardship facing veterans and first responders suffering with addition and/or mental health disorders, its easy to be jaded and not see the efforts being made to minimize these statistics.

- For example, launched in 2007, the Veterans Crisis Line started with 14 trained responders working out of a call center in Canandaigua, N.Y. It's grown to include an online chat and text service with 500 responders in three call center locations. Because many responders are Veterans, they're familiar with the challenges Veterans face.
Continuing care after the call, chat, or text, Veterans Crisis Line responders can refer Veterans to a local suicide prevention coordinator (SPC). Available in each VA medical center across the country, SPCs can connect Veterans to the counseling and services they need.
Responders are also available 24/7 to help active-duty service members and their families and friends through a crisis through the Military Crisis Line. Service members, including members of the National Guard and Reserves, along with their loved ones, can call to receive free, confidential support.

What is Being Done?

- Since 2009, the VA has worked to reduce the prescription of opioids to veterans by using what is called the Step Care Model; combining pain management with CBT-based counselling to manage chronic pain without heavy dependance on pills. Together with VA's Opioid Safety Initiative (OSI), VA has successfully maintained a downward trend, reducing opioid prescribing overall by 63%.

- The VA has also worked to increase the number of in and out-patient facilities across the United States, by creating more clinics and emergency health care locations throughout the country.

What is Being Done?

- The U.S. Military and other First Responder Units all over the country offer enrollment in courses referred to as SARP (Substance Abuse Recovery Programs) for their active, retired and veteran personnel. These programs are designed to assess and treat substance use disorders through outpatient and intensive outpatient programs.

- More and more clinical teams are also turning to evidence-based physiotherapeutic approaches when dealing with SUD or maladaptive behavior.

- Civilian Providers are making more of an effort to reach out to the Veteran and First Responder Community. Windsor Laurelwood, a treatment Center for Mental Health and Substance Abuse Disorders, began The Guardian Program, which specifically catered their treatment to fit the needs of military and first responder clients.

What is Being Done?

- Dr. Eric Pendersen and his colleagues from The RAND Corporation, Recognized that young veterans are often unlikely to seek care at traditional VA medical centers, researchers have begun to develop alternative, novel methods of treatment engagement and delivery. For example, Dr. Pedersen developed a web-based, single-session intervention to reduce alcohol use among young veterans. In just 2 weeks, using Facebook as a recruitment site, they recruited a sample of 784 veterans. The intervention uses personalized normative feedback (PNF) and was found to reduce number of drinks per week as well as binge drinking 1 month later. The advantages of an intervention like this one include the fact that it requires no clinician time or patient travel to a VAMC. In addition, web-based interventions reduce other barriers to care such as stigma.

What is Being Done?

- Evidence-based psychotherapies and behavioral interventions for the management of SUDs typically involve short-term, cognitive-behavioral therapy (CBT) interventions. These interventions focus on the identification and modification of maladaptive thoughts and behaviors associated with increased craving, use, or relapse to substances. In addition, they may help reduce SUDs by helping incentivize individuals to achieve and maintain abstinence (e.g., contingency management therapies), or increase their ability to successfully manage stress without substances. Behavioral interventions can be delivered in person, via telehealth, and/or via the Internet.

What is Being Done?

- Established Evidence-based Recovery Programs such as SMART Recovery, have begun to modify their programs to specifically fit the veteran and first responder demographics' needs regarding SUD and PTSD treatment. Set to launch within the UK in 2023, then to follow shortly in the U.S., SMART is developing the SMART Veterans Program, which similar to the Family & Friends Program of the same non-profit, will focus specifically on catering the CBT-based tools and life skills of their program, for the particular needs of the veteran and first responder community, suffering from SUD, MHD or behavioral/emotional maladaptive disorders.

The Problems of Connectivity

With so many organizations bringing these resources online for their personnel, why are numbers still so alarming high for this demographic regarding substance use disorder and mismanagement of mental health? Because there are still many obstacles standing in the way of recovery progress.

Such as...

- **Rural Areas**
  According to the VA Office of Rural Health, there are ~3.4 million rural veterans (41%) that comprise the total number of veterans enrolled in VA health care system. Access to care, particularly mental health services, is problematic for veterans residing in rural areas, due to lack of technology available, transportation issues and facilities being few and far between.
- **Female Veterans**
  In recent years, rates of problematic substance use among female veterans have been increasing. SUD diagnoses among female veterans utilizing VA services have increased by 81% from 2005 to 2010 Some female veterans may feel uncomfortable seeking SUD treatment within the VA. Female veterans may find it difficult to disclose substance use to providers due to perceived stigma and shame associated with being a female substance user. Additionally, female veterans with SUDs have higher rates of childhood sexual abuse, military sexual trauma, and domestic violence than female veterans without SUDs, and women with PTSD are particularly at risk of developing substance-related problems.

Also...

- **Dual Diagnoses**
  According to a report published by NIH, Veterans with SUDs commonly meet criteria for co-occurring mental health disorders, such as PTSD, depression, anxiety, and adjustment disorder. Among Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans diagnosed with an SUD, 82%–93% were diagnosed with another comorbid mental health disorder. Notably, veterans with an SUD diagnosis were three to four times more likely to receive a PTSD or depression diagnosis and less than 1% of veterans received an isolated diagnosis of SUD without any diagnosis of a co-occurring disorder. Prevalence rates of SUDs and co-occurring disorders among OEF/OIF veterans echo findings from studies on Vietnam-era veterans, although post-Vietnam veterans are more likely to be dually diagnosed. Notably, individuals presenting with multiple diagnoses of SUDs and comorbid disorders demonstrate greater symptom severity and poorer treatment outcomes. Dually diagnosed veterans are also more likely to have experienced homelessness and to receive VA disability benefits. Psychiatric symptoms, such as symptoms associated with depression and PTSD, can precede or exacerbate drug and alcohol misuse and psychological distress can increase substance craving. Thus, there is an urgent need for efficacious treatments aimed at treating not only the SUD but also the co-occurring disorder.

And Finally…

- **Stigma**
  Another challenge to treatment that is sometimes encountered by veterans is the stigma associated with seeking SUD treatment. Efforts to integrate SUD care within the context of other mental health care would be helpful. So, instead of having to seek care at the “addiction clinic,” veterans could be seen at a general “mental health clinic” that would address a myriad of issues (e.g., anxiety, depression, bereavement, PTSD, couples and family therapy). Furthermore, integrating SUD care into primary care would take it another step further in reducing stigma and increasing access to care.

- Additionally, the hypermasculine military and first responder culture often places importance and value on self-reliance. Therefore, military veterans and their Responder brethren may be more likely to strive to solve mental health issues on their own and view getting professional mental health treatment as a sign of “weakness”. Additionally, they may feel the need to help “protect” family or friends by not talking about their symptoms or struggles.

Hear Their Voices

These challenges are no secret and every organization that services the veteran, and first responder community is aware of the hardships this population goes through to receive the help they need. But how many of us have taken the time to listen to a veteran or a Responder speak about their experiences? How many of us have been privileged to be trusted with seeing the people we so readily call “Heroes” at their most vulnerable? For the sake of this presentation, we had the honor of interviewing volunteers from the SMART Recovery Veteran & First Responder National Group Meetings, which they dubbed themselves “The SMARToon”. The following slides are portions of their real life struggles they have faced in their journey to achieve recovery. For the sake of anonymity, the names are not listed, but their testimonies could not be more authentic.

Hear Their Voices

"No one ever grows up saying they want to be an alcoholic. As an EMT, I was involved in responding to numerous fatal accidents. Some continued to haunt me long after the incident. I was having thoughts and dreams about them, analyzing in my mind over and over, what I could have done differently that could have made for better outcomes. It was driving me insane. PTSD wasn't really talked about much back then with just the exception of military war vets. I didn't even know it was considered a thing in my fire and EMS community.

"Steve"

30 years retired Fire and EMS

Hear Their Voices

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The trauma is repetitive. In some shifts, you don’t have time to process one before another is being thrown at you. Seeking recovery treatment is scary for active nurses and health professionals because of fear of being reported to the board. I have to hide my recovery from my employers and others because I fear for my license even when there are no legal issues involved.

“Amy”

24 years Emergency Trauma Medicine

Hear Their Voices

“My first experience with recovery was when my wife went to a magistrate and had the cops take me to the hospital. This was a bad move; my PTSD, coupled with my intoxicated state, led to a situation where the cops almost shot me. Sending armed men into a home of someone with PTSD from combat, may not always be the best move. People with PTSD in my experience, can have exaggerated fear reactions and aggression. The Army did a poor job of identifying my problems while I was in, even though I had been to mental health treatment before I got out of the service. I was diagnosed with general anxiety disorder and sent on my way. I eventually entered IOP which was difficult for me, listening to people complain about petty issues when I was upset about babies being killed and the like. If my trauma had been identified earlier, it would have been much easier for me.

“Pete”

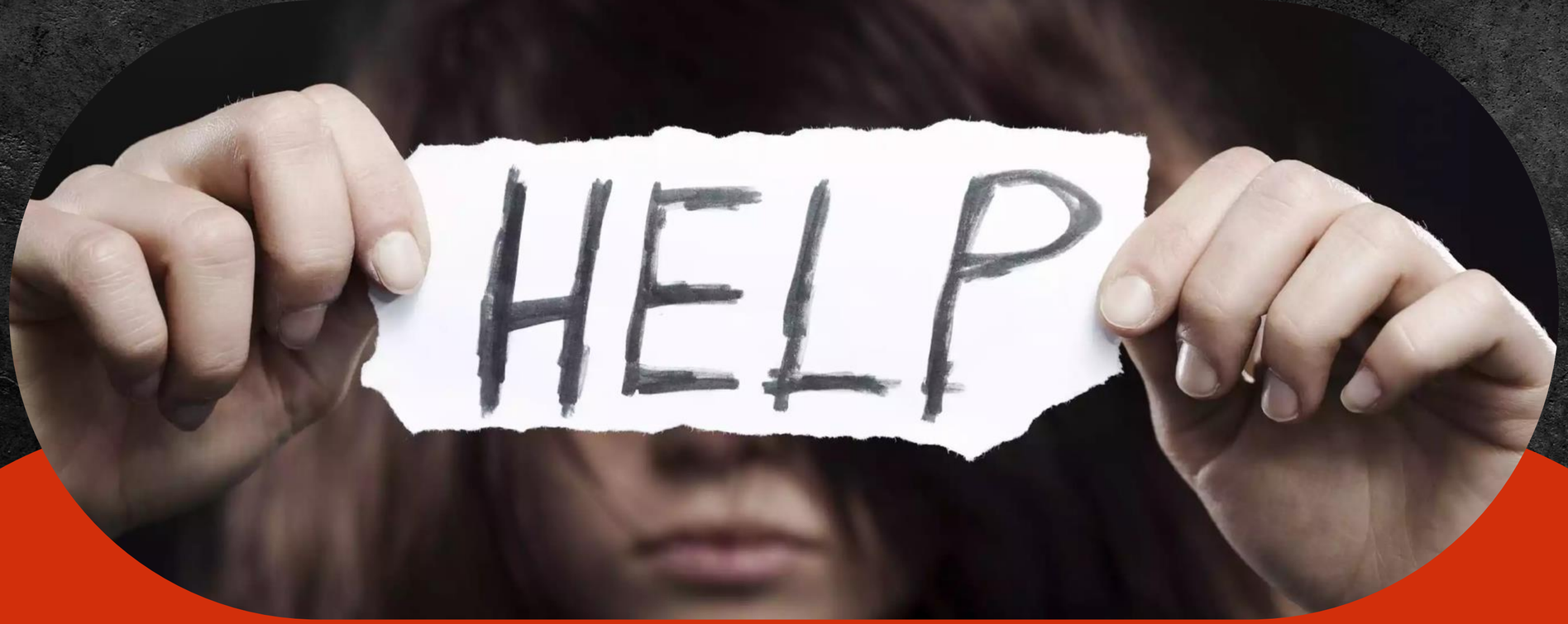
8 years retired Army Infantry

Hear Their Voices

“As I’m still Active Duty, I cannot speak to the retired veteran experience. But here in the Navy, it's been clear that AA is forced on us as the “end all, be all” recovery group. I think this is really demotivating. It presents distorted thoughts along the lines of, ‘If I don’t fit into this program, then there is no hope for my recovery’. One size does NOT fit all. I had to request to use SMART Recovery as my recovery group, as it was an unknown to the Navy SARP offered to me.

“Jay”

12 years Active-Duty Navy

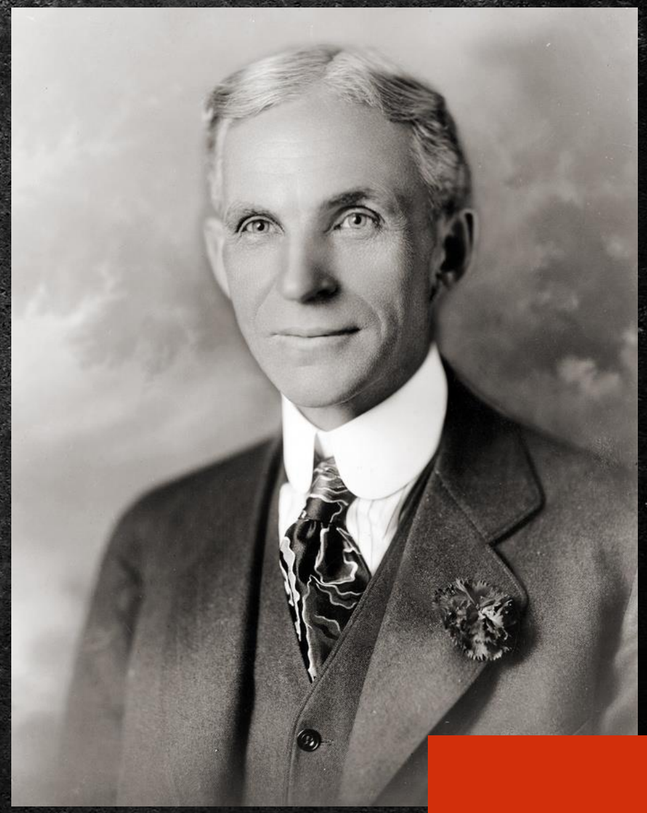


These men and women suffer more for their commitment to their professions, country and communities, more than most of us will ever know. It is deplorable that they should suffer more, when simply wanting to find help for themselves.

There are many out there, indeed many in this very conference, who are giving their all to make a difference for the veteran and first responder community suffering with addiction and mental health disorders. But we still can do so much more.

How We Can Start to Change the Game

- Henry Ford once wrote, “Coming together is a beginning. Keeping together is progress. Working together is success.”



- One of the MAJOR changes required in the recovery community to invoke change, is open communication. The “One Size fits all” or “Our way or the Highway” mentality is an antiquated approach to modern treatment. One of the first aspects that needs to be accomplished is to first stop looking at the problem from a point of excuses. It doesn’t matter what any of us believe addiction is. It we lose ourselves on the constant debates over what this disorder is or isn’t, we lose the opportunity to save more lives. As a former military personnel, I was accustomed to being presented a problem and multiple ways of approach to overcome it. We didn’t not waste time or energy contemplating why the problem existed or who was to blame. We knew people were counting on us to do our jobs and we put our focus on exactly that.

- There is absolutely no reason, we cannot start to do the same within the recovery community.

How We Can Start to Change the Game

- What that means is creating an interconnecting link of resources, across multiple platforms of recovery services. This is a change that will start from the very top of government providers to the non-profit community drop-in center around the corner. As organizations begin to offer multiple pathways of recovery for a wider array of problematic disorders, with a more inclusive mentality for any and all to find a successful means to their personal recovery goals, we will begin to see less and less of our service men and women succumbing to these dreadful numbers of lost lives.

Combining resources at one generic location will also limit the Amount of stigma associated with seeking help.

How We Can Start to Change the Game

- The Stigmas and stereotypes that have plagued addiction for hundreds of years need to stop. Period. They are not only holding us back from modernizing recovery but literally costing us lives. How many men and women suffer needlessly because of their fear of revealing their disorders to their employers? How many have fallen prey to the darkest forms of addiction because that help never came? How many have lost their lives because they decided to cease to exist, rather than live with the pain, guilt or shame?

- As organizations that employ these individuals, we count on to maintain the comfortabilities we take for granted in this society, there needs to be an abundance of understanding, support and resources for those who are desperately seeking answers. A service member should not lose their badge, rank, privileges or position permanently because they are suffering from a medical disorder. They should be given the same honor, respect and dignity we award them when we shake their hands, hug them or simply state, “Thank you for your service”.

How We Can Start to Change the Game

- If you are an organization that aids the veteran and first responder recovery community, make sure you are offering all they require to reach their goals. If you do not have services for these brave men and women, find out how you can connect to other who do, to link what you can offer, to better their lives. If you are not involved in recovery at all, but want to do something to make a difference, reach out to those in your communities, networks and institutions that are and find out how you can be of service.

- No problem is insurmountable. We have the opportunity to form a coalition of the willing, to face a common threat together, united. Let us find better ways to serve those who have proudly, served us.

Thank You

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