S. HRG. 110–187

FIELD HEARING ON ADDRESSING MENTAL HEALTH CARE NEEDS OF VETERANS IN THE STATE OF WASHINGTON

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

AUGUST 17, 2007

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AUGUST 17, 2007

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WITNESSES

FIELD HEARING ON ADDRESSING MENTAL HEALTH CARE NEEDS OF VETERANS IN THE STATE OF WASHINGTON

FRIDAY, AUGUST 17, 2007

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:45 a.m., in Bates Technical College-South Campus, Tacoma, Washington, Hon. Patty Murray, Member of the Committee, presiding.

OPENING STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Good morning to all of you. I would like to officially call this hearing of the Senate Veterans' Affairs Committee to order. First of all, I want to thank Bates Technical College for hosting this event today. I really want to thank them and all their staff for helping us set up and putting this together today, and I really appreciate all they have done. I want to welcome all of you who are here today and I want to thank you for coming. As everyone here knows, the topic of this Committee hearing today is veteran's mental health care. As the senior member of the Senate Veteran's Affairs Committee, I am holding this hearing here in Washington State to better understand how the invisible wounds of war have impacted those who have born the burden of battle and how this has and will impact their families and their communities. I want to acknowledge the staff and doctors at the VA who are some of the most caring and compassionate I have ever met. I agree with many of the veterans who believe that the care at the VA is excellent, and I'm here today not to give the VA a black eye or to bash them, but to look at ways that we can do things better. Sometimes we do things just because they've always been done a certain way, but if we could do better by our vets, we should.

I'm here to listen today and to ask questions so that I can take the stories and information I hear back to Washington, DC, with me and advocate for the resources that can make our VA system do better. Our understanding of mental illness has come a long way since the famous incident in 1943 when General George Patton slapped a soldier being treated at a hospital in Italy for exhaustion. PTSD, or Post Traumatic Stress Disorder, has had a variety of names throughout the years, after the Civil War it was called soldier's heart; after the First World War it was called shell shock;

after the Second World War it was called battle fatigue, and after the Vietnam War it was called post-Vietnam syndrome.

Although PTSD as it is called today has changed names over the years, the horrors of wars have remained the same. Our understanding of the impact of that warfare has had on the minds of warriors has evolved over the years. But one thing we do know for sure is that the mental wounds that our men and women in uniform suffer can run just as deep and can be just as devastating as the physical injuries that are sustained on the battlefield. The wars in Iraq and Afghanistan are no exception. As the Iraq War enters its fifth year, it is clear that the fighting overseas has taken a tremendous toll on the lives of our troops who have served this Nation so honorably, as well as their families who've born the sacrifice in so many different ways.

When it comes to identifying and treating all of the returning veterans with mental health problems, we are facing serious challenges. According to the VA, one third of all returning Iraq veterans who have enrolled in the VA have sought treatment for a mental health problem. That is an astounding statistic, but it is also probably too low. We know that many servicemembers and veterans do not seek care because of the stigma surrounding treatment or because of fear that a mental health diagnosis will negatively impact their military career. And far fewer will speak out about their own experiences in a forum like this as I've found out when I began searching for servicemembers and veterans to testify about their personal mental health illness.

My staff spoke to a number of veterans with compelling and heartbreaking stories to share, but who for many reasons did not feel comfortable testifying publically. Some veterans were concerned that sharing their struggle would negatively impact their jobs, others thought it would impact their military career or the perception of their fellow troops, while others did not feel comfortable sharing their struggles because they had not told their family or their friends. I so appreciate the bravery and willingness of the veterans and the family members on our first panel who have come today to share their stories with all of us. Their testimony and openness in answering questions will allow all of us to better understand the hidden costs of war. They are here speaking out for a lot of people who couldn't be here today or couldn't feel that they could do this, and their testimony is going to have a far-reaching impact and effect on the policies of our country and the lives of all who serve.

We know that as troops are deployed overseas for the third, fourth and some now even fifth tour of duty, the likelihood of PTSD and other mental health care conditions increases. We also know that the Iraq War has created unique challenges for the military and the VA to provide care for all the veterans needing health care treatment, whether they're 20 years old and just back from Iraq, or a Vietnam veteran who is experiencing PTSD for the first time. But we've known about many of these problems for a long time and, unfortunately, the National VA has too often failed to act. Last year the GAO issued a report indicating that the VA did not spend all the mental health money it was provided by Congress. The bureaucracy and poor communication from the VA central of-

fice likely resulted in mental health funds being used for other health care purposes. In the spring of 2006, a senior VA official said that waiting lists at VA facilities across the country rendered mental health care and substance abuse treatment virtually inaccessible. And just this past February the American Psychological Association released a report that found many servicemembers and their families are not receiving mental health care because of the limited availability of such care and the barriers to accessing it.

Our National Guard and Reserve members have been particularly hard hit. These citizen soldiers who leave their families and jobs at home to serve our Nation overseas often live in areas far away from VA medical centers making it difficult for them to receive care once they do return home.

I hear from Guardsmen, Reservists and their families all the time who've encountered problems accessing care at the VA, and that has to change. We are also now hearing that Vet Centers, an integral part of the VA's mental health care network don't have enough staff to meet the growing number of veterans who are accessing our clinics. According to a recent *USA Today* article, the number of returning veterans from Iraq and Afghanistan has more than doubled since 2004, but the staffing levels at our Vet Centers have increased by less than 10 percent. It is clear that the VA is still not on a war-time footing to deal with this problem. It's also clear that the Administration and the top VA has failed to make the mental health treatment needs of our veterans into account as a part of the cost of this war, and sadly that has cost them and our families dearly.

Fortunately, there is some help on the way. This year, the Senate passed a budget that provides the VA with $43.1 billion for this fiscal year. That is $3.6 billion more than the President's budget and 99 percent of what the Independent Budget, which is an independent analysis of these budgetary needs put together by four major veterans service organizations called for. In addition, Congress sent to the President an emergency supplemental bill that provides $1.8 billion in directed funding for veteran's health care, including $100 million in funds directed to veteran's mental health care programs. The President did not request any funding for veterans in his supplemental, but we fought in Washington, DC, to make sure we had it, because caring for our troops when they return home is a cost of war.

This funding will help the VA to better meet the needs of the estimated one third of returning Iraq and Afghanistan veterans who have sought care at the VA for mental health problems. In addition, recently the Senate passed the Dignified Treatment of Wounded Warriors Act which will help meet the needs of our troops and our veterans as they transition from the battlefield to the VA and everywhere in between. That bill will require the Department of Defense and the VA to work together to develop a comprehensive plan to prevent, treat and diagnose TBI and PTSD. It also directs the two agencies to develop and implement a joint electronic health record so that critical medical records are not lost as our wounded troops move from the battlefield doctors to medical hold and on to the VA. It will also require the military to use VA standards for rating disabilities only allowing deviation from VA standards when

it will result in a higher disability rating for our servicemembers, and it will require the military to adopt the VA presumption that a disease or injury is service-connected when our heroes who are healthy prior to service have spent six months or more on active duty.

With our troops fighting overseas, with their tours being extended, it's up to all of us to make sure they don't have to fight for health care or benefits when they return home. Those critical pieces of legislation will ensure the VA has the resources it needs to care for our veterans so our veterans have what they need. But we cannot stop there. We have to continue hearing from our veterans, troops and their families on the ground so that we can provide the resources and make the changes needed to provide the highest level of care possible, and that is why I'm holding today's hearing. Your stories and the information that we share today will help uncover the true cost of this war and the impacts it has had on our veterans and on our families.

This is an official U.S. Senate hearing, and as such, we have to follow the same procedures that are used at hearings in Washington, DC. That means that testimony is limited to the invited witnesses. There are strict time limits, which these timing lights in front of me will indicate, and we have a court reporter here today who will create a formal record of today's proceedings. Unfortunately, that also means that we will not be allowed to take questions or comments from this audience, but I want to ensure everyone that is here today, you will have an opportunity to share your views. We do have a comment form that you can fill out. We also have a sign-up sheet so you can get updates from me as I continue to work for vets back in the U.S. Senate. And in addition, I want you to know I have created a section on my web site where veterans throughout our state can share their stories with me. The address of that is *murray.senate.gov/veterans*, and you will see a section under that called share story. Please use it. I want to hear from you.

So with that, let me explain how today's hearing is going to work. Today we're going to hear from three panels of witnesses, the first panel that is before you now is consists of veterans, family members and advocates, and I, again, want to extend a very special thank you to each of our Panel I participants for their courage to come here and to speak out publically about some very personal issues. Each one of you is speaking out for someone who could not be here today, and for that, I thank you very much. The second panel will consist of officials from the federal VA, the State Department of Veterans Affairs, the Department of Defense and the Washington National Guard. They're going to give us a birds-eye view of what is happening with mental health care throughout the state and our country. Our third panel is going to consist of mental health professionals who work directly with our troops and veterans and who will be able to speak to the specific issues affecting the care of our wounded soldiers.

Despite the quality of our witnesses and the many topics that they will discuss during their testimony, I know that there are more challenges we won't have time to talk about today. So if you do have a concern that we don't cover, I want you to write it down

and give it to my staff members who are here. When I call on our first panel, each witness will have up to 5 minutes to present your testimony, and then I will ask you all questions. Of course, as you know, your full written statement will be entered into the Committee record, and when we're done with the witnesses on the first panel, I will then call on our second panel and our third panel. I do know that we have a lot of veterans in our audience today, and I want to take this time to thank each and every one of you for your service to our country.

If you need any help from the VA, I want you to know we have representatives here on-site who can help you file a claim. You can meet with officials from the VA regional office, the Washington State Department of Veterans Affairs and the VA Hospital in a room that we have set up nearby. If you do need help with an existing claim, members of my staff are here and they can help you resolve a claim with the VA.

Because of federal privacy rules, we will need a signed letter giving us permission to investigate your case before we can do anything else, so I invite anyone who is here with a claim, if you need help, please find one of our staff members and we are more than eager to help you.

We also have two professional staff members who are here with us today from the Senate Committee on Veterans' Affairs, Patrick McGreevy from Chairman Danny Akaka's staff; and Lupe Wissel from Ranking Member Craig's staff are here if you want to raise your hand so we know who you are. They've traveled out here from Washington, DC, and I want to thank you very much for being with us today.

With that we are now going to begin with our first panel. I am going to introduce them to you, and then they will each have 5 minutes to testify and then I will ask questions. As I said, our first panel consists of veterans, family members and veteran's advocates, and we have a very distinguished panel in front of us today. Testifying before us on our first panel, and I will read the entire order and then we will go through you, we have Kathy Nylen, she is a Department Service Officer with the American Legion in Washington State. Next to her is Brandon Jones. Brandon is a member of the Washington Army National Guard and was deployed with the members of the 81st Brigade beginning in November of 2003. Sarah, his wife, was hoping to be with us to give a family perspective today, but like many family members, ran into a babysitting issue and because of that can't be here. Tell her we would love to have her testimony in writing if that is possible. We have Lieutenant Colonel Carol Seger, who is the State Family Programs Director for the Washington National Guard. Stephen Franklin has joined us. He returned from Iraq in 2005 after a year of deployment. We have Daniel Purcell who is a member of our Washington Army National Guard and deployed with his unit to Iraq in February of 2004. And our last one here is Ron Fry, he is the Deputy Commander of the Blue Mountain Veteran Coalition. Thank you all so much for being here today. And, Kathy, we will begin with you.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO DEPARTMENT OF VETERANS AFFAIRS

Veterans have long been frustrated by the combative VA benefits claims process. The Veterans Disability Benefits Commission is now studying the system and will recommend changes in a final report that is expected in October. In addition, the Institute of Medicine found that the VA's compensation system for emotionally disturbed veterans has little basis in science, is applied unevenly and may even create disincentives for veterans to get better.

Question 1. How can we change the VA claims process so that it doesn't negatively impact the recuperation of veterans?

Response: The Department of Veterans Affairs (VA) is continually striving to improve the compensation claims process and is evaluating all recommendations from authoritative sources. Mental disability among veterans is a major issue, especially Post Traumatic Stress Disorder (PTSD). VA is addressing the process for evaluating the severity of a veteran's PTSD symptoms and assigning an appropriate evaluation of disability compensation. We have revised the standardized examination format for PTSD for use by all examiners so that consistent and more useful information will be available for claims adjudication personnel. Additionally, VA is considering the recommendation of the Institute of Medicine of the National Academies that PTSD have its own specific multidimensional rating criteria, rather than being evaluated based on generalized criteria used for all mental disorders.

Question 2. How many Iraq and Afghanistan war veterans have filed any type of VBA disability compensation or pension claim?

Response: The information provided below is based on a match between Department of Defense (DOD) data on servicemembers deployed in support of the Global War on Terror (GWOT) for the period from September 11, 2001 through May 31, 2007, compared to VA data covering September 11, 2001 through September 30, 2007.

This data match identified veterans who were deployed during their military service in support of GWOT, and who have also filed a VA disability claim either prior to or following their GWOT deployment. Many GWOT veterans had earlier periods of service, and filed for and received VA disability benefits before being reactivated.

VBA's computer systems do not contain any data that would allow us to attribute veterans' disabilities to a specific period of service or deployment.

For the period covered, 223,564 of 754,911 GWOT veterans filed a claim for disability benefits either prior to or following their GWOT deployment. Of those, 181,151 veterans were determined to have a service-connected disability, 17,371 were denied service-connection, and 23,042 veterans had original claims pending as of September 30, 2007.

Question 3. How many Iraq and Afghanistan war veterans have filed a claim for a mental health condition? How many were granted? How many were denied? How many are waiting for a decision?

Response: VBA does not track information specific to mental health conditions claimed by GWOT veterans. We have compiled data on GWOT veterans for the 10 most prevalent service-connected disabilities granted, which includes PTSD. As of September 30, 2007, there were 31,465 GWOT veterans service-connected for PTSD. This represents 4 percent of the total GWOT veteran population, and 17 percent of those GWOT veterans who have been granted any service-connection. This data is based on veterans separated from military service on or before May 31, 2007, as reported by DOD.

Question 4. How many total claims does VBA expect from Iraq and Afghanistan war veterans? How many of those does VBA expect will be for any type of mental health condition? And how many for PTSD?

Response: In fiscal 2007 the Veterans Benefit Administration (VBA) completed nearly 829,000 claims. Of those, just over 110,000 (13 percent) were claims made by GWOT veterans. This information is based on GWOT veterans discharged through May 2007 as reported to VA by DOD and self-reported by GWOT veterans when they filed their disability claim. At the present time, we expect GWOT claims will continue to represent the same percentage of our overall workload in 2008 and 2009. Projecting future demand for the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) conflict remains extremely difficult for a number of reasons.

First, many OEF/OIF veterans served in earlier periods, and their injuries or illnesses could have been incurred either prior to or subsequent to their latest deployment. We are unable to identify which OEF/OIF veterans filed a claim for disabilities incurred during their actual overseas OEF/OIF deployment.

Second, we significantly expanded our outreach to separating servicemembers. Over the last 5 years, we conducted over 38,000 briefings attended by over a 1.5 million active duty and Reserve personnel. Additionally, through the benefits delivery at discharge program, servicemembers are encouraged to file and assisted in filing for disability benefits prior to separation. Many servicemembers with disabilities are submitting disability claims earlier. However, the impact of these efforts on future application trends and benefits usage is not known.

Third, VBA lacks historical data for claims activity by veterans of prior wars on which to base projections of benefits usage for OEF/OIF veterans. The only data available are the numbers and percentages of veterans currently receiving benefits by era of service.

We continue to add veterans to our compensation rolls many years after their service. Many of these are a result of additional conditions presumed to be related to service in Vietnam. PTSD claims have also increased from Vietnam veterans. We have no basis for determining if service in Afghanistan and Iraq will result in similar claims patterns.

Question 5. What is the average wait time for new war veterans compared to all other veterans, who wait 6 months for an initial decision?

Response: In fiscal 2007, VBA completed nearly 825,000 claims, Of these, just over 110,000 were claims filed by GWOT veterans. Their claims were processed in an average of 179 days. The remaining claims were completed in 184 days.

VA is continuously seeking ways to improve the timeliness of processing claims received from GWOT veterans. In February 2007, VA began providing priority processing of all OEF/OIF veterans' disability claims. This initiative covers all active duty, National Guard, and Reserve veterans who were deployed in the OEF/OIF theaters or in support of these combat operations, as identified by the DOD. Therefore, claims received from GWOT veterans before February 2007 were not processed on a priority basis. As a result of this initiative we expect to see improvements in our timeliness in FY 2008.

VBA also added an indicator/flash in our VETSNET system to clearly identify GWOT veterans and improve the management of their claims. The system alerts the claims examiner that the case being processed is to be handled in a priority manner.

VA does face challenges in assisting GWOT National Guard and Reserve members with their claims, due to difficulties in obtaining their active duty medical records. These members are sometimes mobilized with units other than their home unit. Their medical records created while on active duty may not get back to their home unit for some time, if at all.

VA is taking a proactive approach in seeking to obtain medical records faster from the National Guard. VA met with the National Guard to discuss their health readiness records and electronic readiness records, and how the VA can have access to those records. The VA Regional Office in St. Petersburg, FL, is entering into a pilot program with the National Guard in order to receive medical records electronically.

STATEMENT OF KATHY D. NYLEN, DEPARTMENT SERVICE OFFICER, DEPARTMENT OF WASHINGTON, THE AMERICAN LEGION

Ms. NYLEN. Thank you, Senator. I would like to thank you for this opportunity to express the American Legion's views on the mental health needs of those men and women who have served our country and safeguarded our freedom. I would like to say that in light of the recent report in the *Washington Post* that the Army is now experiencing the highest suicide rate in history, I feel that this hearing could not have been held at a better time. As the Department Service Officer in Washington State, I am intimately aware of the types of claims and issues being raised by our clients to the Department of Veteran Affairs. I also serve on our national task force and have had the privilege of visiting polytrauma centers and Vet Centers throughout the country. I consider it an honor and privilege to be able to speak with for veterans who are unable to do so for themselves.

I would like to highlight a few items in my written testimony. A recent study shows that 31 percent of OEF/OIF veterans seen at

VA health care facilities are receiving mental health or psychosocial diagnoses. I would like to point out that quite often when we talk about mental health disorder, we always think PTSD, but I do want to make sure everybody is aware that there are many other mental health illnesses encompassed in that, that our troops are suffering from such as depression, anxiety and panic disorders among others. The early detection and intervention are necessary to prevent chronic mental illness disabilities. As you mentioned in your opening statement, according to the VA, one third of the veterans are being diagnosed and treated for mental health disorders making that the second most common medical problem of these war veterans.

Funding is a continued concern. I would ask that we would continue to push for mandatory funding for the VA health care system and the VA in whole. Without funding, they will not be able to meet the challenges before them. One of the areas I have seen a downsizing of is within VA mental health services that are being contracted outside of the VA. I have received several complaints from veterans and counselors alike that their level of care being provided is being decreased from the one-on-one individual counseling to more use of the group counseling. In answer to this issue, VA has stated that the necessary care is being provided as needed; however, I'm here to tell you that the word on the street is one of disappointment and difficulty of adapting to the group counseling environment. The signature wound of the Global War on Terror is Traumatic Brain Injury. The American Legion is concerned that our veterans are often misdiagnosed resulting in errors both in medical treatment and disability compensation rating. The DOD policy of redeployment without allowing adequate time to determine if there are any physical or mental issues to address has placed our men and women at risk for significant long-term medical problems. We would like to see that all returning servicemembers are routinely evaluated for Traumatic Brain Injury and that a system be established to ensure the follow-up since some symptoms are not manifested immediately.

Active duty members who are being placed on medical evaluation board proceedings here in Washington State are finding themselves waiting an inordinate amount of time for a decision. They're waiting months and in some cases nearly a year. They understandably get frustrated, and when they're offered the chance to be discharged, we see them accepting lower disability ratings from the med board process than what they are entitled to. I have personally assisted a number of clients once their VA rating has been established to go back and upgrade their military status to that of a medical retiree in order to receive those benefits they're entitled to. A major obstacle for veterans seeking mental health services or any other medical service is timely accessibility. Those who need care for readjustment or other mental health issues need immediate attention and not be placed on a wait list. Many do not seek the immediate assistance, and so, their mental health condition may be more advanced by the time they do decide to seek care, and again, they require quick response.

The Department of Veteran Affairs has augmented staff at 12 Vet Centers and is creating 23 new Vet Centers within the next 2

years. I am pleased that Everett has been selected as a location for one of those Vet Centers here in Washington State. Vet Centers are a unique and invaluable asset for veterans seeking readjustment counseling. Vet Centers are community based. Veterans are assessed the day they seek services. They receive immediate access to care and are not subjected to wait lists. They are designed to provide services exclusively for veterans that serve in theaters of conflict or experience military sexual trauma, and they provide mental health counseling not just to the veteran, but to those who have been their support system, like the spouse and children.

We are eagerly anticipating the budget proposed. We urge continued support for mandatory funding and ask that your colleagues be enlightened as to the need of mandatory funding for VA health care.

In conclusion, the American Legion realizes the Department of Veterans Affairs faces many difficult challenges addressing the complex mental health issues of our Nation's heroes. The network of trained knowledgeable service officers of the American Legion and other veterans service organizations are ever ready to assist those individuals accessing their benefits. We are their advocates and we are here to work with them and to ensure that they receive the maximum that they're entitled to. We will continue to monitor and work closely with the VA to ensure they do receive those benefits.

Senator Murray, for your accomplishments on behalf of Washington State veterans and their families, I thank you. I look forward to continuing this trend, and again, thank you for this opportunity to present our views on this critical issue.

PREPARED STATEMENT OF KATHY D. NYLEN, DEPARTMENT SERVICE OFFICER, DEPARTMENT OF WASHINGTON, THE AMERICAN LEGION

Senator Murray, Thank you for the opportunity to express The American Legion's views on the mental health needs of those men and women who have served our Country and safeguarded our freedom. As the Department Service Officer in Washington State for The American Legion, I am intimately aware of the types of claims and issues being raised by our clients to the Department of Veterans Affairs and consider it an honor and privilege to speak for those unable to do so for themselves.

A recent study—entitled Mental Health Disorders Among 103,788 US Veterans Returning From Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities—can be utilized to illustrate the importance of timely accessibility for those who suffer from mental health issues. Of 103,788 OEF/OIF veterans seen at VA health care facilities, 31 percent received mental health and/or psychosocial diagnoses. Mental health diagnoses were detected soon after the first clinic visit, approximately 13 days. Sixty percent of most initial diagnoses were made in mostly primary care settings. The youngest group of these veterans (age 18–24) had a greater risk for receiving mental health diagnoses. The study concluded that the co-occurring mental health diagnoses were detected early in the primary care setting. This early detection and intervention are needed to prevent chronic mental illness and disability. If those who seek care are forced to wait months to be seen for their appointments, opportunities for early detection of mental health issues will decrease, allowing the conditions to worsen and making them more difficult to treat.

According to the Veterans Health Administration (VHA) Office of Public Health and Environmental Hazards, of the returning Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans who have sought care at VHA facilities, mental health problems are the second most common medical problem of these war veterans. There has been significant restructuring of VA mental health services during the past several years which has often resulted in a downsizing of in-patient based care, and the shift of treatment programs from residential-based to ambulatory-based programs. I have received several complaints from veterans and counselors alike that the level of care being provided has been decreased from one-on-

one counseling to more group counseling. In answer to this issue, VA has stated that the necessary care is being provided however, the "word on the street" is one of disappointment and difficulty adapting to the group-counseling environment.

During the past several years, the number of veterans provided specialized substance abuse treatment has declined, while the funding for such treatment has been significantly decreased. The Veterans Health Administration now has more mental health patients seeking treatment with fewer mental health providers. However, as more OIF/OEF veterans return, many continue to need increased access to mental health services, including, but not limited to, Community Based Outpatient Clinics, Mental Health Intensive Case Management, Substance Abuse Disorder Programs, and Compensated Work Therapy Programs.

The signature wound of the Global War on Terror is Traumatic Brain Injury and The American Legion is concerned that veterans are often misdiagnosed resulting in errors both in medical treatment and disability compensation ratings. The policy of redeployment without allowing adequate time to determine if there are any physical or mental issues to address has placed our young men and women at risk for significant long-term medical problems. We would like to see that all returning servicemembers are routinely evaluated for TBI and that a system be established to ensure follow-up evaluations since some symptoms are not manifested immediately.

A common complaint heard from those servicemen and women being evaluated by a Medical Evaluation Board to determine eligibility for continued service is that they are waiting months, and in some cases nearly a year, for a decision. They understandably get frustrated and when offered the chance to be discharged, we see them accepting a lower disability rating than they are entitled to. We have assisted a number of clients in correcting their military status in order to receive the retirement benefits they are entitled to once the VA rates the same disabilities, which DOD rated at less than 30 percent.

A major obstacle for veterans seeking mental health services—or any other medical service—is timely accessibility. Wait lists and staffing shortages affect the speed of delivery of care system-wide. Those who need care for readjustment or other mental health issues need immediate attention. Since many do not immediately seek assistance when their problems first manifest, their mental health condition may be more advanced by the time they decide to seek care—requiring quick response. I would like to reiterate the findings of the study in my opening and the concerns we have that if those who seek care are forced to wait months to be seen for their appointments—mental or physical health —opportunities for early detection of mental health issues will decrease, allowing the conditions to worsen and making them more difficult to treat.

The Department of Veterans Affairs plan to augment staff at select Vet Centers and to create 23 new Vet Centers within the next 2 years, bringing the number of Vet Centers to 232, will improve access to readjustment services for many combat veterans and their families—some of which reside in underserved areas. Vet Centers are a unique, invaluable asset for veterans seeking readjustment counseling. Because Vet Centers are community based and veterans are assessed the day they seek services, they receive immediate access to care and are not subjected to wait lists. Designed to provide services exclusively for veterans who served in theaters of conflict, or experienced military sexual trauma, they provide mental health counseling to not just the veteran, but those in his or her support system—like the spouse and children. Services are provided in a non-clinical environment, which may appeal to those who would be reluctant about seeking care in a medical facility. A high percentage of the staff, more than 80 percent, are combat veterans and can relate to the readjustment issues experienced by those seeking services. We are pleased that Everett has been selected as one of the sites for a new Vet Center but see a need for additional sites in rural areas.

In conclusion, The American Legion realizes the Department of Veterans Affairs faces many difficult challenges addressing the complex mental health issues of our Nation's heroes. We will continue to monitor and work closely with VA to ensure veterans receive the treatment and benefits they are entitled to.

Thank you again for this opportunity to present our views on this critical issue.

Senator MURRAY. Thank you very much, Kathy. We will turn to Brandon Jones. Thank you for being here to share your story.

STATEMENT OF BRANDON D. JONES, MEMBER, WASHINGTON ARMY NATIONAL GUARD

Mr. JONES. Senator Murray, thank you very much for the opportunity to be able to speak here today. My name is Brandon Jones. I served on active duty from 1994 to 1997 and have been a member of the Washington Army National Guard since January of 2000. As a veteran of Operation Iraqi Freedom, I was deployed to the Middle East with the 3rd Brigade, 1st Cavalry Division in 1996. I was activated and deployed for Operation Iraqi Freedom for the 81st Brigade beginning 2003.

I would like to share my experience and observations about the difficulties that my family and I faced during my activation in 2003–2004 and would also like to talk about what I saw other soldiers facing and experiencing which made the process of serving the Nation and the community a trying and sometimes emotional and financially overwhelming experience. In November 2003, I was called to full-time active duty with 81st Brigade and was given a very short notice when my unit was mobilized. In that time, I had to give up my civilian job and took an income loss of over $1,200 a month. My wife had to drop out of classes at Olympic College in order to be able to care for our children. I went from living at home and seeing my children on a daily basis to living on base, which is just one mile away from my home, and visiting my children periodically. To my kids I went from being their dad full time to being the guy that just dropped by the house every once in a while for a visit.

The three months mobilization before my deployment were very stressful. We struggled financially, and although we reached out for help, we were told financial resources available were strictly available for active duty soldiers on Fort Lewis. It wasn't until we were threatened with eviction and repossession of our only vehicle that my wife was able to obtain a small amount of assistance that was, again, generally set aside for active duty soldiers. Our families helped us make up the rest. They covered about 60 percent of what we owed. The stress made it difficult for my wife and I to keep a positive attitude, for our children to feel comfortable, and for me to concentrate on the mission that was ahead. When my wife and I reached out for marriage counseling prior to our deployment, we were again made to feel like we were using up resources that were set aside for active duty soldiers on base.

Let me remind you, this was all stuff that took place prior to my deployment. After 110 days in theater, I was MEDEVACED due to a heart condition.In MED Hold, myself and other soldiers were left to figure things out on our own. There was no information posted or available for incoming soldiers to where they could seek help or counseling for the issues they had experienced when they were downrange. I found this very surprising since some of the soldiers that were MEDEVACED were there after being injured in explosions, mortar attacks or other combat related incidents.

During my first deployment to the Middle East in 1996, I developed a sleep disorder due to the stresses that I experienced while I was there. When I was MEDEVACED in 2004, I experienced many of the same disturbances in my sleep pattern. I explained that to my MED Hold platoon sergeant and I explained that my

sleep disturbances may affect my performance and he helped me get referred to the community mental health clinic at Madigan. There I was seen by a mental health professional and was offered sleeping pills to get me through the disturbance, but was not offered any help to treat the underlying conditions that were causing the sleep disturbance. I, like many other soldiers, was threatened with UCMJ action when my sleep disorder and issues interfered with my duties as a soldier, like for instance, when I showed up late for formation or, on occasion, fell asleep during duty. My only saving grace is when I was counseled, I wrote in my statement that I tried to seek help for my sleep disorder and received nothing.

My sleep disorder has continued to affect my civilian employment, and I thank God for my wife and her ability to be able to kick me out of bed in the morning when I'm running late. Another thing I observed on Med Hold is that soldiers were using alcohol and sometimes drugs, both prescription and illegal to treat themselves because they weren't aware of any services that may be available to them. While I was in Med Hold I perceived a mentality of, return them to duty or send them home. If anything caused disruption to this process by a soldier behaving in any unsoldierly manner with the use of alcohol or drugs, no time was taken to help the soldier but UCMJ action was started almost immediately.

I was often frustrated by the fact that noncombat veteran soldiers were put in charge of taking care of combat veterans. I don't believe that it was a lack of sympathy or caring on their part, but rather a lack of sympathetic understanding and appropriate training on how to deal with the stress-related issues. Ultimately, this sort of lack of understanding, training and information resulted in the loss of life through suicide by a close friend of our family. My friend was MEDEVACED because of his inability to cope with the stresses of combat. After his suicide his wife informed us that he was supposed to have been on suicide watch, that he was supposed to have been receiving help and intervention in the form of counseling and medications, instead he was sent home alone. He was not released to the care of his family. He was sent to dwell in his own mind to a point that he couldn't handle it any longer. He put a gun to his head and took his own life. His widow and two stepchildren asked over and over again how this could have happened and what they could have done differently.

I find myself asking the same questions whenever he comes to mind. More so, I find myself asking where was the appropriate care? Where were those that were assigned to look after his well-being and were the resources available? And did they have the appropriate training to recognize the mental health conditions the soldiers suffer from? Obviously there were not enough resources, not enough training and not enough information, otherwise he might be here today telling his story.

I hope that something will be done to increase the communication of available resources for soldiers and their families. I hope more will be done to raise the awareness of Post Traumatic Stress Disorder and combat-related stresses, not only for the soldier that goes off to war, but for the families and children that bear the burden from having a loved one taken from their home.

PREPARED STATEMENT OF BRANDON D. JONES, MEMBER,
WASHINGTON ARMY NATIONAL GUARD

My name is Brandon Jones. I served on Active Duty from 1994 to 1997, and have been a member of The Washington Army National Guard since January 2000, and am a Veteran of Operation Iraqi Freedom. I was deployed to the Middle East with the 3rd Brigade of the 1st Cavalry Division in 1996 and I was activated, and deployed with the members of the 81st Brigade beginning in November 2003.

I want to share my experience and observations about the difficulties my Family and I faced during my activation in 2003, and also to talk about what I saw my fellow Soldiers' experience that made the process of serving our Nation and Community trying, and at times emotionally and financially overwhelming.

In November 2003, when I was called to full time duty with the 81st Brigade. I was given a very short notice that my unit was being mobilized. In that time I had to give up my civilian job—an income loss of about $1,200 a month—and my wife had to drop out of classes at Olympic College to care for our children.

I went from living at home and seeing my children on a daily basis to living on base—just one mile from home—and visiting my children periodically. To my kids, I went from being their dad to the guy who drops by the house for a visit once in a while.

The three months of mobilization before my deployment were very stressful. We struggled financially. Although we reached out for help, we were told that the only financial resources available were strictly for active duty soldiers at Fort Lewis. It wasn't until we were threatened with eviction and repossession of our car that my wife was able to obtain a small amount of assistance generally reserved for Active Duty Soldiers. Our families helped us make up the rest. About 60 percent of what we were in need of.

The stress made it difficult for my wife to keep a positive attitude, for our children to feel comfortable and for me to concentrate on the mission ahead of me. When my wife and I reached out for marriage counseling prior to my deployment, we were made to feel that the few sessions we were given were a favor to us and that we were taking up a resource meant for active duty Soldiers from the base.

Let me remind you that all of this happened before I was even deployed.

After 110 days in theater, I was MEDEVACED due to a heart condition. In our MED Hold, soldiers were left to figure things out on their own. There was no information posted or available for incoming soldiers as to where they could seek help or counseling for issues related to their deployment. I found this very surprising, since some of these soldiers were MEDEVACED after being injured in an explosion, mortar attack, or other combat related incidents.

During my first deployment to the Middle East in 1996, I developed a sleep disorder due to the stresses I experienced while I was there. When I was MEDEVACED in 2003, I experienced many of the same disturbances in my sleep pattern. I explained to my MED Hold platoon sergeant that my sleep disturbances may impact my performance, and he helped to get me referred to the community mental health clinic at Madigan.

There I was seen by a mental health professional and was offered sleeping pills to get me through the disturbance, but was not offered any help to treat the underlying problem. I, like many other Soldiers, was threatened with UCMJ action when my sleep disorder interfered with my duties as a Soldier, like when I showed up late for formation or when I fell asleep during duty. My only saving grace was that when I was counseled, I wrote in my statement that I had tried to get help for my sleep disorder but had not received anything. My sleep disorder has continued to affect my civilian employment. I never get a full night's sleep and I thank God for my wife who pushes me out of bed if I do oversleep so that I can make it to work on time.

Another thing I observed in Med Hold was that Soldiers were using alcohol and sometimes drugs—both prescription and illegal—to treat themselves. This was because they weren't aware of services available to help them. While on MED Hold I perceived a mentality of "return them to duty, or send them home," and if anything caused disruption in that process by a Soldier having behavioral issues caused by using alcohol or drugs, no time was taken to help the soldier, but UCMJ action was immediately initiated.

I was often frustrated by the fact that non-combat veteran Soldiers were put in charge of the care of combat Veterans. I do not believe that it was a lack of caring on the part of the leadership, and command, but rather a lack of sympathetic understanding, and lack of appropriate training of how to deal with combat related stress issues.

Ultimately this sort of lack of understanding, and information resulted in the loss of life through suicide by a close friend of our family. My friend was MEDEVACED because of his inability to cope with the stresses of combat. His wife informed us that he was supposed to be on suicide watch. He was supposed to have been receiving help and intervention in the form of counseling and medication. He was sent home ALONE!!! He was not released to the care of his family, he was sent to dwell within his own mind to the point that he could not handle it any longer. He put a gun to his head and took his own life. His widow and two stepchildren asked over, and over again: "how could this have happened, and what could we have done differently?"

I find myself asking the same question whenever he comes to mind. More so I find myself asking where was the appropriate care? Where were those assigned to ensure his well-being, and were they aware of the resources available, and did they have the appropriate training to recognize the mental health conditions this Soldier suffered from? Obviously there were not enough resources, training, or information. Otherwise he might be here today, instead of me telling his story.

I hope that something will be done to increase the communication of available resources for Soldiers AND their families. I hope that MORE will be done to raise awareness of PTSD, and combat related stresses, not only for the Soldier that goes off to war, but for the Families, and Children that bear the burden of having their loved one taken from their home.

Senator MURRAY. Thank you very much. I really appreciate you sharing your story. Ms. Seger.

STATEMENT OF LIEUTENANT COLONEL CAROL SEGER, STATE FAMILY PROGRAMS DIRECTOR, WASHINGTON ARMY NATIONAL GUARD

Ms. SEGER. Senator Murray, distinguished guests and fellow citizens, my name is Lieutenant Colonel Carol Seger, and I've served in the Army National Guard for over 28 years. I'm currently assigned as the State Family Programs Director and my charter in that job is to assist military families, which include our servicemembers and our veterans in becoming self-reliant through education and empowerment. Family assistance is provided before, during and after deployments.

We can help our families when the soldier returns by helping them transition into civilian life. When they call us for help, we evaluate their circumstances and try to find the appropriate information and referral for them.

Reintegration back into civilian life is complex and it takes time, and the entire family, as you heard from Mr. Jones, the entire family suffers when the mental health needs are not acknowledged and resolved. It can strain even strong marriages. PTSD and other mental health conditions are sometimes difficult for a servicemember to come to grips with. In some cases it can take years for them to admit that they have PTSD. After our veterans acknowledge that they need help, medical professionals must be made available to diagnose and treat them. The National Guard has no organic resources on mental health to help on weekends or otherwise.

As the number of combat veterans continues to grow, so does the need for mental health coverage. Our mental health delivery system must be made available for our veterans when they realize they need help and they ask for it. The Network for Relief and Aid Organizations, Crisis Support, web sites for children, web sites for self-help, medical information, volunteer organizations among the commercial, federal, state, nonprofit and local services is a huge maze to sift through when the family may already be in crisis.

As resources change, improve or disappear, we must be able to provide them with resources to help them during their crisis. Again, we must help them find those right solutions with knowledgeable and experienced assistance. The National Guard continues to help improving resources to our families, soldiers, airmen through reunion and reintegration briefings, family activity days, marriage retreats and a transition assistance program, but we have more work to do. One of the ways that the National Guard provides assistance to our families and combat veterans is through our Family Assistance Coordination Centers or FACCs. We have eight FACCs in the State of Washington, and they cover local communities in 12 towns. They are manned by temporary staff.

We must keep this essential link to find the right resources for our families and veterans. The need for FACCs is abundantly clear in the number of inquiries they respond to in a month. They range from over 2,600 contacts in a month to over 7,500 contacts in July this year, which included youth camps. Our assistance has helped members of every single component and branch except for the U.S. Coast Guard. The need for our FACC services is growing, and we need to ensure this resource for our veterans and their families is available. The funding for FACCs should not be tied to mobilization as it currently is, rather it should be a constant service provided to families, military members and combat veterans.

Medical assistance should not be limited to the first three to six months after their return to their home when issues such as PTSD or TBI can take years or longer to manifest and resolve. The longer the problem is not treated, the more complicated the treatment becomes due to complications that arise from the lack of treatment. As a result, again, our families suffer, sometimes on a daily basis. We should be proud of the progress we've made so far and commit ourselves to the long term for our families and veterans. More robust medical and mental health care services and permanent staffing of our FACCs are needed to help our veterans and our families now and in the future.

As we look ahead to continued deployments, I encourage everyone here to continue our collaborative efforts and improve services to care for those who have given so much. Thank you.

PREPARED STATEMENT OF LIEUTENANT COLONEL CAROL SEGER, STATE FAMILY PROGRAMS DIRECTOR, WASHINGTON ARMY NATIONAL GUARD

Chairman Akaka, Senator Murray, Members of the Committee and distinguished guests, I am truly honored to be here today and to have this privilege to speak to you on behalf of my fellow Guard Family members, Soldiers, Airmen and Combat Veterans. My name is Lieutenant Colonel Carol Seger and I have served in the National Guard over 28 years. I am currently the State Family Programs Director and I work to assist military Families, which includes our Servicemembers and Veterans, to become self-reliant through education and empowerment. We help our Families by helping the Soldier'/Airman/s transition to civilian life after returning from deployment. We evaluate their circumstances and provide the appropriate information and services. We help our Families regardless of their geographical dispersion or deployment status.

Reintegration back into civilian life is complex and it takes time. The entire Family suffers when a Veteran's mental health needs are not acknowledged and resolved; it can strain even the strongest of marriages. PTSD and other mental health conditions are sometimes difficult for Servicemembers to come to grips with. In some cases it can take years for our Combat Veterans to admit they have PTSD—long after their access to medical treatment has expired. After our Veterans acknowledge that they need help, medical professionals must be available to diagnose

and treat them. The National Guard has no organic mental health capability for weekend assistance or otherwise. As the number of Combat Veterans continues to grow, so does the need for mental health coverage. Our mental health delivery system must be available for our Veteran's when they realize they need help and ask for it.

The network for Relief and Aid Organizations, Crisis Support, web sites for Kids, Self Help web sites, medical information, Volunteer Organizations among the commercial, Federal, state, non-profit and local services is a huge maze that is difficult to sift through when the Family may already be in crisis. As resources change or improve or disappear, we must be able to provide them with up-to-date resources. Again, we must help them find the right solutions with knowledgeable and experienced assistance.

The National Guard continues to improve providing resources to our Families, Soldiers and Airmen through Reunion and Reintegration Briefings, Family Activity Days, Marriage Retreats and the Transition Assistance Program; but we have more work to do.

One of the ways the National Guard provides assistance to our Families and Combat Veterans is through our Family Assistance Center Coordinators or FACCs. We have eight FACCs in Washington, covering offices in 12 communities that are manned by temporary staff. We must keep this essential link to find the right resources for our Families and Veterans. The need for FACC services is abundantly clear in the number of inquiries they respond to in a month. They range from over 2,600 contacts in a month to over 7,500 in July of this year, which includes support to Youth Camps. Our assistance has helped members of every component and branch except for the Coast Guard. The need for FACC services is growing and we need to ensure this resource for our Combat Veterans and their Families is available. As for the funding for FACCs, this should not be tied to mobilization; rather, it should be a constant service to be available to provide assistance to Families, Military members and Combat Veterans. Assistance should not be limited to the first three or six months after they return to their home stations when issues such as PTSD or TBI can take months or years longer to manifest and resolve. And the longer the problem is not treated, the more complicated the treatment becomes due to complications that arise from the lack of treatment. As a result, our Families suffer through crisis on a daily basis.

We should be proud of the progress we've made so far and commit ourselves to the long term for our Veterans and their Families. More robust medical and mental health services and permanent staffing of our FACCs are needed to help our Combat Veterans and their Families now and in the future. As we look ahead to continued deployments, resources for our Veterans and their Families will need to continue. I encourage everyone here to continue our collaborative efforts and improve the services to care for those who have given so much. Thank you.

Senator MURRAY. Thank you very much. Stephen Franklin. Thank you.

STATEMENT OF SERGEANT STEPHEN FRANKLIN, MEMBER, WASHINGTON ARMY NATIONAL GUARD

Mr. FRANKLIN. Senator Murray, thank you for the opportunity to be here today. My name is Stephen Franklin. I am a sergeant in the Washington Army National Guard, and I returned from Iraq on December 15, 2005 after a one-year deployment. Approximately 60 to 90 days after my return, I started having a difficult time adjusting to life at home. I found myself constantly checking doors and windows to see if they were locked. I cannot concentrate and was not comfortable around civilians. I was unable to sleep. I was not comfortable in my civilian job as I did not feel safe without the protection of my fellow soldiers around me. I returned to work for the National Guard. I went to the doctor at Madigan. The doctor prescribed me with sleeping pills to try to help me sleep, help me with my sleeping issues, but nothing to help my other issues. Needless to say, the sleeping pills made me too tired to function the next day.

About a month later, a friend pulled me aside and told me that they had noticed a change in my behavior and work ethic and that they were concerned. I've become very short with people, easily drawn to anger and had to walk away from people so that I would not blow up. I wasn't this way before. I went to the VA at American Lake with my issues. The doctor diagnosed me with PTSD. The doctor prescribed me with depression pills and more sleeping pills. I told the doctor that I could not function in the morning after taking the sleeping pills. The doctor told me that she thought I should try both medicines.

Once again, the medicines did not work. The depression pills brought on side effects that I could not stand, including nausea, vomiting and grogginess. The sleeping pills had the same negative side effects. I joined the PTSD group which met twice a week, anywhere from two to five members. There were veterans from OIF/OEF and Vietnam. I have attended the group for eight to nine months, and it seemed to work while I was there. But once I left, I was right back in the same rut that I had been trying to get out of for almost a year now. Over the course of many doctor visits in the past year and a half, I have told the doctor that I have felt the need for something to relax me, not knock me out cold. They continue to raise and lower doses of depression pills and sleeping medicine.

Finally on July 25, 2007, the doctor at the VA finally listened to me and got me the right medication. I have been able to live with PTSD and my family can now live with me. Throughout my transition home, my PTSD made things very difficult on my family. I had become standoffish, short-tempered. I was not able to give my wife or children the affection that they needed. I was extremely fortunate that my wife was so supportive, as it would have been so much harder for me to recover without her understanding. Overall, I feel that the care I received was good, but I am frustrated that the doctors would not listen to me sooner. If only the doctors could have listened to me, the soldier, and not just categorize me as another soldier with PTSD, I would have been feeling better a year and a half ago.

PREPARED STATEMENT OF SERGEANT STEPHEN FRANKLIN, MEMBER, WASHINGTON ARMY NATIONAL GUARD

My name is Stephen Franklin, and I returned from Iraq on December 15, 2005, after a one-year deployment. Approximately 60 to 90 days after my return I started having a difficult time adjusting to life at home. I found myself constantly checking doors and windows to see if they were locked. I could not concentrate and was not comfortable around civilians. I was unable to sleep. I was not comfortable in my civilian job, as I did not feel safe without the protection of my fellow soldiers around, and returned to work for the National Guard.

I went to the doctor at Madigan. The doctor prescribed me with sleeping pills to try and help my sleeping issue, but nothing to help with my other issues. Needless to say, the sleeping pills made me too tired to function the next day.

About a month later, a friend pulled me aside and told me that they had noticed a change in my behavior and work ethic and they were concerned. I had become very short with people, easily drawn to anger, and had to walk away from people so that I wouldn't blow up. I wasn't this way before.

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Once again, the medicines didn't work. The depression pills brought on side effects that I couldn't stand, including nausea, vomiting and grogginess. The sleeping pills had the same negative side effects.

I joined a PTSD group which met twice a week with anywhere from 2–5 members. There were veterans from OIF/OEF and Vietnam. I attended the group for 8–9 months and it seemed to work while I was there, but once I left I was right back in the same rut that I had been trying to get out of for almost a year now.

Over the course of many doctors visits in the past year and a half I have told the doctor that I felt I needed something to relax me, not to knock me out cold. They continued to raise and lower doses of depression pills and sleeping medicine.

Finally, on July 25, 2007, the doctor at the VA finally listened to me and got me the right medication. I have been able to live with PTSD and my family can now live with me. Throughout my transition home, my PTSD made things very difficult on my family. I had become stand-offish, short tempered, and was not able to give my wife or children the affection that they needed. I was extremely fortunate that my wife was so supportive, as it would have been so much harder to recover without her understanding.

Overall, I feel like the care I received was good, but I am frustrated that the doctors wouldn't listen to me sooner. If only the doctors would have listened to me "The Soldier" and not just categorized me as just another soldier with PTSD I would have been feeling better a year and a half ago.

Senator MURRAY. Thank you very much. We now turn to Dan Purcell.

STATEMENT OF SERGEANT DANIEL PURCELL, MEMBER, WASHINGTON ARMY NATIONAL GUARD

Mr. PURCELL. Senator Murray, thank you for this opportunity. I truly appreciate it. Second I would like to say that as a Washington State Guardsman, I'm proud to serve. I'm proud of my duty, and I would certainly do it again. My story is approximately 3 years old and still counting, but it is not some anomaly. It is indicative of that which has happened to so many other returning veterans requiring medical attention for not only mental, but physical injuries incurred both on and off the battlefield. In my unit alone after our deployment, we lost two guardsmen for mental health reasons, one for self-medicating and the other just lost it on his job one day; both were in their early 20's and neither were able to travel the necessary distances to get help from the VA.

On May 29, 2004, while serving as an embedded Army photojournalist with the 1st Calvary Division in Sadr City, Iraq, I severely injured my left foot during a mission to bring in one of Muqtada Al-Sadr's lieutenants. Though the injury was not life threatening, without proper medical care it continued to plague me throughout the remainder of my deployment. Since my return home in February of 2005, I have spent the last two and a half years getting bounced from the active duty component to the VA health care system and back to the active duty component in search of medical treatment for my injury and its rapidly deteriorating condition. During this time I have also had to deal with post-deployment anxiety and depression issues, a majority of which was aggravated by the bureaucratic asylum I found myself in. Unlike Iraq where the mission and the enemy were clear, I was now faced with a new enemy called budget cuts, rationed resources and misplaced priorities. Rarely has a day passed that I have not been angry about the undignified way I have been treated by the institutions that are supposed to be here to ensure my medical recovery, or angry about the life I've had to give up in my almost futile quest

to find medical redress for injuries, or angry for having to fear for a very uncertain future.

Every day is a new day and another exercise in futility. We always have to fight for something, whether it's the right type of medical treatment, fair compensation for being found medically unfit for duty, or something as simple as the right to go home on pass to see your child. Imagine if Congress had to fight for the same things. I imagine they would be a little more empathetic toward better treatment for injured veterans. Support for our troops doesn't end with a 15-second soundbite. On June 19th of this year I finally received the surgery I desperately needed. It has been a long and arduous journey. My foot injury would not have survived another deployment or a day at the range for weapons qualification. Still there is no closure. Though the surgery was without complications, the doctor's prognosis was 60 to 80 percent chance of success with two caveats. The first is that I won't know for at least a year as to how successful the surgery was, and the other is that I may have to have another surgery in the next several years anyway.

The initial injury could have been fixed quickly by casting the foot and stabilizing it for six to eight weeks, but because it was allowed to fester for 3 years, the injured bone had to be removed, and what was left of the tendon it had been rubbing on had to be reconstructed. In the last 3 years my career has languished. My daughter has grown all the more distant by our geographical separation. I have yet been able to reintegrate back into civilian society, and in the next year I stand to lose my current job as a military technician due to my injury and its uncertain prognosis. Sadly, I, like so many of my fellow veterans, have lost faith with the business as usual attitude of our current system.

We went to war and were changed. Why can't our bureaucracy change too? We need fearless leadership willing to act on our behalf and not more good ideas that never leave the paper they are written on. We need people willing to put our needs above their own individual agendas and act just as we did in putting our country's need above all else when it mattered most. The fact of the matter is we are not tools that are to be casually discarded when broken or found to be no longer useful. We are also taxpayers who want to know what our elected representatives and their agents are going to do to correct this grievous unjustice.

I know what is being done and what isn't, and I know that we have been denied a right that was a condition of our service. I know that it just doesn't make sense when Congress can allocate millions of dollars for new gym equipment and I can't get the $20,000 or $30,000 to correct an injury incurred on the battlefield. I also know we can do much better, and in truth, it really seems disingenuous to me that we should go to such great lengths to help the world when so many of our own people are left wanting for basics. Thank you for the opportunity.

PREPARED STATEMENT OF SERGEANT DANIEL PURCELL, MEMBER, WASHINGTON ARMY NATIONAL GUARD

I, SGT Daniel Purcell, am a member of the Washington Army National Guard. I deployed with my unit to Iraq in February 2004. Our unit was assigned to the 1st Cavalry Division in Baghdad.

Prior to my deployment I had worked at Boeing, Spokane and was going to school full time to obtain credentials to begin a second career as a medical assistant. At the time of my mobilization in January 2004, I had to withdraw from my college program.

During my tour of duty, I both served as an embedded photojournalist and saw action during combat operations with the 2–5 Cavalry Regiment in Sadr City from March to August 2004, and then I was sent to the 4th Brigade Combat Team area of operation at Camp Taji from September to December.

On May 29, 2004, while on an early morning mission to capture one of Muqtada Al-Sadr's lieutenants I rolled my foot stepping off some stairs and injured my foot severely. By the time we returned to our base my foot was so swollen I was unable to walk and was taken to the aid station. The initial examination and x-ray did not indicate a broken bone so I was given 7 days of bed rest to allow the swelling to go down and then I was to report back to duty.

In the months following the incident, my foot never healed properly and continued to plague me while on combat operations. Several visits to the aid station only netted me more Ibuprofen.

Following my return to Washington State in February 2005, I brought my previous injury to the attention of the redeployment clinic at Madigan Army Medical Center. It was determined that my injury was nothing more than a bone spur despite my expressed concerns regarding the difficulty I was having in walking.

I was told I could get it looked at while using my 6 months of TRICARE Transitional Assistance. In March I returned to Spokane and sought treatment at Fairchild AFB. I was told that I could go but would only be seen on a standby basis only. Without an appointment I opted not to go and sit all day in the waiting room to see if there was a cancellation and they could fit me in.

In April I accepted a job offer working for the Washington Army National Guard at Camp Murray as a military technician. I took this job because for the most part it would put me next to the VA and MAMC where I thought I would have access to medical treatment for my foot. This was a very painful decision because I had already left my daughter for the year I was in Iraq, but now I had to leave again for some indeterminate period.

After assuming the new job, I immediately tried to get seen at MAMC. First, I was told I had to go to the VA. Then when I was finally given an appointment for Podiatry I had to wait 3 months (May to July).

Beginning with my first appointment in July, I was seen once in August and again in October. In November they finally did a bone scan and had determined what the issue was. When I tried to make a follow up appointment for a treatment plan, I was told my 6 months of TA was up and that I would have to go to the VA for further treatment despite my many protests.

For the next year and a half I languished at the VA awaiting treatment or surgery for an injury that was now deteriorating rapidly.

In July 2005, I was referred to the American Lake VA by a Dr. Colson (VA Psychiatrist) for a mental health intake interview. At the time I was experiencing severe panic attacks. Getting the appointment took only days, however, it took 4 months to actually get a follow up appointment with a counselor. I was eventually diagnosed with PTSD following another six more months of counseling.

Since my return from Iraq in 2005, I have not been able to fully integrate back into civilian society. I place a large part of this problem on our government bureaucracy and its agents.

Though I have been diagnosed with PTSD I have not been able to find relief. I have had to spend, literally, a majority of my time trying to find medical treatment for my injuries sustained in Iraq. I have been bounced from the Army to the VA back to the Army and almost bounced back to the VA again.

I have had to wait, literally, for months at both the VA and Madigan Army Medical Center to be seen just for my foot injury. I have even gone so far as to use my personal insurance and money to get my other injuries looked at by civilian doctors.

What kind of government and its agents vote to send its citizens to war, and all but refuse to treat their injuries when they return?

Why do our elected officials have access to better medical treatment than the soldiers who protect and defend this country with their very lives? But more importantly, why are so many of the same elected officials so grievously unwilling to do the right thing by the same veterans they sent to war?

Senator MURRAY. Thank you very much, Dan. I appreciate it. Mr. Ron Fry.

STATEMENT OF RON FRY, DEPUTY COMMANDER, BLUE MOUNTAIN VETERAN COALITION

Mr. FRY. Senator Murray, I would like to begin by recognizing you for the battles that you have waged over the years on behalf of our Nation's veterans. When no one in the Veterans' Administration would listen to the cries for help from the veterans, Senator Murray did. She took off her tennis shoes, put on her combat boots and made good things happen for veterans, and she still is. Through her actions she saved three veterans hospitals in Washington State, caused the establishment of necessary Community Based Outpatient Clinics and was very instrumental causing much needed funding for veterans health care be increased to our Nation's veterans. Senator Murray, you are our hero.

I'm Master Sergeant retired Ron Fry of the United States Army. I served my last 17 years out of 20 with Special Forces, 2 years in Vietnam running special operations, wounded twice and a number of other things. I'm here to tell you after 36 years of being away from the war, it's just as fresh in my mind as it was 36 years ago. The things that are being described by these people today happened to us back then, and I'm quite sure if you had a World War II veteran, or if you have a Korean War veteran, or a family member from back in those days, they would be telling you the same thing and having experienced the same kinds of problems that they have with themselves, and the same kinds of problems they're having with the VA, Congress and the Administration of getting the promised help that they earned when they went into military service and went through the combat.

I would like to thank all of the Members of the Veteran' Affairs Committee, especially the panel members, and I would really like to thank all of the combat veterans who are here. We've got to stand up and fight for those who can't. The VA and the military under this current Administration has had an attitude of putting the dollar before the welfare of the veteran and his family or her family. That has got to cease, and I'm proud to say that a lot of that changed January 1 and we're getting more and more of the benefits sent to the veteran that needs it.

The problem of mental health that our veterans have encountered is now recognized as Post Traumatic Stress Disorder. The illness didn't just happen. It was caused by American soldiers being sent, and I'm including all of the military branches, exposed to the horrors of war. Our servicemen were then upon being sent into those war zones were expected to do something our culture speaks against in our churches, in our homes, from our mothers, fathers, we were expected to go in and kill people, and we did. But it's not as simple as that. Once you have killed them, you stand over them, and I've been there and done that. You recognize that thing on the ground is a human being. One of them that I had the experience of being with had a diary on him and the diary was written to his wife and had drawings of her in it; that particular diary and that particular incident, one of many that haunts me day and night even today. The injustice of killing people to solve political and/or economical problems just goes beyond me.

The veteran that is exposed to the horror of watching other veterans being killed, his friends, people he shares his time with, peo-

ple that look out for him and people that he looks out for, those memories of those horrible things will last that veteran and be with them for the rest of his life, her life. There is no fading. I've talked to the to VA doctors about this and I have asked them in treatment, because I'm a patient there as well, will PTSD ever go away and leave me in peace? Their response universally has been, no, you will always have it, and in most cases you can probably expect it to increase in severity. I've talked with a gentleman who is going to speak today, and I am interested in hearing what he has to say, because he says there is a cure for PTSD. I don't think so. And so I would like to know what it is.

The memories of those war-time experiences don't fade. You can smell the gunpowder. You can feel the explosions. You can hear the screams and the cries. They're here right now with us, not just in me, but other vets out there. Some of these veterans as well. Unfortunately, the return of the veteran does not meet with an understanding of what they experienced in combat. When I came back from Vietnam 36 years from my second tour, as was my first, I was given a wonderful plane ride home, served great food, had a couple cans of cold beer, and landed in McChord Air Force Base. When we landed there, I got off the airplane, took my bags, walked right straight through the lobby, got in a cab, rode to the bus station and went home. There was no counseling. There was no preparations to help defuse me, because in Vietnam just prior to that airplane ride, I was picked up on the battlefield in a helicopter. When I entered that helicopter, there were stacks of plastic bags with American soldiers' bodies in them like cords of wood. All I could do to get into the airplane was sit on them. That was my final exposure to Vietnam. Those are the kinds of things our veterans are experiencing in combat. Those are the kinds of things that most doctors, psychologists and others, I challenge them to able to understand that have not been there. It's one thing to learn what the schools teach. It's another thing to experience what your veterans are truly going through.

Now, veterans when they come back, they don't know that they have PTSD. They just know that there is a lot of trouble that they're having with their life and their family. Veterans usually have to be told that they have a problem, and usually have to be carried to the VA or to a counselor somewhere who can treat that problem for PTSD. They procrastinate. They would rather go back in seclusion somewhere than deal with the problems. One way they do that is they go back into alcohol or they start alcohol, drug abuse to try to escape the memories of those things. While many of those who are responsible for treating that veteran and helping American families of those veterans to heal—thank you—so that they can become whole again. And I'm sorry about taking up too much of your time. I'm going to break off that and just run through this, because there are a couple of things here that we need to make sure that are taken care of.

Senator MURRAY. Ron, I want you to know all of your written testimony will be part of the record and you have very compelling testimony, but if you can wrap up, I want to make sure that—

Mr. FRY. Yes.

Senator MURRAY [continuing].—we have time for testimony.

Mr. FRY. I would suggest that you do get hold of a copy of my testimony, and probably that testimony could be assigned for almost all combat veterans who have had to serve in this country. We need less bureaucracy and more leadership like we get from senators like Patty Murray. We need that. We need to stop studying and start treating more. We need to increase the availability of medical staff to our veterans and not decrease it, and Senator Murray has been an advocate for that for the longest period of time. So let's get on the ball and quit being a bureaucrat with a priority of saving money as opposed to treating American veterans. Let's put Americans number one. Thank you, Senator.

PREPARED STATEMENT OF RON FRY, DEPUTY COMMANDER,
BLUE MOUNTAIN VETERAN COALITION

I would like to begin by recognizing Senator Murray for the battles she has waged over the years on behalf of this Nation's Veterans. When no one in the Veterans' Administration would listen to the cries for help from the Veterans Senator Murray did. She took off her tennis shoes and put on her combat boots and made good things happen for Veterans. Through her actions she saved three Veterans hospitals in Washington State, caused the establishment of necessary Community Based Outpatient Clinics and was very instrumental in causing much needed funding for Veterans health care to be increased. Senator Murray you are our hero.

I would like to thank all Members of the Senate Veterans' Affairs Committee, panel members, guests and most important the Combat Veterans to include all Veterans that are here today. The Veterans truly appreciate the opportunity the Senate Veterans' Affairs Committee has given us to provide critical input on Veterans mental health issues and the problems facing our Veterans, thank you.

The problem of mental health illness that our Veterans have encountered is now recognized as Post Traumatic Stress Disorder (PTSD). This illness didn't just happened, it was caused. American Soldiers, Sailors, Airmen, Marines and Coast Guardsmen were introduced to the horrors of war by our Nation. Our servicemen were then expected to kill the enemy by any means possible. They were expected to align the sights of their weapons upon another human being and make the final decision to pull the trigger and kill that human being. The act of killing or being killed begins the development of PTSD. The Veteran then is exposed to the horror of watching other Veterans being killed and/or maimed in such horrible ways that the memory lives on inside the Veteran the rest of his/her life.

The memory of those war experiences will continue to fester themselves in the mind of the veteran and will begin to affect the veterans personality, his relationship with family members, friends, employers and society as a whole.

The Veteran often turns to drinking in excess and in some cases to illegal drugs. He/she will withdraw from family, friends and society. The withdrawal will be misunderstood by those persons that have not gone through the same experiences the Veteran has in combat. Society will shy away from its heroes compounding the problem the Veteran has with PTSD illness.

Veterans, when they finally learn about the Veterans' Administration PTSD Program, turns to the VA for mental health care. The VA mental health Professionals examine the Veteran and make a diagnosis of PTSD that is service connected and begins treatment. The VA treatment facility requires the Veteran to submit a copy of his/her military discharge commonly known as a DD–214 which shows the Veteran's war service.

The disabled Veteran armed with the diagnosis of a service connected disability by a VA Doctor and his/her DD–214 can now apply to the VA benefits side of the VA for disability compensation. The empire built by the VA over the years through its delaying tactics of approving a Veteran's disability claim significantly increases the stress well above his/her current levels. Veterans needing disability assistance now are put through an unnecessary process that often includes an initial denial of benefits followed by probably another denial or the minimum award of disability rating. The VA during its review of the Veterans disability claim will require the Veteran to be seen by a civilian doctor even though a VA doctor has already examined, diagnosed and are treating the Veteran for the disability. What a waste of VA Funding! The amount of redundant paper work and the great amount of that paper work surly is one of the major causes of the long stressful delays causing the VA Claims process to take 6 months to many years to complete. While the long drawn

out claims process runs its course disabled Veterans who cannot work due to their disability(s) suffer extreme hardships. Many are forced into bankruptcy and/or become homeless even though the VA doctors have diagnosed the Veterans disability(s). The VA spends huge amounts of money on the Veterans' Administration Benefits side of the VA determining disability eligibility that should have already been determined by the VA doctors and the Veterans DD–214.

The Veterans' Administration Benefits and its Regional offices spend more time looking for bureaucratic type reasons to deny and/or delay the valid disability claim of our Veterans. I have worked on Veterans disability claims for the last 15 years and have read the responses sent by the VA back to the Veteran justifying denial of the claim. What a laugh you would get reading those denials if it weren't for the unjustified pain and stress they put on our Veterans. The first denial appears to discourage the already ill Veteran from continuing to seek his/her valid disabilities claims from the VA. Thank goodness the Veterans Service Organizations have the foresight to develop a network of trained Service Offices to help the Veteran fight for their disabilities benefits from the VA.

Veterans have come to think, and justifiably so, that the VA itself is the major obstacle to the Veterans getting their rightful benefits for service connected disabilities. The current VA system forces the Veteran to go to a VA medical center or clinic which often is the first encounter the Veteran has with the VA. This first appointment with the VA begins with a screening process that concentrates on the Veterans financial status and the category of eligibility he or she falls into.

The first step in determining a Veterans eligibility to receive health care through the VA is the completion of the VA Form 10–10EZ, Application For Health Benefits (Attachment 1). The VA collects financial information on the Veteran, the Veteran's spouse and for some reason on the Veteran's first child. The VA uses data on the Veteran's income, property, and all assets and that of the Veteran's spouse and first born. The information is then compared to the annually adjusted financial thresholds of the MEANS test to determine if the Veteran will have to pay for medical care as spelled out in the VA manual titled Federal Benefits for Veterans and Dependents, 2007 Edition. The MEANS test is a system applied by our government to force the Veteran to pay into the cost of his/her medical care. The Veteran has already earned his/her medical benefits through service to our Country.

This form of stealing from Veterans who have loyally and honorably served this country and earned the right to health care is totally unacceptable. A Veteran is a Veteran and was categorized as such because of service in our Military and therefore should not be penalized because they were able to have some measure of success after their military service. The MEANS Test must be abolished! It is time our government made the people of the United States of America its number one priority instead of the putting so many other countries first. We need to take care of America first.

I have listed below a few areas of concern to our Veterans which include:

1. The budget for Veterans health care must be mandatory instead of the discretionary funding system used now. This system of funding Veterans health care has been a failure. Under this system of funding only a small portion of Veterans needing health care are able to get earned treatment through the VA.

2. The VA, citing funding shortages, through its CARES initiative have either closed medical facilities or greatly reduce the availability of Veterans health care. The VA by reducing health care services at many of VA medical care facilities to 8 a.m.–3:30 p.m. with no services on weekends or holidays. The Veteran is left to forge for medical care on the civilian market. The Veteran who would have his health care paid by the VA but now is at a great risk of having to pay for the treatment that the VA is supposed to be responsible for paying. This problem is serious. The VA in its instructions to Veterans concerning payment of medical bills on the civilian market list 90 days for the VA to settle the bill. Unfortunately, the civilian medical facility holds the Veteran responsible for the bill instead of the VA.

Consequently, when the VA makes a decision to pay the bill and it exceeds the 90-day period as it usually does, the civilian medical agency turns the account over to collections . Veterans that have had this happen to them experienced a negative credit report and seizure of bank accounts and some have had to file for bankruptcy. The VA's response to this problem is to hold the Veterans responsible through current payment procedures for the bill. The VA has in effect forced the Veterans needing health care after hours, weekends and holidays to pay for health care that would have been available at VA Medical facilities had they not been shut down. The copayments that a Veteran pays at the VA has now turned into full cost on the civilian market.

3. The VA headstone provided for a deceased Veteran cannot be placed upon his/her grave until the bill for the burial services has been paid in full. I talked to one

family that cannot afford to pay for those services and has been carrying their father's headstone in the trunk of their car for the past two years. The Veteran who served his/her country honorably deserves better.

4. The red tape of the VA to Veterans holds no valid place in the Veterans need for medical and mental health care. The red tape is viewed as a make work job by some bureaucrat for job security as opposed to a real justifiable need of the Veterans. One example is how long it takes the VA to process the plans and design of a new VA medical hospital or clinic. That process adds years to the time of sending the request for a medical facility or clinic to Congress to be funded. That long drawn out process must be shortened so medical care needs of the Veteran can be met. The Walla Walla Veterans Medical Center is a good example of the problems created by the VA system. The VA had initially set 2009 for the major construction proposal for the Walla Walla Medical Center. That date has now been pushed by the VA forward to 2012. Congress is waiting on the request for funding but the VA process continues to hinder access to medical care needed by our Veterans.

5. In a discussion I had with a VA mental health professional about the probability of all Veterans who have served in combat having some degree of PTSD. The mental health professional said that all combat veterans have PTSD from their combat experiences.

6. The Veterans PTSD illness is having a profound effect upon the families of veterans and especially the families of Veterans that have been sent to combat zones on multiple tours. The Veteran that returns from combat will never be the same person to the spouse and children as when he/she left for the war. The Veteran will return home where he will exhibit the the symptoms of PTSD that has led to abuse of the spouse and children, paranoia, distancing of ones self, high number of divorces, drug and/or alcohol abuse, trouble with the law, suicide and so many more. The Veteran has trouble holding a steady job, he often moves around a lot, has trouble getting along with people, and is extremely uncomfortable in a crowd. Due to the Veterans PTSD illness he/she will have a much lower income producing capability. Thus emerges homelessness of the Veteran and/or family. The Veteran has not chosen to be mentally ill with PTSD but was sent to war by his/her country.

The Veterans of the United States without question picked up their weapons and marched off to war to protect our families and the freedoms we enjoy. The civilian peer that did not have to march off to war is able to pursue a stable and more financially secure life for his/her family. The Veteran and family will have to suffer the effects of combat for the rest of their lives.

Senator MURRAY. Thanks, Ron, very much. Thank you to all of our panelists today, and again, I really appreciate your coming and sharing your personal stories, and I know it's difficult. And as I said in my opening statement, my staff and I had a very hard time getting men or women to come and give their personal experiences. They weren't comfortable discussing them publically, and it all goes to the stigma of mental illness, and I hear that time and time again. It's one thing not to be able to come here and speak publically, that is hard, but if we want soldiers to be able to get treated, it seems to me we have to get past the stigma. And I wanted to ask our three servicemembers who are here, Dan, Brandon and Stephen, what can we do to address the cultural issues of serving in the military so that men and women who serve can get past that and get the help they need? And maybe, Dan, if I could start with you.

Mr. PURCELL. Could I get some clarification on cultural——

Senator MURRAY. Interpret it any way you want to. You're all in the military. You are taught to fight. You come home and then you are supposed to talk about having a mental illness. How can we help soldiers deal with that? Or are we dealing with that or not or what can we do better?

Mr. PURCELL. I think one of the things that we could do better is to acknowledge that war is a different animal. And as I stated earlier, we went to war and we were changed. We were. Can't tell you how. We just are, and I think that we really need to acknowl-

edge that we are not the same people that went forward. And when we come back on—I believe it was Brandon who pointed out in his testimony—it was like, well, what do we do with them? Well, let's give him an Article 15. We don't know. But if we could acknowledge that, yes, we do have something wrong, and maybe we do have to look at it and step outside this paradigm, step outside the box and say, OK, we really do have to look at this differently, and we have to acknowledge that they are not the same and find ways of treating them, get them the help, advise them appropriately. As Mr. Fry here mentioned, instead of talking about it, we need to actually act on this and start getting these veterans the help that they need. We need to be open. And what we're doing here right now, we're talking about it, and what we need to do now is start putting stuff in place. I wish I could be more eloquent about—write it down.

Senator MURRAY. You did great. Let me ask, Stephen, how hard was it for you to ask for help?

Mr. FRANKLIN. It was extremely hard, Senator. It was different for me. I didn't know what was taking place within my own mind. VA said that there is help and once the symptoms started to show, I was able to talk with other veterans who had the same symptoms and problems, that's when I was able to step out of my shell and actually seek the help that I needed.

Senator MURRAY. When you were in the service, did anyone ever say to you, your experiences here may complicate your life when you get home and there is help for you if that occurs?

Mr. FRANKLIN. No one ever told me that, Senator. I never knew that until things that were normal to me before I left started to become a problem to me after I returned, and I was finding a problem dealing with the normal things.

Senator MURRAY. When you came home and separated from service, did anybody give you any information that you may be having trouble sleeping or anything else, did they tell you you could get help?

Mr. FRANKLIN. No one ever informed me of that either, Senator. Friends and family started to say, my you have a problem. And then the doctors at the VA honed right in it was PTSD.

Senator MURRAY. Brandon, you gave us a very eloquent story about a friend who did commit suicide. We're hearing a lot about that. There was a recent study that came out in the last several days. Your friend, a terrible loss to all of us. Do you know if anybody ever reached out to him to give him help?

Mr. JONES. I know that friends and family tried to, but the stigma that is attached to saying or admitting the fact that you are actually experiencing some sort of stress or a problem, automatically assigns a weakness to the person in the eyes of the people that are supposed to be helping them. Everybody gets this idea, like, people like Rambo, that it's just going to go nuts and go crazy, won't be approachable. And I know from talking to his wife that she did everything that she could to try to help him, but eventually just couldn't. Everybody did try to help him. He pushed further away because he was concerned about what would happen to his career.

Senator MURRAY. To his career? And for you, you had a sleeping disorder. You had a lot of stress going on and you said when you were called up, you lost $1,200 a month income. You were close to losing your house, your car. A lot of stress going on in your family before you were even deployed, and what was it like for you? You are in training. You are being trained to go and fight in the Rambo that you just talked about, and yet, you are struggling with an illness that is so opposite of being Rambo. How did you get in your own mind to a place where you could deal with that?

Mr. JONES. I personally just had to learn how to reassign a lot of it and stuff like that and try to make them constructive. It still makes it difficult to focus sometimes on the job that I have to perform. Some are more understanding than others as far as dealing with it. I still personally think it's more difficult for a person to admit their own shortcomings than it is for me—it's much easier for me to tell the story of my friend who killed himself.

Senator MURRAY. I want you to know as we talked to Brandon about his testimony, he only wanted to talk about his friend and not about himself, and so, I appreciate your doing that. So for the three of you, you found help for yourself. How many people are out there that have not?

Mr. PURCELL. In my narrative, I mentioned two people in my unit, but these people seeing it happen, and you're trying to give them guidance where to go and there are these geographical distances that these young men would have to travel, et cetera, et cetera. So a lot of times they just give up because of the distance and the time. I stayed with it. But it took me three years, Senator.

Senator MURRAY. So it was bureaucracy and paperwork that is part of the challenge——

Mr. PURCELL. Absolutely.

Senator MURRAY [continuing].—get past the stigma and ask for help, and then you've got paperwork you have to deal with. Is that an issue?

Mr. PURCELL. Sure. And sometimes it can be as much as like going in and say, OK, I've got these two issues. And they look at you and it's, like, well, we can only deal with one at a time. And it's, like, wow, which one is it going to be, is it going to be A or B? I was paying out of my pocket with my own civilian insurance and my copays to go get B. I had to prioritize and prioritize in my case was my foot injury, but the physical and the mental, these are all intertwined, and it's just utter frustration where people just say, I've had enough and they go away.

Senator MURRAY. What about denial of benefits? I've heard stories of soldiers with a gun in one hand and there is another gun in the other. Is that anything any of you have heard about?

Mr. FRY. You'll find in my prepared statement that I have been a veterans service officer, of sorts. For over 15 years I've processed claims. I've had an opportunity to look into a lot of them. The pattern seems to be that the first time the claim is sent in, and you can ask the veterans in the audience for their opinion, the pattern has been that they're going to expect a denial the first time. It doesn't matter, in many cases, how well it's written or how well it's documented. And that denial is going to come back and they're going to want more information, and you've already given every-

thing you possibly could. It goes back in so there becomes a mountain of paperwork. It's very confusing, very complicated. And I don't understand why when the veteran goes in to get treatment for his or her mental health problem, or any treatment at the VA facility, the first thing they do is screen them. They take a copy of his DD–214, his discharge document, which has on it his war time service, his medals and what have you, and they screen that to see where they're eligible in that hierarchy of things. And then they send them in for a diagnosis with the VA doctors, one of those would be a mental health doctor. When VA diagnosed that person with PTSD, the claim is then prepared and sent forward usually by a veterans service officer. When it gets to VA, they're going to schedule after they go through all these denials of things, they call up a pension hearing. Of all things they're going to have them go right back to some doctor that the VA is paying for on the veterans benefits side of the house to tell them whether this veteran has what the VA doctor has already diagnosed them with the illness.

Senator MURRAY. It seems to me that it's not only cultural, but once you get to the point where you're willing to ask, there is so much paperwork to go through, it's almost denial is the real issue.

Mr. FRY. Yes, and over time——

Senator MURRAY. Ron, you'll have to finish up real quickly and then I'll move to Kathy.

Mr. FRY. OK. Over time it seems as though the VA has structured—and it's not just the VA, the Social Security Office does the same thing—such an obstacle to the veteran getting the benefits claim through, particularly in a timely fashion that it's become almost ineffective.

Senator MURRAY. Kathy, did you want to comment on that.

Ms. NYLEN. Yes, ma'am. I also work extensively with the claims process, and while I will not agree that it is an automatic denial the first time a claim is submitted, I work well enough with the VA to know that that is not true; however, when those claims are denied, the common pattern is the unverifiable stressors. Not every mental health disorder needs a stressor statement for one thing, and we quite often get asked to provide a statement. We see mental health and we start talking PTSD stressor verification when in many cases it's simply just questions which goes a different path to be service connected.

However, the verification of the stressor itself I feel could be better improved again by better recordkeeping between the DOD and the individual's private medical records so that we can go back and verify the events that caused the underlying stressor. But a real problem I think is the rubber stamping that's done when—I'm a sailor, so I am used to saying sailor—a soldier, be that a man or woman, starts having difficulty, is not the same soldier they were, we see them being treated and discharged with the label of having a personality disorder. Personality disorders are looked at automatically as congenital, hereditary, not caused by service, therefore, you are not going to get service connected benefits, and we never look beyond to see what happens. As Mr. Fry and Mr. Purcell mentioned these other men if you go to war, you're changed, and it's just not combat. There is a high incidence now of sexual trauma and rape while on active duty. That's an additional issue, but I do

think the stigma and the attitude of anybody that is dealing with a veteran who is claiming that they experience a stressful event, we must be more aware and open to all possibilities, not ever try to put it into a box, because it's a very individual situation. But the use of a personality disorder on the discharge papers is a huge hurdle to overcome.

Senator MURRAY. Unfortunately, we have to move to our next panel, but I will use what all of you have talked to me about to ask some questions. Do we have anything available for family members? I'm certain that some of the issues you have gone through has impacted your families directly, were they given any kind of support while you were going through this? I will ask our three veterans.

Mr. PURCELL. No, Senator, not in my particular case, I didn't see.

Senator MURRAY. Steve?

Mr. FRANKLIN. Nothing that I am aware of that's readily available to parents or children that was easily accessible.

Senator MURRAY. Well, thank you to this panel. I'm sure that if we had more time, I'd ask you more questions, but we have two more panels, and we need to move to them. Thank you so much.

We would like our second panel to come forward. Testifying on our second panel today are Dr. Antonette Zeiss, the Deputy Chief Consultant in the Office of Mental Health Services, Department of Veterans Affairs in Washington, DC. Diana Rubens, the Western Area Director of the Veterans Benefit Administration from Phoenix, Arizona; accompanied by Carol Fillman, who is the Regional Director of the Veterans Benefits Administration here in Seattle. Dennis M. Lewis is the Director of the VA Northwest Health Network (VISN 20). Accompanying Mr. Lewis is Stan Johnson, who is the Director of the VA Puget Sound Health Care System in Seattle. Major General Timothy Lowenberg, the Adjutant General of Washington. Brigadier General Sheila Baxter, the Commander of Madigan Army Medical Center. And finally, John Lee, who is the director of the Washington State Department of Veterans. I want to thank all of our panelists who are now here before us and for your participation today, and we are going to begin on my far left with Dr. Antonette Zeiss. Thank you very much for coming here.

STATEMENT OF ANTONETTE ZEISS, PH.D., DEPUTY CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES, DEPARTMENT OF VETERANS AFFAIRS

Dr. ZEISS. Good morning, Senator Murray. I'm pleased to be here today to discuss how the Department of Veterans Affairs is addressing mental health care needs of our veterans. We have seen returning veterans from prior eras to the current Operation Enduring Freedom and Operation Iraqi Freedom conflict who have injuries of the mind and spirit as well as the body. Our goal is to treat a veteran as a whole patient, to treat a patient's physical as well as any mental disorders.

Since the start of OEF/OIF, over 717,000 servicemembers have been discharged and become eligible for VA care. Of those, 35 percent have sought VA medical care. Among those veterans, mental health problems are the second most commonly reported health concern. As was mentioned previously, we have now almost 38 per-

cent reporting symptoms suggesting a possible mental health disorder. The diagnosis of Post Traumatic Stress Disorder topped the list for possible mental health diagnoses, but depression and nondependent abuse of substances also have high rates, and there are many other problems that people bring to us as well, so it's important not just to assume PTSD but to do careful evaluations of the full spectrum of possible mental health problems.

VA data show that the proportion of new veterans seeking VA care who have a possible mental health problem has increased over the past two years. For example, the proportion with possible mental health problems at the end of FY 2005 was 31 percent, but that is compared to nearly 38 percent in the most recent report released in April of 2007. PTSD diagnoses during the same time frame went from 13 percent to almost 18 percent.

Funding resources are available for a VA mental health initiative that supports implementation of our comprehensive Mental Health Strategic Plan, and that plan is based on the President's Freedom Commission report on mental health. Using mental health initiative funding, we have done many things to establish many programs, but one statistic, for example, is that we have hired over 3,000 new mental health professionals in the last 2 years, with another 1,000 or so hires in the pipeline and more that will be funded now with the new supplemental budget, which included 100 million for mental health and 20 million for substance abuse.

In addition to our mental health specialty care sites in our medical facilities, we have expanded mental health services in the Community Based Outpatient Clinics with onsite staffing and by telemental health. We have enhanced PTSD, homelessness, and substance abuse specialty care services. We developed a military sexual trauma support team to ensure that VA fully implements military sexual trauma screening and treatment. We are fostering integration of mental health and primary care in medical facilities clinics and in the care of home-bound veterans who are served by VA Home Based Primary Care program. Moreover, the VA provides services for homeless veterans, including transitional housing paired with services to address social, vocational and mental health problems associated with homelessness.

Focusing on concerns about suicide in veterans, the recent report was about active-duty military, but it is certainly a concern for us all. Those mental health needs, and things that have been described by the previous panel, may come to us in people seeking help from VA. We have funded a suicide prevention coordinator in every VA medical facility. A national hotline for suicide prevention is now available and functioning very effectively. I'm happy to provide more information about that if that would be helpful. The VA sponsored its first suicide prevention awareness day, which included every VA facility and will sponsor a VA suicide prevention awareness week September 9th through the 15th, in conjunction with the National Suicide Prevention Awareness Week.

In addition to mental health services at VA facilities, VA's Vet Centers provide counseling and readjustment services to returning war veterans, and in some cases their family members, in a community setting. Vet Centers provide an alternative to traditional access for veterans who may be reluctant to come to our medical

centers and the clinics. At Secretary Nicholson's direction, we have increased the number of staff in our Vet Centers by establishing outreach counselors, many of whom are Global War on Terror veterans themselves. You will hear more about Vet Centers I believe from another panelist as well.

The VA continues to promote early recognition of mental health problems. Veterans are routinely screened in primary care for PTSD, depression, substance abuse, Traumatic Brain Injury, and military sexual trauma. Screening for this array of mental health problems helps support effective identification of veterans who need mental health services, and it promotes our suicide prevention efforts, a major priority for the VA. If anyone screens positive on any of the mental health issues, they get a further suicide prevention screening and then, of course, appropriate referral for services as identified to be needed.

The VA will continue to serve the mental health needs of our veterans through progressive state-of-the-art programs. We're approaching mental health needs of veterans with an orientation that is designed to promote an optimal level of social and occupational function and participation in family and community life for our veterans—not just the treatment of symptoms, but the restoration of a full and meaningful life. Thank you again, Senator for inviting me here today. I will be happy to answer any of your questions.

PREPARED STATEMENT OF ANTONETTE ZEISS, PH.D., DEPUTY CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES, DEPARTMENT OF VETERANS AFFAIRS

Good morning Senator Murray, I am pleased to be here today to discuss how the Department of Veterans Affairs (VA) is addressing the mental health care needs of our veterans.

We have seen returning veterans—from prior eras to the current Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) conflict—who have injuries of the mind and spirit as well as the body. Our goal is to treat a veteran as a whole patient—to treat a patient's physical illnesses as well as any mental disorders.

Since the start of OEF/OIF combat, 717,196 servicemembers have been discharged and have become eligible for VA care. Of those, 35 percent have sought VA medical care. Among those veterans, mental health problems are the second most commonly reported health concerns, with almost 38 percent reporting symptoms suggesting a possible mental health diagnosis. The diagnosis of Post Traumatic Stress Disorder (PTSD) topped the list for possible mental health diagnoses, and depression and nondependent abuse of substances also had high rates.

VA's data show that the proportion of new veterans seeking VA care who have a possible mental health problem has increased over the past two years. For example, the proportion with possible mental health problems at the end of FY 2005 was 31 percent, compared to nearly 38 percent in the most recent report released in April 2007. PTSD diagnoses during this same time frame went from 13 percent to almost 18 percent.

Funding resources are currently available for a VA Mental Health Initiative that supports implementation of our comprehensive Mental Health Strategic Plan that is based on the President's New Freedom Commission on Mental Health. Using Mental Health Initiative funding, we have improved capacity, access and hired over 3,000 new mental health professionals to date.

In addition to our mental health specialty care sites, we have expanded mental health services in Community Based Outpatient Clinics, with onsite staffing or by telemental health. We have enhanced PTSD, homelessness, and substance abuse specialty care services. We developed a Military Sexual Trauma (MST) Support Team to ensure that VA fully implements MST screening and treatment. We are fostering integration of mental health and primary care in medical facility clinics and in the care of home-bound veterans served by VA's Home Based Primary Care program. Moreover, VA provides services for homeless veterans, including transi-

tional housing paired with services to address social, vocational, and mental health problems associated with homelessness.

Focusing on concerns about suicide in veterans, we have funded a Suicide Prevention coordinator in every VA medical facility. A national hotline for suicide prevention is now available and functioning very effectively. VA sponsored its first Suicide Prevention Awareness Day, which included every VA facility, and will sponsor a VA Suicide Prevention Awareness Week September 9–15, in conjunction with National Suicide Prevention Awareness Week.

In addition to Mental Health services at VA facilities, VA's Vet Centers provide counseling and readjustment services to returning war veterans and, in some cases, their family members, in the community setting. These Vet Centers provide an alternative to traditional access for some veterans who may be reluctant to come to our medical centers and clinics. At Secretary Nicholson's direction, we have increased the number of staff in our Vet Centers by establishing outreach counselors, many of whom are Global War on Terror veterans themselves.

VA continues to promote early recognition of mental health problems. Veterans are routinely screened in Primary Care for PTSD, depression, substance abuse, Traumatic Brain Injury, and Military Sexual Trauma. Screening for this array of mental health problems helps support effective identification of veterans needing mental health services, and it promotes our suicide prevention efforts, a major priority for VA.

VA will continue to monitor the mental health needs of our veterans through progressive, state-of-the-art programs. VA is approaching the mental health needs of veterans with an orientation that is designed to promote an optimal level of social and occupational function and participation in family and community life for our veterans.

Thank you again Senator for inviting me here today. I would be happy to answer any questions that you may have.

Senator MURRAY. Thank you, Dr. Zeiss. Diana Rubens.

STATEMENT OF DIANA RUBENS, DIRECTOR, WESTERN AREA, VETERANS BENEFIT ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Ms. RUBENS. Senator Murray, I appreciate the opportunity to testify today on the Veterans Benefits Administration's response to the mental health care and needs of veterans. I am accompanied today by Carol Fillman, the Director of the VA Regional Office in Seattle. At the heart of our mission is the Disability Compensation Program, which provides monthly benefits to veterans who are disabled as a result of injuries or illness incurred during their military service. Today there are more than 7 million veterans of all periods of services receiving compensation benefits. With the focus on mental health needs of our returning veterans, I'm going to talk a little bit about the process for establishing service connection for Post Traumatic Stress Disorder as well as our efforts to expedite the processing of claims from veterans of Operations Iraqi Freedom and Enduring Freedom, including our expanded outreach to current servicemembers, as well as our national hiring initiative and our Benefits Delivery at Discharge program.

The number of veterans submitting claims for PTSD has grown dramatically. From 1999 to 2007, the number of veterans receiving compensation for PTSD has increased from 120,000 to more than 280,000 veterans covering all periods of service. Our OIF/OEF returning veterans number 28,000. Granting service connection for PTSD presents a unique processing complexity because of the evidentiary requirements. Service connection requires medical evidence diagnosing the condition, as well as evidence of a link between the current symptoms and an in-service stressor. And then

of course we also need supporting evidence that in-service stressor occurred.

Our VA regulation established three categories, combat/prisoner of war, personal assault, or noncombat. The majority of these in-service stressors are combat related. Combat status may be established through receipt of certain recognized military citations or other supporting evidence. If the stressful evidence is not easily linked to combat or POW status, we require the veteran submit information to help substantiate the incident and, in conjunction with the Joint Services Records Research Center, we use all resources available in addition to the veteran's military records to verify the claimed stressor occurred. Reasonable doubt is always resolved in the favor of the veteran.

Evidence of a stressor is relevant to establishing service connection for PTSD; however, it is not a factor in evaluating the severity of the disorder. A VA examination is requested once credible supporting evidence has established that the claimed in-service stressor has occurred. Competent medical evidence is also required to provide a link between the stressor and the current PTSD diagnosis. As more veterans are returning from Iraq and Afghanistan, and they're turning to VA for both benefits and medical care, including care for PTSD, it's critical that our employees receive essential guidance, materials and tools to meet the increasingly complex demands of their decision-making responsibilities. To accomplish this goal, the Veterans Benefit Administration has deployed new training tools and centralized training programs to support accurate and consistent decision-making. New employees receive comprehensive training through a national centralized training program. This current curriculum consists of full lesson plans, handouts, student guides, instructor guides and slides for classroom instruction. Recognizing the importance of continuing education, all Veterans Service Center employees also complete a mandatory annual cycle of training consisting of 80 hours of course work.

We've also developed job aids and training sessions to provide employees the skills and tools essential to render fair and timely decisions on PTSD claims. All of our Veterans Service Representatives, as well as the Rating Veterans Service Representatives are required to receive training on the proper development and analysis of PTSD claims. We've also established priority processing for the OIF/OEF veterans. Since the onset of combat operations in Iraq and Afghanistan, we've provided expedited case-managed services for all seriously injured OIF and OEF veterans and their families. This individualized service begins at the military medical facilities where the injured servicemembers return for treatment and continues as these servicemembers are medically separated and enter the VA medical care and benefit systems.

The VA assigns special benefits counselors, social workers and case managers to work with these servicemembers and their families throughout the transition. Since February of 2007, VA has also provided priority processing of all OIF/OEF disability claims. This initiative covers all active-duty National Guard and Reserve veterans who were deployed in the theaters or in support of these combat operations as identified by the Department of Defense. We've also expanded our outreach programs for National Guard

and Reserve components and our participation in the OIF/OEF community events and other information dissemination activities. In order to ensure that VA benefits information is provided to all servicemembers that are separating, including our Reserve and Guard members, we're working with DOD to expand our role in DOD's military pre-separation process specifically providing claims workshops in conjunction with many of our VA benefits briefing for separating servicemembers. In these workshops, groups of servicemembers are instructed on how to complete VA application forms. Personal interviews are also conducted with anyone interested in applying for VA benefits.

Expediting this process is critical to assisting these OIF/OEF veterans in the transition from combat operations back to civilian life. We're continuing to focus on reducing the pending workload and providing more timely claims decisions to veterans of all periods of service. We've actively worked to develop relationships with the National Guard and Reserve to insure local regional offices are notified when the units return from deployments. Designated military service coordinators and OIF/OEF coordinators conduct regular briefings on VA benefits as part of the transition assistance program as well as the disabled transition assistance programs. They're jointly conducted by VA and DOD and Department of Labor at various military institutions around the country.

In partnership with our Veterans Health Administration, the Seattle Regional Office provides these types of individualized case management services to the most seriously injured soldiers at Madigan Army Medical Center. As part of our Benefits Delivery at Discharge program, servicemembers can apply for VA service-connected disability compensation programs and benefits prior to separation so that VA can begin disability payments as quickly after their discharge as possible. Servicemembers who apply for disability compensation benefits under this Benefits Delivery at Discharge program undergo one medical examination instead of both the military separation exam and the VA exam for the disability claims. Timely decisions on servicemembers' disability compensation claims also help ensure the continuity of medical care for their service-connected disabilities. The goal of our BDD program is to deliver benefits within 60 days of discharge.

Senator MURRAY. Again, all of your testimony will be submitted for the record, so if you can sum up, I'd appreciate it.

Ms. RUBENS. I think the last thing that I'd like to mention is the national hiring initiative. We, of course, have received authority to hire more than 3,000 employees over the course of the next year. We've already added more than 800 new employees since April. The Seattle Regional Office has been authorized up to 53 additional employees, and with these additional resources, the Regional Office will continue to make great strides in improving the delivery of services to the veterans. This concludes my testimony. I appreciate being here today and look forward to answering any of your questions.

PREPARED STATEMENT OF DIANA RUBENS, DIRECTOR, WESTERN AREA, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Senator Murray, I appreciate this opportunity to testify today on the Veterans Benefits Administration's (VBA) response to the mental health care needs of vet-

erans. I am accompanied today by Carol Fillman, Director of the Seattle Regional Office, and Tim Clark, Veterans Service Center Manager at the Seattle Regional Office.

At the heart of our mission is the Disability Compensation Program, which provides monthly benefits to veterans who are disabled as a result of injuries or illnesses incurred during their military service. More than 2.7 million veterans of all periods of service currently receive VA compensation benefits. With the focus of today's hearing on the mental health needs of returning veterans, I will discuss the process for establishing service connection for Post Traumatic Stress Disorder (PTSD). In addition, I will address our efforts to expedite the processing of claims from veterans of Operations Iraqi Freedom and Enduring Freedom (OIF/OEF), including our expanded outreach to current servicemembers. Finally, I will speak about VBA's national hiring initiative and the Benefits Delivery at Discharge (BDD) program.

POST TRAUMATIC STRESS DISORDER

The number of veterans submitting claims for PTSD has grown dramatically. From FY 1999 through June 2007, the number of veterans receiving disability compensation for PTSD increased from 120,000 to more than 280,500. The 280,500 veterans receiving disability compensation benefits for PTSD represent veterans of World War II (24,268), the Korean Conflict (11,520), the Vietnam Era (200,876), Peacetime (10,038), and the Gulf War Era (33,855). The Gulf War Era number includes approximately 28,000 OIF/OEF veterans.

Granting service connection for PTSD presents unique processing complexities because of the evidentiary requirements to substantiate the event causing the stress disorder. Service connection for PTSD requires medical evidence diagnosing the condition, medical evidence of a link between current symptoms and an in-service stressor, and credible supporting evidence that the in-service stressor occurred. VA regulations establish three categories of in-service stressors: combat/prisoner of war (POW), personal assault, and non-combat. The majority of in-service stressors are combat related. Combat status may be established through the receipt of certain recognized military citations and other supportive evidence. If the evidence establishes that a veteran engaged in combat or was a POW and the stressor relates to that experience, the veteran's lay testimony alone may establish an in-service stressor for purposes of service-connecting PTSD.

If the stressful event is not linked to combat or POW status, VA requests that the veteran submit information to help substantiate that the incident occurred. In conjunction with the Joint Services Records Research Center (JSRRC), VA uses all resources available, in addition to the veteran's military records, to verify that the claimed stressor occurred. Reasonable doubt is always resolved in favor of the veteran.

Evidence of a stressor is relevant to establishing service connection for PTSD; however, it is not a factor in evaluating the severity of the disorder. A VA examination is requested once credible supporting evidence establishes that the claimed in-service stressor occurred. Competent medical evidence is required to provide a link between the in-service stressor and the veteran's current PTSD diagnosis.

Recognizing that the delay involved in processing complex PTSD claims can inadvertently impact veterans already suffering from stress, the Veterans Health Administration (VHA) offers all returning OIF/OEF veterans professional clinical care. VBA is also expediting the claims process for all OIF/OEF veterans.

TRAINING PROGRAMS

As more veterans returning from Iraq and Afghanistan are turning to VA for benefits and medical care, including care for PTSD, it is critical that our employees receive the essential guidance, materials, and tools to meet the increasingly complex demands of their decisionmaking responsibilities. To accomplish this goal, VBA has deployed new training tools and centralized training programs that support accurate and consistent decisionmaking. New employees receive comprehensive training through the national centralized training program called "Challenge." The current curriculum consists of full lesson plans, handouts, student guides, instructor guides, and slides for classroom instruction. Recognizing the importance of continuing education, all Veterans Service Center employees complete a mandatory cycle of training, consisting of 80 hours of annual coursework.

VBA has developed job aids and training sessions to provide employees the skills and tools essential to render fair and timely decisions on PTSD claims. All Veteran Service Representatives (VSRs) and Rating Veteran Service Representatives (RVSRs) are required to receive training on the proper development and analysis

of PTSD claims. The training materials include medical and military references and pre-recorded video broadcasts pertaining to PTSD development and records research. Recently published PTSD guidance includes "Handling PTSD Claims Based on Stressors Experienced During Service in the Marine Corps" dated June 2005, "Military Sexual Trauma Training Letter" dated November 2005, and "JSRRC Stressor Verification Guide" dated January 2006. Additionally, VBA introduced the PTSD Training and Performance Support System (TPSS) module for VSRs and RVSRs in 2006. The TPSS module is an interactive learning tool in which employees complete self-guided lessons on PTSD development and verification of in-service stressors. Due to the success of the TPSS learning system, a second PTSD module titled, "Rate a Claim for PTSD" was released in July 2007.

PRIORITY PROCESSING FOR OIF/OEF VETERANS

Since the onset of the combat operations in Iraq and Afghanistan, VA has provided expedited and case-managed services for all seriously injured OIF/OEF veterans and their families. This individualized service begins at the military medical facilities where the injured servicemembers return for treatment, and continues as these servicemembers are medically separated and enter the VA medical care and benefits systems. VA assigns special benefits counselors, social workers, and case managers to work with these servicemembers and their families throughout the transition to VA care and benefits systems, and to ensure expedited delivery of all benefits.

Since February 2007, VA has provided priority processing of all OIF/OEF veterans' disability claims. This initiative covers all active duty, National Guard, and Reserve veterans who were deployed in the OIF/OEF theaters or in support of these combat operations, as identified by the Department of Defense (DOD). This allows all the brave men and women returning from the OIF/OEF theaters who were not seriously injured in combat, but who nevertheless have a disability incurred or aggravated during their military service, to enter the VA system and begin receiving disability benefits as soon as possible after separation.

We designated our two Development Centers in Roanoke, Virginia and Phoenix, Arizona, as well as three of our Resource Centers, as a special "Tiger Team" for processing OIF/OEF claims. The two Development Centers assist regional offices in obtaining the evidence needed to properly develop the OIF/OEF claims Medical examinations needed to support OIF/OEF veterans' claims are also expedited.

We expanded our outreach programs for National Guard and Reserve components and our participation in OIF/OEF community events and other information dissemination activities. An OIF/OEF team at VBA Headquarters addresses OIF/OEF operational and outreach issues at the national level and provides support to the newly designated OIF/OEF managers at each regional office. The OIF/OEF team is also coordinating the development of national memoranda of understanding (MOUs) with each of the Reserve Components to formalize relationships with them, mirroring the agreement between VA and the National Guard Bureau signed in 2005. Having an MOU with each Reserve Component will help ensure that VA is provided service medical records and notified of "when and where" reserve members are available to be briefed during the demobilization process and at later times.

In order to ensure that VA benefits information is provided to all separating servicemembers including Reserve and Guard members, we are working with DOD to expand our role in DOD's military pre-separation process. Specifically, we are now providing "Claims Workshops" in conjunction with many of our VA benefits briefings for separating servicemembers. At such workshops, groups of servicemembers are instructed on how to complete the VA application forms. Personal interviews are also conducted with those applying for VA disability benefits.

Expediting the claims process is critical to assisting OIF/OEF veterans in their transition from combat operations back to civilian life. We are also continuing to focus on reducing the pending workload and providing more timely claims decisions to veterans of all periods of service.

OUTREACH

Veterans returning from Iraq and Afghanistan are eligible for a full array of benefits offered through VBA. Educating veterans on the resources available to them is accomplished through numerous outreach activities held at military bases, VA Medical Centers, and Reserve and National Guard units.

VA has actively worked to develop relationships with National Guard and Reserve to ensure local regional offices are notified when units return from deployments. Designated Military Service Coordinators and OIF/OEF Coordinators conduct regular briefings on VA benefits as part of the Transition Assistance Program (TAP)

and Disabled Transition Assistance Program (DTAP). These programs are jointly conducted by VA and the Departments of Defense and Labor at various military installations around the country. In addition to providing benefits information at the TAP and DTAP briefings, VBA coordinators help servicemembers complete benefits claims.

In partnership with the Veterans Health Administration, the Seattle Regional Office provides individualized case management services to the most seriously injured soldiers at Madigan Army Medical Center.

BENEFITS DELIVERY AT DISCHARGE PROGRAM

The Benefits Delivery at Discharge (BDD) program is a jointly sponsored VA and DOD initiative to provide transition assistance to separating servicemembers who have disabilities related to their military service.

Under the BDD program, servicemembers can apply for VA service-connected disability compensation and related benefits prior to separation from service, which allows VA to begin payment of benefits as soon as possible after discharge. Servicemembers who apply for disability compensation benefits under the BDD program undergo one medical examination instead of both a military separation exam and a VA exam for the disability claim. Timely decisions on servicemembers' disability compensation claims also help ensure continuity of medical care for their service-connected disabilities. The goal of the program is to deliver benefits within 60 days of discharge.

The Seattle Regional Office operates BDD sites at the Ft. Lewis/McChord Air Force Base and in Bremerton, Washington. Over the past 6 months, the Seattle Regional Office completed 1,133 BDD claims.

NATIONAL HIRING INITIATIVE

I am pleased today to be able to discuss with you our national hiring initiative. We have already added more than 800 new employees since April, and our plans call for adding a total of 3,100 new employees by the end of next year. These employees will be placed in critically needed positions in our regional offices throughout the Nation.

Along with the multitude of activities involved in a recruitment program of this magnitude, we have begun the critical tasks of training, equipping, and acquiring space to house our new employees. We are accelerating the training of these employees and focusing in specialized areas of claims processing in order to have them "online" and productive within a few months. This will be followed by ongoing, carefully structured, and progressively complex training until full journey expertise is achieved.

As a result of this hiring initiative, the Seattle Regional Office has been authorized to hire 53 additional employees. With these additional resources, the Regional Office will continue to make great strides in improving the delivery of benefits and services to the veterans of Washington.

Senator Murray, this concludes my testimony. I greatly appreciate being here today and look forward to answering your questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO DIANA RUBENS, DIRECTOR, WESTERN AREA, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Veterans have long been frustrated by the combative VA benefits claims process. The Veterans Disability Benefits Commission is now studying the system and will recommend changes in a final report that is expected in October. In addition, the Institute of Medicine found that the VA's compensation system for emotionally disturbed veterans has little basis in science, is applied unevenly and may even create disincentives for veterans to get better.

Question 1. How can we change the VA claims process so that it doesn't negatively impact the recuperation of veterans?

Response: The Department of Veterans Affairs (VA) is continually striving to improve the compensation claims process and is evaluating all recommendations from authoritative sources. Mental disability among veterans is a major issue, especially Post Traumatic Stress Disorder (PTSD). VA is addressing the process for evaluating the severity of a veteran's PTSD symptoms and assigning an appropriate evaluation of disability compensation. We have revised the standardized examination format for PTSD for use by all examiners so that consistent and more useful information will be available for claims adjudication personnel. Additionally, VA is considering

the recommendation of the Institute of Medicine of the National Academies that PTSD have its own specific multidimensional rating criteria, rather than being evaluated based on generalized criteria used for all mental disorders.

Question 2. How many Iraq and Afghanistan war veterans have filed any type of VBA disability compensation or pension claim?

Response: The information provided below is based on a match between Department of Defense (DOD) data on servicemembers deployed in support of the Global War on Terror (GWOT) for the period from September 11, 2001 through May 31, 2007, compared to VA data covering September 11, 2001 through September 30, 2007.

This data match identified veterans who were deployed during their military service in support of GWOT, and who have also filed a VA disability claim either prior to or following their GWOT deployment. Many GWOT veterans had earlier periods of service, and filed for and received VA disability benefits before being reactivated.

VBA's computer systems do not contain any data that would allow us to attribute veterans' disabilities to a specific period of service or deployment.

For the period covered, 223,564 of 754,911 GWOT veterans filed a claim for disability benefits either prior to or following their GWOT deployment. Of those, 181,151 veterans were determined to have a service-connected disability, 17,371 were denied service- connection, and 23,042 veterans had original claims pending as of September 30, 2007.

Question 3. How many Iraq and Afghanistan war veterans have filed a claim for a mental health condition? How many were granted? How many were denied? How many are waiting for a decision?

Response: VBA does not track information specific to mental health conditions claimed by GWOT veterans. We have compiled data on GWOT veterans for the 10 most prevalent service-connected disabilities granted, which includes PTSD. As of September 30, 2007, there were 31,465 GWOT veterans service-connected for PTSD. This represents 4 percent of the total GWOT veteran population, and 17 percent of those GWOT veterans who have been granted any service-connection. This data is based on veterans separated from military service on or before May 31, 2007, as reported by DOD.

Question 4. How many total claims does VBA expect from Iraq and Afghanistan war veterans? How many of those does VBA expect will be for any type of mental health condition? And how many for PTSD?

Response: In fiscal 2007 the Veterans Benefit Administration (VBA) completed nearly 829,000 claims. Of those, just over 110,000 (13 percent) were claims made by GWOT veterans. This information is based on GWOT veterans discharged through May 2007 as reported to VA by DOD and self-reported by GWOT veterans when they filed their disability claim. At the present time, we expect GWOT claims will continue to represent the same percentage of our overall workload in 2008 and 2009. Projecting future demand for the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) conflict remains extremely difficult for a number of reasons.

First, many OEF/OIF veterans served in earlier periods, and their injuries or illnesses could have been incurred either prior to or subsequent to their latest deployment. We are unable to identify which OEF/OIF veterans filed a claim for disabilities incurred during their actual overseas OEF/OIF deployment.

Second, we significantly expanded our outreach to separating servicemembers. Over the last 5 years, we conducted over 38,000 briefings attended by over a 1.5 million active duty and Reserve personnel. Additionally, through the benefits delivery at discharge program, servicemembers are encouraged to file and assisted in filing for disability benefits prior to separation. Many servicemembers with disabilities are submitting disability claims earlier. However, the impact of these efforts on future application trends and benefits usage is not known.

Third, VBA lacks historical data for claims activity by veterans of prior wars on which to base projections of benefits usage for OEF/OIF veterans. The only data available are the numbers and percentages of veterans currently receiving benefits by era of service.

We continue to add veterans to our compensation rolls many years after their service. Many of these are a result of additional conditions presumed to be related to service in Vietnam. PTSD claims have also increased from Vietnam veterans. We have no basis for determining if service in Afghanistan and Iraq will result in similar claims patterns.

Question 5. What is the average wait time for new war veterans compared to all other veterans, who wait 6 months for an initial decision?

Response: In fiscal 2007, VBA completed nearly 825,000 claims, Of these, just over 110,000 were claims filed by GWOT veterans. Their claims were processed in an average of 179 days. The remaining claims were completed in 184 days.

VA is continuously seeking ways to improve the timeliness of processing claims received from GWOT veterans. In February 2007, VA began providing priority processing of all OEF/OIF veterans' disability claims. This initiative covers all active duty, National Guard, and Reserve veterans who were deployed in the OEF/OIF theaters or in support of these combat operations, as identified by the DOD. Therefore, claims received from GWOT veterans before February 2007 were not processed on a priority basis. As a result of this initiative we expect to see improvements in our timeliness in FY 2008.

VBA also added an indicator/flash in our VETSNET system to clearly identify GWOT veterans and improve the management of their claims. The system alerts the claims examiner that the case being processed is to be handled in a priority manner.

VA does face challenges in assisting GWOT National Guard and Reserve members with their claims, due to difficulties in obtaining their active duty medical records. These members are sometimes mobilized with units other than their home unit. Their medical records created while on active duty may not get back to their home unit for some time, if at all.

VA is taking a proactive approach in seeking to obtain medical records faster from the National Guard. VA met with the National Guard to discuss their health readiness records and electronic readiness records, and how the VA can have access to those records. The VA Regional Office in St. Petersburg, FL, is entering into a pilot program with the National Guard in order to receive medical records electronically.

ADDITIONAL INFORMATION REQUESTED BY HON. PATTY MURRAY FROM DIANA RUBENS, DIRECTOR, WESTERN AREA, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

1. Total claims filed by Global War on Terrorism (GWOT) veterans—222,424.
2. Total claims denied—17,414.
3. Total claims currently pending—27,440 first-time claims and 9,948 reopened.
4. We do not have data on the number of mental health claims that have been filed or that are pending. Our data does show that 30,005 GWOT veterans are service-connected for Post Traumatic Stress Disorder (PTSD). Determining the total number who are service-connected to some degree for "mental health" issues would require that we do a special data run for the full range of diagnostic codes that relate to mental health.

Senator MURRAY. Thank you very much. Dennis Lewis.

STATEMENT OF DENNIS M. LEWIS, FACHE, NETWORK DIRECTOR, VISN 20, DEPARTMENT OF VETERANS AFFAIRS

Mr. LEWIS. Yes, good afternoon, Senator. I would like to thank you for this opportunity to discuss what the Department of Veterans Affairs, Northwest Health Network is doing. I am accompanied by Stan Johnson, the director of the Puget Sound Health Care System, and I'd like just to take a moment to thank all the active-duty service personnel and the veterans of the audience for the sacrifices you and your families have given on behalf of our country. The VA really only exists for one reason, and that is to provide services to you.

Veterans Integrated Service Network, VISN 20 is fortunate to employ some of the most respected health care professionals in the country. Through their efforts and with the support of our dedicated staff and with your help, we have expanded mental health capacity and programs tremendously in recent years. Since FY 2005, we have increased mental health programs staffing by over 20 percent, 125 FTE, 63 of those positions were added in Washington State. Throughout the VISN, these additions have allowed us to improve coordinated care delivery in such areas as Post Traumatic Stress Disorder, substance abuse, homelessness and Trau-

matic Brain Injury. In all, VISN has introduced more than 40 new mental health initiatives in Washington State, which have been supported by over $4 million since FY 2006 alone.

We've also expanded mental health services at 23 Community Based Outpatient Clinics or CBOCs. In fiscal year FY 2006, VISN 20 was first in Veterans Health Administration for mental health access in CBOCs. VISN 20 is also a national leader in care and coordination in telehealth, serving almost 1,700 veterans with the latest technology. We've introduced telemental health to close to half of our CBOCs allowing us to evaluate the follow-up patients without them having to travel long distances. This treatment method is especially effective in rural areas and it's one that we are aggressively continuing to expand. Across the country there is a sense of urgency in reaching out to Operation Enduring Freedom and Operation Iraqi Freedom veterans. Through the end of FY 2006, VISN 20 facilities had treated 12,164 OEF/OIF servicemembers and veterans. In FY 2006, 2,849 OEF/OIF veterans were seen in Washington State and 24 percent of those were diagnosed with PTSD.

We are applying what we have learned through research and clinical experience about the identification and treatment of mental health conditions and other chronic or persistent courses of illness in such a manner that the staff is proud to say that VISN 20 delivers 21st century care to 21st century combat veterans. We are conducting aggressive outreach efforts to contact these soldiers. As early as 2004, the VA Puget Sound Health Care System pioneered a collaborative effort with eight agencies, including the Department of Defense, the State of Washington and other state and federal and community entities creating a memorandum of understanding focusing on coordinating services for returning veterans. These efforts have now been duplicated in Oregon and Idaho with much success.

Our medical centers are also actively collaborating with State, National Guard and Reserve components to ensure that no returning veterans slips through the cracks. In 2005, VA Puget Sound activated the Deployment Health Clinic which consists of an integrated combat care team, which serves as entry points for returning veterans. VISN 20 has also established the regional Polytrauma System of Care. Again, VA Puget Sound has been designated the Polytrauma Network Site and works with VA's Polytrauma Rehabilitation Center in Palo Alto. Our Boise and Portland facilities have established Polytrauma Support Clinic Teams, and each of our facilities have designated a Polytrauma point of contact. Our Vet Centers provide readjustment counseling community outreach for combat veterans and their families, and as I believe you've already heard mentioned, by the end of 2007 a new center will be open in Everett, Washington.

In summary, VISN 20 is committed to providing world class mental health care to all veterans, regardless of the era they have served in. We remain keenly aware of the importance of our mission and the challenges that lie ahead. I believe that our current and planned efforts go a long way toward meeting that challenge, and I am extremely proud of the staff and I thank you for your continued support.

Senator, that concludes my prepared remarks.

PREPARED STATEMENT OF DENNIS M. LEWIS, FACHE, NETWORK DIRECTOR, VISN 20, DEPARTMENT OF VETERANS AFFAIRS

Good morning Senator Murray. Thank you for the opportunity to discuss the Department of Veterans Affairs (VA) NW Health Network and the mental health services we are honored to provide our Nation's veterans. I would like to request my written statement be submitted for the record.

Veterans Integrated Service Network (VISN) 20 is fortunate to employ some of the most respected mental health professionals in the country. Through their efforts, and with the support of our dedicated staff, we have expanded mental health capacity and programs tremendously in recent years. In fact, since Fiscal Year (FY) 2005, we increased mental health program staffing by over 20 percent, adding a total of 125 new positions.

Sixty-three of these positions were added in Washington State. Throughout the VISN, these additions have allowed us to improve coordination care delivery in areas such as Post Traumatic Stress Disorder (PTSD), Substance Abuse, Homelessness, and Traumatic Brain Injury (TBI). In all, VISN 20 has introduced 40 new initiatives in Washington, supported by over $4 million in enhanced funding, since FY 2005.

We also expanded Mental Health services at each our 23 Community Based Outpatient Clinics (CBOCs). In FY 2006, VISN 20 was first in VHA for mental health access in CBOCs.

VISN 20 is also a national leader in Care Coordination and Telehealth, serving almost 1,700 veterans with the latest technologies. We have also introduced telemental health at close to half of our CBOCs, allowing us to evaluate and follow patients without them having to travel long distances. This treatment method is especially effective in rural areas, and we will continue to expand it.

Across the country there is a sense of urgency in reaching out to Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans. Through the end of FY 2006, VISN 20 facilities have treated 12,164 OEF/OIF service members and veterans. In FY 2006, 2,849 OEF/OIF veterans were seen in Washington, 24 percent of whom were diagnosed with PTSD.

We are applying what we have learned through research and clinical experience about the identification and treatment of mental health conditions and other chronic or persistent courses of illness. VISN 20 delivers 21st century care to 21st century combat veterans.

We are conducting aggressive outreach efforts to contact these soldiers. As early as 2004, the VA Puget Sound Health Care System (PSHCS) pioneered a collaborative effort with 8 agencies—including DOD, the State of Washington and other state, Federal and community entities—creating a Memorandum of Understanding focused on coordinating services for returning veterans. These efforts have now been duplicated in Oregon and Idaho with much success. Our medical centers also actively collaborate with state National Guard and Reserve components to ensure that no returning soldier slips through the cracks.

In 2005, VA Puget Sound activated a Deployment Health Clinic (DHC), which consists of an integrated combat care team who serves as entry points for returning veterans.

VISN 20 also established a regional Polytrauma System of Care. Puget Sound has been designated the Polytrauma Network Site and works directly with VA's Polytrauma Rehabilitation Center in Palo Alto. Our Boise and Portland facilities have established Polytrauma Support Clinic Teams, and each of our facilities have a designated Polytrauma point of contact.

Our Vet Centers provide readjustment counseling and community outreach to combat veterans and their families. By the end of 2007, a new Center will open in Everett, Washington.

In summary, VISN 20 is committed to providing world class mental health care to all veterans, regardless of the era in which they served. We remain keenly aware of the importance of our mission and the challenges which lie ahead. I believe that our current and planned efforts go a long way toward meeting this challenge, I am extremely proud of our staff, and I thank you again for your continued support.

This concludes my statement. At this time I would be pleased to answer any questions you may have.

Senator MURRAY. Thank you very much. General Lowenberg.

STATEMENT OF MAJOR GENERAL TIMOTHY LOWENBERG, ADJUTANT GENERAL, STATE OF WASHINGTON

General LOWENBERG. Thank you. Senator Murray, I want to thank you for your leadership and commitment to these issues and for this opportunity to testify on behalf of National Guard soldiers and airmen and other Reserve component members. On Tuesday of this week, a State Department released a survey of its employees who had been assigned to unaccompanied tour locations. One out of six self-reported post assignment stress disorders and mental health problems, and these are not people like our soldiers and airmen who are shot at, who are subjected repeatedly to high-yield explosions and who are lured into booby trapped buildings while on forced security missions. Yesterday the Army released a report documenting the highest rate of soldier suicides in more than a quarter of a century, and that report shows that twice as many females serving in Iraq and Afghanistan committed suicide as female soldiers not sent to war.

What do these statistics have to do with National Guard soldiers and airmen? If one out of six State Department employees currently serving in Bosnia, lived in Liberia and other unaccompanied tour locations report self stress-related adjustment disorders, then no one should question the problems faced by our soldiers, who just like their active-duty counterparts are subjected to live fire and explosive blasts that threaten their lives and the lives of their fellow members and who are repeatedly exposed to such trauma during their year to year and a half long deployments and during their recurring combat assignments.

What distinguishes National Guard soldiers and airmen from their active-duty counterparts is not their capabilities or their importance to America's combat operations, or even the nature and severity of their recurring trauma, but rather the community and support network from which they deploy in the United States, and perhaps more importantly to which they return at the conclusion of their combat tour, and second, their eligibility for and access to physical and mental health care. With rare exception, active-duty personnel live on or near full-service military installations. Regardless of their duty location, they are eligible for year-round medical treatment. When they return from an overseas assignment, they're generally given a half day work schedule for the first month, and they and their fellow soldiers are together every day allowing them to individually and collectively normalize their combat experiences. They're also surrounded by family and friends who understand and who often themselves have experienced the same kind of trauma.

Guard soldiers by contrast come from communities throughout the state. They are not surrounded before or after their deployment by family or community members who share their experiences, or who can appreciate or even conceptualize the trauma that they endured. Guard soldiers, unlike their active-duty counterparts go through a 10-day demobilization process after returning to the U.S., and after that 10 days, they return to civilian life and have no contact with their unit or their fellow soldiers for 3 months. Another distinguishing factor is the Guard units are not authorized to treat our soldiers or airmen for any physical or mental condition before or after their active-duty tour. In fact, we don't even have

psychologists or social workers available in the National Guard. We have medical officers, but they're authorized to do only two things: emergency examinations and fitness-for-duty physicals. The only time a Guard soldier is eligible for medical treatment is when they are on federal active duty, and even that eligibility ends three drilling assemblies after they rejoin their unit after demobilization.

It's no wonder then that our soldiers' exposure to Traumatic Brain Injury and Post Traumatic Stress Disorder is often masked during these first few months post-demobilization. Regrettably, our study shows that in the months that follow when our soldiers and airmen are no longer eligible for military medical treatment, these conditions often blossom into intractable problems of unemployment, substance abuse, family separation and divorce.

To correct these problems and inequities, I recommend four steps that would dramatically enhance the readiness of our force. First, Guard and Reserve members are an integral part of America's 21st century fighting force. Give our members the year-round physical and mental health treatment they need to be a combat ready force. Authorize Guard medical personnel to treat Guard members. Staff Guard medical units with psychologists and social workers and require mental health screening upon demobilization and periodically thereafter, and give hiring preference to military and VA medical workers who have combat experience.

Second, recognize the Guard Reserve members live and work in communities that are often far removed from their own military units and from active duty and VA medical facilities. Approve and fund remote care near the member's hometown. Stop making our soldiers and airmen choose between no care and once again leaving behind their families and employers to obtain care at a distant military or VA medical facility.

Third, fund and require returning Guard soldiers and airmen to drill with their units immediately upon being demobilized. This will enable them to readjust and normalize with their fellow unit members, just like their active-duty counterparts and fund and provide parallel readjustment activities for Guards, spouses and family members who can gather together and continue their support for one another concurrent with these initial training assemblies.

Fourth, Guard transition assistance counselors do a terrific job, but as Carol Seger told you, there are far too few of them and the very program is designed to be a short-term program. We need to increase the number of transition assistance in each state and make the program permanent. Thank you for this opportunity to testify. I look forward to your questions.

PREPARED STATEMENT OF MAJOR GENERAL TIMOTHY LOWENBERG,
ADJUTANT GENERAL, STATE OF WASHINGTON

Thank you for the opportunity to appear before you today. Although I am a federally recognized, U.S. Senate-confirmed Air Force General Officer, I want to emphasize at the outset that I am testifying on behalf of the State of Washington and I am doing so as a state official in state status and at state expense. Unlike other military officers who typically appear before your Committee, nothing I say has been reviewed, edited or otherwise approved by anyone in the Department of Defense. My formal testimony, oral statement and responses to your questions should therefore be understood to be the independent "field" input of a senior Reserve component commander.

IMPORTANCE OF FULL SPECTRUM CARE FOR ALL MILITARY SERVICE COMPONENTS

I am grateful for Congress' attention to Guard and Reserve matters in recent National Defense authorization bills, in support for the National Guard Yellow Ribbon Reintegration Program, and in studies to address the needs of National Guard soldiers and airmen following overseas combat tours.

National Guard soldiers and airmen are serving in combat environments that put them at risk for trauma from blasts and debilitating and life-threatening physical injuries. The constant stress, fear, and vigilance required to survive in these conditions can create long-lasting consequences that later manifest as Post Traumatic Stress Disorder (PTSD). Repeated exposure to these stress conditions and repeated and extended combat tours exacerbate these problems. Guard men and women, like other combatants, are subjected to blasts from improvised explosive devices (IEDs) and other high yield explosives. Civilian studies of Traumatic Brain Injury (TBI) are instructive in dealing with brain trauma patients, but these studies are typically based on patients who have experienced a single traumatic blast exposure. Military personnel, on the other hand, especially ground forces, experience several TBIs in the course of a single combat tour and many Guard soldiers and airmen have served more than one combat tour or have had their tours of duty extended for up to a year and a half or longer at a time.

Because extended tours and recurring combat tours are a recent phenomenon, we do not know what the long term effects will be on the mental health of Guard and Reserve combatants. Until recently, there was no routine screening for TBI upon completion of a Guard member's combat tour. Without proper screening, many mental health conditions are masked and go untreated. I urge you to require and fund a system that assures mental health screening takes place upon completion of each combat tour and at periodic intervals thereafter.

Mindful of these soldier and airmen needs, the Washington National Guard has developed independent, State-specific networks of transitional support for returning servicemembers and their families. We have partnered with numerous state and Federal agencies, including the Washington Department of Veterans Affairs (WDVA) and the Federal Veterans Administration (VA), and private non-profit organizations to develop a model reintegration program and we have extended the program's services to all military Reserve components.

The State of Washington was also the first state in the Nation to establish a state-funded Post Traumatic Stress Disorder (PTSD) and War Trauma Treatment Program (HB 2095). This law, enacted in 1991, allows the Washington Department of Veterans Affairs to offer readjustment counseling services to war-era veterans and their family members. These services include grief and counseling support for eligible state residents and family members, including National Guard and Reserve members who serve in times of conflict. The program's licensed mental health professionals offer a wide-range of specialized treatment as well as referrals to a variety of other services. That being said, there is still more that can and should be done to assist National Guard members by expanding and funding medical coverage, particularly mental health coverage, to a full spectrum of care.

NATIONAL GUARD AND RESERVES—UNIQUE CONSIDERATIONS

The ongoing Global War on Terrorism has transformed National Guard and Reserve components from a strategic reserve to a fully capable, combat-ready operational reserve. This shift has occurred as much from necessity as from conscious policy objective. The simple fact is that we can no longer project or sustain American military power or influence anywhere in the world without relying upon and fully integrating National Guard and Reserve personnel into all aspects of Defense Department operations. DOD and VA benefits programs, however, especially those that address physical and mental health coverage, are still too often tied to the 20th century strategic reserve paradigm and fail to recognize or accommodate the unique needs of 21st century National Guard and Reserve members.

The capabilities and operational integration of Guard and Reserve forces mask the fact that they are fundamentally different than active duty forces. Among these differences is the home-station environment from which our members deploy and to which they return at the conclusion of their combat tours. Another fundamental difference is the degree to which our members have access to physical and mental health care while in training status and upon completion of their active duty tours.

When active duty personnel return from overseas combat tours, they are generally retained in their unit for a minimum of six months. During the first 30 days after return to home-station, they are given a half-day work schedule to allow them to decompress and gradually reintegrate with their family and friends. Active duty

members and their families also typically live on or near their home-station and are therefore surrounded by a community that fully understands and shares their personal and professional experiences. Soldiers and airmen who experienced trauma together overseas still see each other every day and have an opportunity to individually and collectively "normalize" what they experienced in the combat zone. Military treatment facilities, physicians and other health care professionals are also readily available at home-station to address their medical needs.

By contrast, National Guard members report to duty from, and return to, communities scattered throughout the state. The unit to which they are assigned for training is often geographically removed from the community in which they live and work. When called to active duty, they either mobilize as a member of the unit to which they commute for monthly training or as a replacement "filler" to "round out" another deploying unit from their state or some other state. Under past mobilization models, National Guard soldiers have spent 3 to 4 months preparing for combat, 12 to 18 months in the overseas theater of operations, and then a mere 5 to 10 days demobilizing at an active duty installation, followed by 5 days at their home town Readiness Center. Under the new model for mobilization, the goal is for National Guard soldiers to spend 1 to 1½ months preparing for combat, 10 months in the overseas theater, and then 5 days demobilizing at an active duty installation and 5 days as their home town Readiness Center.

Upon release from active duty, National Guard soldiers return to their families and civilian work schedules with no opportunity to decompress or normalize their experiences. Their immediate family, which typically has no comparable combat experience, is their only sounding board. Their friends and neighbors in the surrounding community, unlike the friends and neighbors of most active duty personnel, also lack a common background or shared understanding of the Guard members' experiences. Under current policies, Guard members are also excused from participating in unit training for 90 days post-demobilization and therefore have an extended break in contact with the other solders with whom they served overseas.

National Guard and Reserve members also have far less access to medical care because of their dispersion in communities far from DOD and VA treatment facilities. TRICARE benefits end far too soon after release from active duty. Mental health issues, in particular, are not easily diagnosed and often surface long after the servicemember's six-month post-deployment coverage and eligibility for health care ends. This results in Guard and Reserve personnel with PTSD and TBI needs having no access to military health care. Without approval and funding to seek civilian care through the TRICARE network they must wait until the overstressed Veterans' Administration mental health care program can provide assistance.

Our members' post-deployment separation from fellow unit members and from access to medical care can cause small PTSD or TBI disorders to blossom into intractable patterns of unemployment, substance abuse, family separation and divorce. Even when these problems come to our attention, National Guard units have no organic military mental health providers nor are we authorized to provide direct medical care for our soldiers and airmen. Once demobilized, Guard members have virtually no access to health care unless a formal Line-of-Duty has been completed for the specific medical condition. Since mental health issues often fail to surface until long after the Guard member is released from active duty, such LODs are difficult to initiate, investigate and adequately document. Moreover, Guard members, unlike active duty soldiers and airmen, are often reluctant to seek help because of concern about the impact on their civilian employment. This is particularly true for law enforcement and other public safety employees. National Guard soldiers and airmen also tell us they don't report problems because of fear of being denied remote care (i.e., care near their place of employment or residence) and being required to leave their families to get care at a distant active duty installation.

RECOMMENDATIONS FOR ENHANCING SUPPORT FOR NATIONAL GUARD SOLDIERS AND AIRMEN

We owe National Guard and Reserve soldiers and airmen fully resourced, full spectrum care that is responsive to the unique medical, psychological, and family support needs of the Guard and Reserve force. One size does not fit all. Upon demobilization, members of the National Guard and Reserves transition back to a fundamentally different environment and have significantly different needs than their active duty counterparts. It is particularly important that we provide geographically dispersed health care where it can most readily be accessed by our combat veterans and their families.

Although beyond the jurisdiction of this Committee, Congress should review the policy of excusing returning Guard members from attendance at unit training as-

semblies for the first 90 days post-demobilization. It would be better to fund unit assemblies during this period in which National Guard soldiers and airmen can reconnect with their colleagues and "normalize" in the company of their peers. It would also be desirable to have parallel meetings for the members' spouses and family members. This would somewhat replicate the support system provided for active duty personnel and help National Guard soldiers and airmen internalize their experiences and more effectively reintegrate into their home communities.

The number of transition assistance advisors in each state also needs to be increased. Our advisors do an excellent job identifying the support needs of returning soldiers and airmen, but we simply don't have enough advisors to handle all the demands placed upon them.

National Guard members require and deserve greater access to health care at military and Veterans' Administration facilities and these facilities themselves must be better staffed and funded. The National Guard and Reserves are now an integral part of America's combat forces and must have a commensurate level of access to health care. Mental health care, in particular, is dependent on access and on the availability of trained providers. Mental health staffing should include, to the maximum extent possible, providers with direct combat experience. National Guard units should also be staffed with clinical psychologists and social workers to provide care to Guard members on par with what is provided to active duty members before, during and after deployments. Such enhancements would go a long way toward ameliorating misdiagnosis and "failure to treat" problems. Full medical coverage, and especially mental health coverage, should continue for at least a year following a Guard member's release from active duty and a regime of subsequent periodic screening should also be authorized and adequately resourced.

CONCLUSION

National Guard and Reserve units are an integral part of America's 21st Century fighting force. Current and future operations will therefore continue to expose Guard and Reserve forces to unprecedented trauma in protracted and recurring life-threatening situations. It must be recognized that while the exposure to trauma is the same throughout the force, members of the Guard and Reserves come from decidedly different environments than their active duty counterparts and they return to military programs and civilian communities that have far fewer resources and support systems than those enjoyed by active duty members returning to Federal military installations. These differences must be recognized and accommodated by designing, implementing and resourcing physical and mental health care for members of the Guard and Reserve that is equal to that received by active duty personnel.

Thank you for considering the recommendations I have made for redressing current system deficiencies. I look forward to your questions.

Senator MURRAY. Thank you. General Baxter.

STATEMENT OF BRIGADIER GENERAL SHEILA BAXTER, COMMANDER, MADIGAN MEDICAL CENTER, FORT LEWIS, WASHINGTON

General BAXTER. Good afternoon, Senator. Thank you for this opportunity and thank you for your leadership here in the State of Washington and the other Washington as well. I'm happy to be here. I am the Commanding General for Madigan Army Medical Center. Madigan has a proud history of innovative health care programs and dedicated staff professionals who are committed to the delivery of quality health care. I'm eager to talk today about our partnership between us and the VA and excited about the progress we're making toward providing comprehensive seamless care to our warriors and their families. We are particularly proud of our ongoing initiatives to reach out and support the psychological health needs of our servicemembers.

Six months ago a series of stories published in the *Washington Post* caused all of us in the Army Medical Department to take an in-depth look at our outpatient services. Additionally, the acting Surgeon General of the Army dispatched a multi-disciplinary Tiger

Team to assess the provision of health care services at 11 installations across the country, including Fort Lewis. The Tiger Team found several areas where we could improve performance while also identifying several best practices. In March of this year, Army leadership established the Army Medical Action Plan to examine problem areas, including staffing issues, facility concerns, bureaucratic processes and administrative delays in an effort to generate achievable solutions.

Ultimately, the AMAP team produced an Army Operations Order. It was signed by the Vice Chief of Staff of the Army which directed the accomplishment of over 135 tasks. At Madigan we are working diligently to implement these changes. On July 13 of this year at Fort Lewis, we established a Warrior Transition Unit. This new organization of structure provides every Warrior in Transition with a triad of support, which includes a squad leader, case manager and physician. The mission of this triad is to support the needs of the warrior and his family through the complexity of this healing process, and if necessary the medical board process.

Additionally, we assigned an ombudsman to serve as an advocate for every Warrior in Transition and to help soldiers navigate through the medical evaluation process. An important element of the Army Medical Action Plan is the transition from the military health system to the Veterans Health Administration. We're focusing extra attention on the hand-off from DOD to DVA. For the past two years our part—our partners in the VA have had two social workers embedded at Madigan to facilitate the transition of warriors from DOD health system to the VA. Today these two VA social workers work side by side with our case managers to provide that seamless transition.

For many of our warriors we understand that this is an uncertain time that we are taking steps to eliminate the uncertainty and to make the transition not only seamless, but a pleasant experience. I would like to briefly summarize some of the areas the Army has participated in to improve behavioral health services. In 2003, we revised the Post-Deployment Health Assessment originally developed in 1998. The same year we launched the first Mental Health Advisory Team into theater. Never before had the mental health of combatants been studied in a systemic manner during conflict. The psychologists on the team at that time was the Chief of Psychology at Madigan, Colonel Bruce Crow. This and subsequent Mental Health Advisory Teams have influenced our policies and procedures, not only in theater but before and after deployment as well. In 2005 the Army rolled out the Post Deployment Health Re-assessment, the PDHRA. The PDHRA provides warriors with an opportunity to identify any physical and behavorial health concerns they may be experiencing that may not have been present immediately after their redeployment.

Madigan Army Medical Center expanded this basic program with a program we call the Soldier Wellness Assessment Pilot Project (SWAPP). SWAPP extends the basic PDHRA program to include a comprehensive physical and mental health screening and provides an opportunity for soldiers to have a face-to-face session with a credentialed behavorial health provider. This program has reduced stigma by requiring all soldiers and their leadership to participate,

so every soldier that goes through the program sees their commander leader go through this program, and we know that that helps to reduce the stigma. This program has been recognized within the medical department as a best practice and continues to provide first class care to our Fort Lewis warriors, both prior to and after their redeployment 90 to 100 days upon their redeployment.

Additionally, we are utilizing new technologies in multiple ways as we develop online programs for post-deployment care and explore the expanded use of virtual reality treatments for PTSD. Before we can treat PTSD with these cutting edge modalities, they must first be recognized. Our staff is fully engaged and participating in the Army directed mild Traumatic Brain Injury and PTSD chain teaching, and by October 18, 2007, soldiers and leaders at all levels and in all organizations will complete this training designed to assist in recognizing PTSD and TBI, the hidden wounds of war. This training is currently being expanded to include an IPod version in videos for civilians and family members in both English and Spanish.

Senator Murray, thank you for this opportunity to participate in this hearing. And in closing, Madigan and the Western Region are committed to providing a level of care that is equal to the quality of service that is provided by these great warriors. We recognize our challenges and we are striving every day to continue to improve the process.

PREPARED STATEMENT OF BRIGADIER GENERAL SHEILA BAXTER, COMMANDER, MADIGAN ARMY MEDICAL CENTER, FORT LEWIS, WASHINGTON

Senator Murray, thank you for providing me the opportunity to participate in this important discussion. I am Brigadier General Sheila Baxter, Commanding General of the Western Regional Medical Command and Madigan Army Medical Center. Madigan has a proud history of innovative health care and a dedicated staff of first-rate health care professionals. I am eager to talk about the terrific relationship between Madigan and our VA partners and I am excited about the progress we are making toward providing comprehensive, seamless care for our Warriors and their Families. I am particularly proud of our ongoing initiatives to reach out and support the psychological health of our Servicemembers, Veterans, and their Family Members.

Six months ago, a series of stories published in the *Washington Post* caused those of us in the Army Medical Department to take an in-depth look at our outpatient processes. Additionally, the Acting Surgeon General of the Army dispatched a multidisciplinary Tiger Team to assess the provision of health care services at eleven installations across the country, including here at Fort Lewis. We found many areas where we could improve performance. We also found some areas at Fort Lewis that were identified as "best practices" to be emulated across the Army. In March of this year, Army leadership established the Army Medical Action Plan (AMAP) Team to examine problem areas—be they leadership issues, facility concerns, bureaucratic processes, or administrative delays—and generate achievable solutions. Ultimately, the AMAP team produced an Army Operation Order, signed by the Vice Chief of Staff of the Army, which directed the accomplishment of over 135 tasks. At Madigan, we are working hard to implement all of these actions. The biggest step was the establishment of the Warrior Transition Unit on 13 July. This new organizational structure provides every Warrior in Transition with a triad of support, which includes a squad leader, nurse case manager, and physician. The mission of the triad is to support the needs of the Warriors and their Families through the complexities of the healing and, if needed, medical board process.

An important element of the Army Medical Action Plan is the transition from the military health system to the Veterans Health Administration. We are focusing extra attention on the hand-off from DOD to DVA. For the past two years, we have had two VA social workers placed at Madigan to facilitate the transition of Warriors from the DOD healthcare system to the DVA healthcare system. For many of our Warriors, this is a scary, uncertain time, but we are taking steps to eliminate the

uncertainty and to make the transition not only seamless but a less-challenging experience.

Our actions must consistently honor the service of our Warriors. We are committed to providing the best quality health care to our Servicemembers with physical injuries resulting from War. We are equally committed to saving and improving lives where the injuries are not so visible. Although robust behavioral health care services were available to our beneficiaries before the Global War on Terror began, they have steadily improved over the last 5 years as the needs of our population changed. The Army and the Department of Defense have made significant advances in the provision of behavioral health services since the attacks on 9/11.

I would like to briefly summarize some of the areas the Army has participated in to improve our behavioral health services. In 2003, we revised the Post-Deployment Health Assessment, originally developed in 1998. That same year we launched the first Mental Health Advisory Team (MHAT) into theater. Never before had the mental health of combatants been studied in a systematic manner during conflict. The psychologist on that team was, at that time, the Chief of Psychology at Madigan (Colonel Bruce Crow). This and subsequent MHATs have influenced our policies and procedures not only in theater but before and after deployment as well. In 2005, the Army rolled out the Post Deployment Health Reassessment (PDHRA). The PDHRA provides Warriors with the opportunity to identify any new physical or behavioral health concerns they may be experiencing that may not have been present immediately after their redeployment. Madigan Army Medical Center expanded on this basic program with a program I will speak to further in a minute.

In 2006, the Army Medical Department (AMEDD) piloted a program at Fort Bragg, North Carolina intended to reduce the stigma associated with seeking mental health care. The Respect-Mil pilot program integrates behavioral healthcare into the primary care setting, providing education, screening tools, and treatment guidelines to primary care providers. It is now in the process of being implemented at fifteen other sites across the Army. Here at Fort Lewis, we have programs for primary care psychology support within our Soldier Family Medicine Clinics. Also in 2006, the Army incorporated into the Deployment Cycle Support program a new training program called "BATTLEMIND" training. It is a strengths-based approach that highlights the skills that helped Warriors survive in combat instead of focusing on the negative effects of combat.

The Army's efforts to address behavioral health continued in 2007 as we expanded BATTLEMIND training with modules for pre-deployment training and for spouses; our Behavioral Health web site went live in March; our Behavioral Health Proponency Office and AMEDD Suicide Prevention Office both stood up in March; our new PTSD training course started in June; and recommendations from the Department of Defense's Mental Health Task Force were released in June. We are participating with our sister Services and Health Affairs to review the Mental Health Task Force recommendations, the Traumatic Brain Injury Task Force recommendations, the recommendations from the President's Commission on Care for the Wounded Warrior, and other recent thoughtful reviews to implement a coordinated program.

Congress provided tremendous financial support to allow us to better understand and treat both PTSD and TBI. The funds provided in the Fiscal Year 2007 Emergency Supplemental will significantly jump start our improvements in behavioral health care.

Shifting back to some of the key programs that we have here in Washington State, I would like to mention first our expanded version of the PDHRA program. Consistent with our approach of reaching out to all of our population, not just those who come into our clinical settings, we have created a program called the Soldier Wellness Assessment Pilot Program (SWAPP) that extends the basic PDHRA program to include a comprehensive physical and mental health screening and provides the opportunity for a face-to-face session with a credentialed behavioral health provider for all Warriors. This program has been recognized within the Medical Command as a Best Practice and continues to provide first-class care to Fort Lewis Warriors both prior to and as they return from deployment. We are utilizing new technologies in multiple exciting ways, as we develop online programs for postdeployment care and explore the expanded use of Virtual Reality treatments for PTSD.

Senator Murray, thank you for the opportunity to participate in this important discussion with you and the Members of this Committee. The Army and the Army Medical Department are committed to providing a level of care—physical, emotional, spiritual—that is equal to the quality of service provided by these great warriors. We recognize our challenges and are striving daily to continue improving the quality care we provide to our Warriors and family members. Our Wounded Warriors and

their Families deserve the best we have to offer and we in the Army Medical Command are honored to care for them. I look forward to your questions.

Senator MURRAY. Thank you very much, General Baxter. John Lee.

STATEMENT OF JOHN LEE, DIRECTOR, WASHINGTON STATE DEPARTMENT OF VETERANS AFFAIRS

Mr. LEE. Thank you, Senator. I would be remiss if I didn't join the chorus to your fan club here. Thank you for all that you do and that of your staff. I have to tell you, they are incredibly responsive, always there to help us with our issues and I want to thank them. You know, I have a sense that we're not here today for commercials on all the great stuff that we're doing. I want to point out, however, since we went to war since 2003 and the stories you heard today, we have done a tremendous amount of reshaping the kinds of things we do. I want to tell you that through the help of General Lowenberg, we have done outreach to every National Guard unit in the State of Washington taking benefits specialists and job specialists and counselors to those weekend events to assist people making access to all their stuff. Recently, General Baxter allowed two full-time staff of the Washington State Department of Veteran Affairs to be embedded, I will use that word, in the medical hold contingent so that now at the front end of people leaving active duty, we will be able to have a conversation with them, look them in the eye about the stuff that is available for them when they transition out of the military. But Brandon said, "I hope something can be done to increase the communication available to the services that we earned in our service to our country."

And, so, in closing, Senator, I will tell you that I have some ideas, and I would like to work with you and your staff, because one of the greatest obstacles government faces is this idea that we cannot share private information about the veterans and family members we are obligated to serve without some kind of high-level, complicated database, or incredibly complex legal documents. And I'm here to tell you that that offends me. I think we can move beyond that and the men and women that are serving our country that we are obligated to provide services to expect us to do no less. Thank you.

Senator MURRAY. Thank you very much. Thank you to all of our panelists. You know, you all had an opportunity to listen to our first panelists speak today talking about the stigma, talking about how difficult it was to come home and ask for care, the challenge to their families, the bureaucratic nightmares they get in, the denials of service that creates more difficulties for them as they try to deal with mental health. I assume all of you are concerned as I was as we listened to that panel that we have so many people today who are not accessing mental health care. Would anybody like to comment?

General LOWENBERG. Frankly, I found the testimony to be heart wrenching, not surprising, but very disturbing. As John Lee just pointed out, I think we have done a great deal since the 81st Brigade returned from Iraq to provide a more obvious and readily available network of support, but we still have soldiers and airmen who fall through that network and that unity of effort. More needs

to be done, and as I pointed out to you, there are several systemic problems with Reserve components at large to included the National Guard that really limit what we can do to really help our—

Senator MURRAY. What's surprising to me, General, because you say you don't have mental health experts available for National Guard and Reserve when we have men and women who have been not called up ones or twice, but even three and four times now, and yet, you don't have that. Have you asked for that?

General LOWENBERG. Well, the Congress and the Defense Department, they have not made the shift from a 20th century strategic Reserve to a 21st century operational Reserve.

Senator MURRAY. Does that take an act of Congress?

General LOWENBERG. Yes, it does. It requires authorization and appropriation to the Armed Services Committees for those kinds of positions.

Senator MURRAY. Mr. Lewis, were you surprised by the panel and—

Mr. LEWIS. I don't think surprise is the word, more disturbed. Despite the improvements that have been made and all of the systems that are put together, it's very clear that we're still failing. No matter how much we communicate, the word still doesn't get out. As you know, at VA we can provide some very limited services to families if the family accompanies the veteran to a session, but we can't provide something single. And given the various legislative mandates under which each of our different organizations operate, each one of us is trying to do what we can within those, but there are still these wide gaps between all of us, and the best thing would be to close those gaps.

Senator MURRAY. General Baxter, you've heard about the culture and stigma within the Army. You served in the Army. What—what do we have to do to change that stigma?

General BAXTER. Yes, ma'am, and as I mentioned here at Fort Lewis, I've got to tell you, LTG Dubik was very instrumental in leading the charge in reducing that stigma. We developed the Soldier Wellness Assessment Program, we also, two years ago started what we call the senior wellness stress seminar for senior leaders. We have generals who come in and talk about their stress, because we feel that if you see general officers and Sergeants Major and their spouses come in and talk about it at the highest level, and we meet quarterly, and so, those leaders set the example in helping to reduce the stigma. I have to tell you that leaders are taking this seriously. It was unfortunate to hear those stories this morning. I can tell you, Senator, that we are making improvements daily. The triad that I mentioned, with the squad leader and the case manager, wrapping around the soldier to navigate them through the MEB—Medical Evaluation Board process. We are hiring additional personnel—I have 100 mental health providers working at Madigan. We're hiring an additional 14 mental health providers.

Senator MURRAY. Do you think there is still a culture within the services despite all of that that says, you're a macho soldier, mental health is not part of being macho?

General BAXTER. Yes, ma'am, and I think that as we continue to educate the cadre—as we continue to educate our war fighters in how to deal with PTSD and TBI, I think we will see a change in

culture. But what we're doing right now with the chain teaching programs, I think that will help, and the Army has driven that from the top down.

Senator MURRAY. Let you ask you, General Baxter, the Army's report on suicide which came out yesterday which was part at Madigan, and I assume you were part of writing that?

General BAXTER. Yes, ma'am.

Senator MURRAY. 99 confirmed suicides among active duty soldiers during 2006.

General BAXTER. I'm sorry, I was not a part of writing that article that you are talking about.

Senator MURRAY. You were part of the report, participation in the report?

General BAXTER. Which report?

Senator MURRAY. The report that came out yesterday on suicide.

General BAXTER. No, ma'am, I was not a part of that report.

Senator MURRAY. Well, the report was that there were 99 confirmed suicides among active-duty soldiers during 2006. Do we know how many unsuccessful suicide attempts there were?

General BAXTER. I don't have that information, ma'am, but I have my chief of psychology here. He may be able to answer that.

Colonel GAHM. And perhaps the next panel—

Senator MURRAY. I'll ask him on the next panel and I want to know what counts as a suicide and that, so if you could be ready to answer that question, I would appreciate it. Well, let me ask you this, General Baxter, because I've heard when the report came out, the Army responded broken marriages and Dear John letters were one of the main factors behind suicide. It seems to me that PTSD and brain damage are significant as well. Can you explain why the report distances itself from those factors.

General BAXTER. No, ma'am, but I can tell you that we have a number of services that we provide to soldiers including our chaplains as part of those teams that are embedded with the units. We have retreats that we provide here at Fort Lewis for soldiers who have come back from deployment, and their spouses are a part of that. There are a number of services out there, we are now going to embed social workers in the barracks. We were just down at the Navy facility in Balboa a week ago. One of the things that we noticed as a great model is that they have their behavorial health technicians live in the barracks with the soldiers, and they're finding that the number of complaints in terms of how they adjust when they come back go down.

Senator MURRAY. Well, we know the report yesterday just talked about suicide within the services. Dr. Zeiss, I assume that report did not include soldiers who committed suicide once they were separated from the units?

Dr. ZEISS. That's my understanding.

Senator MURRAY. Does the VA keep the numbers for those additional suicides?

Dr. ZEISS. We certainly are trying to develop better mechanisms of capturing suicides. We're working with the National Death Register to get that information so that we can get information about all veterans. There is also research going on trying to extend the

information, so we track the number of suicides that occur that are known to the system, that is, that has been reported back.

Senator MURRAY. Do you have any numbers you can share with me on that?

Dr. ZEISS. I don't have them with me. I can certainly get that—

Senator MURRAY. I would like you to give them to me as part of the record, and I have to tell you, it's extremely troubling to me, because as I travel around and talk to veterans often around the state, I inevitably have someone come up to me afterwards to share a story with me. In fact, this week we had an incident where we were at one of the clinic openings, and a veteran came up to me. He had been denied benefits, denied benefits, denied benefits and denied benefits, and he asked for my help. I had one of my staff members stay with him afterwards, and he actually told my staff member that he had a rifle sitting at home, and if he couldn't get help from us talking to him that day, he was going to end his life. That is really disturbing to me. He had actually been separated for a number of years, I think it was 26 years. We have a lot of stories like that out there of people who don't know who to access, who have been denied benefits, are tired of trying to work through the system. I would ask, Mr. Lewis or Dr. Zeiss, what are we doing to reach out and help these young kids, or even older adults who may have served many decades ago before we see these kinds of statistics come out?

Mr. LEWIS. I can't speak from the national level, but I can speak from a local level. The suicide prevention coordinators of course are the newest position that have been put in place. Numbers of social workers, psychologists, psychiatrists that have been put in place not only at the facilities but also down at the CBOC levels now in addition to the telemental health initiatives, we've outreached to the local community facilities, hospitals. Our CEOs are meeting with their CEOs. Our mental health professionals are meeting with their mental health professionals to talk about ways when a veteran comes in we're notified that there is someone there in need. And, of course, we communicate constantly with the veterans groups, the VSOs and ask them to notify us and let us know as well.

Senator MURRAY. Well, the person I'm talking about, similar to many stories I've heard, I've tried over and over and over again and had been denied services. Dr. Zeiss, let me ask you: If a veteran comes into a VA Hospital with a headache or not sleeping or family issues or anything, will that veteran see a PTSD expert that day?

Dr. ZEISS. That would depend on the process of screening. Assuming they're coming into primary care, which I assume from your description, they would be screened for PTSD that day. And if there is a positive screen for PTSD or for any other mental health problem, they would be seen within 24 hours for an evaluation for the urgency of the need for—

Senator MURRAY. If somebody comes in and says, I'm having headaches, are they seen that day, do you know?

Dr. ZEISS. Yes.

Mr. LEWIS. There are no mental health waiting lists in Washington State.

Senator MURRAY. Well, it is difficult, because the stories I hear out there are different than that. So how do we understand what is happening out there with people who say they can't get in or are denied care, they're told to come back? How do we rectify that?

Mr. LEWIS. If it's on a specific case, I can answer. When I'm presented with the generalities, I can give you what we attempt to do and how we attempt to outreach to veterans. And we're there and we're no longer expecting them to come to us. We're trying to get out to them as much as possible.

Senator MURRAY. Well, let me change how I'm asking this question. I hear a lot that the VA claims process is something that contributes highly to the stress of individuals who are already under stress. What can we do to change that process so it doesn't become part of the stress that they are in?

Ms. RUBENS. The claims process is undoubtedly a complex process. There are many laws and regulations. To the degree that we can work to expedite, and we have changed our process, expedite the process for those new and returning, particularly for OEF/OIF veterans. We have done that in the regional office. We have a team established to address those as quickly as they come in. I think the other thing that we have tried to do, because it is a complex process, is ensure we have got more quality trained workforce so that we're doing a better job looking for consistency in our determinations so that as veterans in Washington State are treated, it would be the same as any other state and working to quite honestly reach them more quickly in our BDD system and partnering with DOD in an effort to, if you will, get them in and get their records more quickly so that years don't go by where we now have to go back out and search for records on military service.

Senator MURRAY. How many Iraq and Afghanistan war veterans have actually filed any types of BDA claims?

Ms. RUBENS. I don't have the exact number of how many have filed. I can tell you we have roughly pending 45,000 now.

Senator MURRAY. You have 45,000 pending?

Ms. RUBENS. Correct.

Senator MURRAY. And how many of those are for mental health?

Ms. RUBENS. That I don't know. I can get that——

Senator MURRAY. Can you give me an estimate.

Ms. RUBENS. I can see if we can get the specifics on how many of those claims involve mental health issue.

Senator MURRAY. How many claims or grants—

Ms. RUBENS. I don't know. I don't have——

Senator MURRAY. Do you know how many were denied?

Ms. RUBENS. No, I don't.

Senator MURRAY. Do you know how many are waiting for a decision?

Ms. RUBENS. Roughly—we have roughly 45,000——

Senator MURRAY. 45,000 waiting.

Ms. RUBENS. In process right now.

Senator MURRAY. OK. I would like to know from you how many of our Iraq and Afghanistan veterans—I mean, we can go back previous wars, but let's just ask that question. Can you get back to me for the record how many have filed the claim, how many have

been denied a claim, how many are waiting and how many were for mental health.

Ms. RUBENS. OK.

Senator MURRAY. And if you could just guess for me, what is the average wait time for veterans coming in state from any war to get services.

Ms. RUBENS. For veterans benefits or for——

Senator MURRAY. Just an initial appointment or decision.

Dr. ZEISS. If you are asking about being able to get an appointment for mental health services from the Veterans Health Administration side of the house, as I said earlier, the standard now is that if anyone requests or is referred for mental health services, they will see someone or talk on the phone with someone (if they're a bit more distant and don't want to drive in) within 24 hours. And within 14 days, they will have a full evaluation with a treatment plan developed.

Senator MURRAY. General Baxter, let me go back to you. In the last 6 years, the Army has diagnosed and discharged more than 5,600 soldiers because of personality disorders, and those numbers are continuing to increase. I'm told that it's unlikely that a member of the Armed Forces would display symptoms of personality disorder after they were sent to combat that is not already evident during extremely stressful training that they go through. Shouldn't it be obvious to the military that the servicemember has a personality disorder by the time they are sent to combat?

General BAXTER. What we're doing now, ma'am, is we have a number of assessment tools that we're using for soldiers, and I can just speak for Fort Lewis. We have what we call the pre- and post-deployment assessment program of soldiers. To give you an example, we had a soldier in the engineering unit six months before deployment, who walked into the pre-deployment progress and said, "I just put a gun to my wife's head last night." We were able to get him in to see a psychiatrist immediately. I can only speak for the Fort Lewis process.

Now we are doing pre-deployment assessments on soldiers. We have an opportunity as they are assessed in their unit for commanders to identify that, and I go back to the chain teaching requirement that we're all going to get here in the next 90 days that will help to identify the symptoms if a soldier is having those types of personality disorders.

Senator MURRAY. We are running out of time, but I want to ask one other question, and it disturbed me. I saw an AP that the study on the suicide rates said that about 20 percent had been diagnosed with a mood disorder such as bipolar disorder and depression, 8 percent had been diagnosed with anxiety disorder, including Post Traumatic Stress Disorder, which is one of the signature wounds of this war. Can someone tell me why we're sending men and women into combat with those kinds of conditions in the first place. General Baxter?

General BAXTER. Again, Senator, all I could say is that I don't have those numbers in front of me, and I'll let my psychologist speak to it in the next panel. That is his field. I can just tell you what we're doing at Fort Lewis, as I just mentioned, to try and alleviate the issues of sending soldiers and, as you know, some of

these symptoms do not appear until three or four months down the road. Now, we do have stress management teams in theater. We have psychologists, psychiatrists in theater to assess soldiers as they go to war, so I've got to tell you, there are two stop gaps here, before they leave Fort Lewis, and when they get into the theater, we have combat stress teams throughout the theater, both Afghanistan and Iraq to assess soldiers as well.

Senator MURRAY. General Lowenberg, how about in the National Guard and Reserves?

General LOWENBERG. Once again, Senator, we have no internal resources by which we can do any of those assessments.

Senator MURRAY. So you may well be sending somebody into combat that should not be sent to combat, simply because of the lack of mental health professionals?

General LOWENBERG. Once the soldier or airman is mobilized, they are removed entirely from our command and control and become a member of the Army or Air Force, and they are entirely subject to the administration of those systems from that time until they deploy, throughout their deployment and until they actually demobilize. So all of those resources are in the active Army and Air Force. They are not provided to the National Guard.

Senator MURRAY. Well, we have a lot of issues that we need to look at from bureaucracy nightmares, times and waits that people have in getting through paperwork, rejections of their claims, obviously our combat troops on the ground, the entire stigma how we get through our cultural issues for mental health is something that we're going to keep working on, and I appreciate all of your testimony today. I do have more questions that I will submit to you that I'll ask for you to answer to submit to the record. I do want to get to our third panel of experts as well, so I want to thank all of you for coming today and I'd ask that our third panelists come forward at this time.

We do have our final panel. Everybody has been very patient. We want to make sure we get to them. These are our mental health professionals, and with us today are Dr. Miles McFall, the Director of PTSD Program at the VA here in Seattle; Colonel Greg Gahm, Chief of the Department of Psychology at Madigan; Robert Ramsey, the Team Leader at Tacoma Vet Center; and Dr. Anthony Barrick who is a licensed mental health counselor and now practices in Seattle. He formally worked with the Navy and Army. And, Dr. McFall, we will begin with you.

STATEMENT OF MILES MCFALL, PH.D., DIRECTOR, PTSD TREATMENT PROGRAMS, VA PUGET SOUND HEALTH CARE SYSTEM

Dr. MCFALL. Thank you, Senator Murray, for the privilege of appearing before you today and thank you for all you do for veterans and the VA. I will briefly review the VA Puget Sound Health Care System's specialized mental health programs for veterans with stress-related mental health problems and then discuss briefly our efforts in outreach as well as research. VA Puget Sound Health Care System hosts an array of six complementary clinical treatment programs tailored to the unique needs of veterans from all eras of military service. First let me discuss our PTSD outpatient

clinics that exist at both divisions of VA Puget Sound Health Care Systems, each of which offer a full array of psychotherapeutic treatment, medication or pharmacological treatments, as well as case management interventions.

During FY 2006, these two PTSD outpatient clinics treated more than 3,400 veterans, and also evaluated and triaged an additional 1,000 veterans, approximately 15 percent are women veterans. Our women veterans are cared for by a specialized team of therapists from our Women's Trauma Program, which is embedded into our PTSD outpatient programs at each division of VA Puget Sound Health Care System. Secondly, our PTSD inpatient program that is located in Seattle is a 12-bed inpatient program for veterans that serves veterans throughout the four-state region of VISN 20. This PTSD inpatient program provides comprehensive intensive inpatient psychiatric and medical care, and during FY 2006 we served over 259 veterans with PTSD and related problems. Incidentally, veterans from Iraq and Afghanistan increasingly use this inpatient PTSD program. We have seen more than 110 so far. They rely on this program because we're capable of providing a platform for treating those who have both PTSD as well as TBI-related injuries. It gives us access to the Polytrauma Program while they reside in our PTSD inpatient program.

Third, our PTSD Domiciliary at American Lake campus serves about 100 veterans annually. It provides extended care for veterans discharged from the PTSD inpatient program that I just mentioned. It's also an alternative to intensive inpatient care for veterans who don't need an initial stay in an intensive inpatient program. Veterans receive rehabilitation and recovery-oriented interventions typical to help them gain stability, cope with chronic symptoms, avert homelessness, engage in activation oriented and socialization programs and to access to case management services to help with finances and housing and this kind of thing.

Fourth, our deployment health clinics that you heard about earlier are really the hub of specialized post-combat care for most Iraq and Afghan veterans at our facility. The Deployment Health Clinic provides primary medical care and mental health services provided by the PTSD program staff detailed to that setting. In a single setting, organizing care in this way with deployment clinics, both at American Lake and the one in Seattle improves access to care and allows the VA to coordinate care with the essential support services, which include the polytrauma program, and pain service, which is very, very important. The Seattle deployment health clinic has seen about 700 veterans, and the American Lake deployment health clinic has seen about 500 veterans thus far.

Fifth, our VA Puget Sound Health Care System liaisons and our PTSD programs staff collaborate actively with Madigan Army Medical Center, our Vet Centers and the Washington State Department of Veterans Affairs, supporting an integrated system of care for veterans with military-related stress disorders. I'll describe a few examples of integrated and collaboration of our VA PTSD program with other agencies. First, we detail psychiatrists to our three Western Washington Vet Centers which don't have medical personnel so that these Vet Centers can provide medication management onsite for patients who are concurrently enrolled in psycho-

therapy at the Vet Centers. And our psychiatrists follow up patients using telemedicine technology so that the veterans don't have to travel to the VA. They can get all their care at the one site at the Vet Centers. A second example is that active-duty servicemembers utilize our VA clinical care programs, particularly our inpatient PTSD programs that I mentioned earlier in Seattle, and they also use, of course, the deployment health clinics, polytrauma program, and other services upon referral from Madigan or other DOD installations.

Let me move on a little bit to our outreach efforts. VA Puget Sound Health Care System PTSD mental health personnel and other staff from our facility have partnered with the Washington State Department of Veterans Affairs, the Washington State National Guard and a host of other federal and state agencies to conduct an aggressive outreach program for OIF/OEF veterans because we believe early intervention for Iraq/Afghani vets is really the best method of preventing normal readjustment responses from evolving into chronic PTSD. Mental health staff at these VA facilities in Western Washington have provided screening, counseling and education to nearly 3,000 active-duty servicemembers during 32 family activity day events since 2005 that were organized by the Washington State Department of Veterans Affairs and National Guard.

I also want to mention that PTSD research is a vital component of providing the best care possible to our veterans and servicemembers. VA Puget Sound Health Care System PTSD research investigators have amassed over $23 million thus far in competitive research funds from the VA, Department of Defense and National Institutes of Health and have published more than 60 scientific papers on underlying mechanisms and treatment approaches for PTSD.

This concludes my testimony. Again, thank you for the opportunity to appear here today before you.

PREPARED STATEMENT OF MILES MCFALL, PH.D., DIRECTOR,
PTSD TREATMENT PROGRAMS, VA PUGET SOUND HEALTH CARE SYSTEM

Good Morning, Senator Murray. Thank you for the opportunity to discuss VA Puget Sound Health Care System's service to veterans with stress-related mental disorders. I would like to request my statement be submitted for the record. I will begin by discussing our medical center's specialized mental health programs, then later move to our outreach and research plans.

VA Puget Sound hosts an array of complementary clinical treatment programs uniquely tailored to the needs of veterans from all eras of military service.

1. Our Post Traumatic Stress Disorder (PTSD) Outpatient Clinics offer a full spectrum of care including pharmacological, psychotherapeutic, and case management interventions. During FY06 we treated more than 3,400 veterans, approximately 15 percent of whom were women. Our women veterans are cared for by a specialized team of therapists from our Women's Trauma Program.

2. The PTSD Inpatient Program is a 12-bed inpatient PTSD program for veterans in VISN 20. The PTSD Inpatient Program provided comprehensive intensive inpatient psychiatric and medical care to 259 veterans with PTSD and related disorders in FY 2006. OIF/OEF veterans—more than 110 so far—increasingly rely on this program because it simultaneously evaluates and treats both PTSD and Traumatic Brain Injury (TBI), in collaboration with our Polytrauma program.

3. The PTSD Domiciliary serves about 100 veterans annually, provides extended care for veterans discharged from the PTSD Inpatient Program, and is an alternative to intensive inpatient care. Veterans receive rehabilitation and recovery-oriented interventions designed to help them gain stability, cope with chronic symp-

toms, avert homelessness, engage in activation-oriented programs to counter social isolation, and access case management services.

4. Deployment Health Clinics (DHC) are the hub of specialized post-combat care for most OIF/OEF veterans at our facility. The DHC provides primary medical care and mental health services (provided by PTSD program staff) in a single setting, improves access to care, and allows VA to coordinate care with essential support services. The Seattle DHC has seen about 700 veterans and the American Lake DHC has seen about 500 veterans.

5. VAPSHCS Liaisons and PTSD Program staff collaborate with Madigan Army Medical Center, Vet Centers and the Washington Department of Veterans Affairs (WDVA) to support a system of care for veterans with military-related stress disorders. Recently, VA Puget Sound PTSD programs deployed psychiatric staff to three Vet Centers in western Washington and used telemedicine to follow patients in these settings. Additionally, active duty servicemembers utilize our PTSD programs, particularly the PTSD Inpatient Program and DHCs, after referral by Madigan Army Medical Center and other DOD installations.

VA is conducting aggressive outreach with WDVA, the Washington State National Guard, and a host of other Federal and state agencies because early intervention for OIF/OEF veterans is the best method for preventing normal readjustment responses which can, in certain instances, solidify into chronic PTSD. Mental health staff from VHA facilities in Washington provided screening, counseling, and education to nearly 3,000 active duty servicemembers during 32 "Family Activity Day" events since 2005.

PTSD Research is vital to providing the best care possible to our veterans and servicemembers. VA Puget Sound research investigators have amassed over $23 million in competitive research funds from VA, the Department of Defense (DOD), and the National Institutes of Health (NIH) and have published more than 60 scientific papers on underlying mechanisms and treatment approaches for PTSD.

This concludes my testimony. Thank you for the opportunity to appear before you today, Senator Murray. I would be happy to answer any questions you may have.

Senator MURRAY. Thank you very much. Colonel Gahm.

STATEMENT OF COLONEL GREGORY A. GAHM, CHIEF, DEPARTMENT OF PSYCHOLOGY, MADIGAN ARMY MEDICAL CENTER, FORT LEWIS, WASHINGTON

Colonel GAHM. Senator Murray, thank you for this opportunity as well. It's important for us to have this opportunity to speak to the important programs that we're doing at Fort Lewis, many of which have been recognized by the GAO, by the DOD Mental Health Task Force, and by the Military Child Education for the innovative and forward reaching. Nevertheless, we realize that it's important for us to continue to move forward to develop more programs that expand the services that we are operating. One of the programs that General Baxter mentioned was our Soldier Wellness Assessment program. The DOD has mandated for all servicemembers a 90 to 180 post-deployment mental health evaluation, and we took that further. We ensured that for every soldier we have at Fort Lewis they get a face-to-face mental health visit with a credentialed mental health counselor, even if they deny they have problems at that time.

We feel that this approach helps to address the issues of stigma, because everyone has to see the mental health, so no one knows—no one has to worry about why am I going to mental health. It addresses the comfort level of seeing them, because even if that person doesn't really need that care that day, they now are familiar with what mental health care is, and it allows us to ensure that we in case findings identify individuals with needs. We've expanded the program in addition to being a more comprehensive program all to do with pre-deployment, so we can collect at pre-de-

ployment the resilient skills and how we can help soldiers better deploy and better prepare for the future.

At this time I briefed a couple of initiatives that we have ongoing at Fort Lewis. Besides the SWAPP, we have programs reaching out to the community through the school system where we're working with all the school districts in the local area to train—work directly with the student, as well as work with the teachers and counselors to help them prepare—help them address the deployment issues with their students with themselves and help them better prepare for the challenges they face should bad things happen. We have programs working with case managers where we embedded them to address some of the concerns that were mentioned here before to ensure that we really have mental health providers successful to getting anyone wherever they need to—wherever they want to be seen.

And then in addition to the physical presence, we've leveraged technology to reach out beyond where we can have people available to build an online Internet based service program for after appointment needs. I was directed by Congress and the National Defense Authorization Act 2006, and Madigan is leading this initiative, which is a broad DOD NDA partnership to build services that will be available to both military beneficiaries, but anyone else who would access this, because it's a non-opportunity to achieve preclinical care to help them identify what their problems may be, to help identify who maybe we would suggest should get face-to-face care and who can benefit from online services. This is an initiative we're very proud of. We have been working hard for quite a while now, and we're going to be unveiling a pilot version in September of this year.

As mentioned also we're exploring the use of virtual reality technology, which is really just a tool that we can use in exposure therapy to allow servicemembers to re-experience in a controlled environment the stressors they experienced in deployment and to have a therapist available to help them adjust and decondition essentially to the negative impact they've had from that. And in the interest of time—one final thing is that in our primary care clinics, we've also moved psychologists to primary care clinics so that we have—working directly with consults—consultants to the primary care providers. We don't have to have the soldiers go over to mental health clinic even. If the primary care provider identifies a potential need for services, they can pull the person aside, walk them right over and say, yeah, I'd like to get you to talk to this person today, one more avenue we have for ensuring that care is available as much as it can be. And with that, I would like to conclude pending your questions.

PREPARED STATEMENT OF COLONEL GREGORY A. GAHM, CHIEF, DEPARTMENT OF PSYCHOLOGY, MADIGAN ARMY MEDICAL CENTER, FORT LEWIS, WASHINGTON

Senator Murray and distinguished Members of the Committee, thank you for providing me the opportunity to address the broad range of mental health concerns affecting our Servicemembers and Veterans. As Chief of the Department of Psychology at Madigan Army Medical Center, I am proud to oversee the delivery of care provided by my psychologists to the Servicemembers and Family Members served by Madigan. I am also proud of our ongoing initiatives to reach out and support the psychological health of Servicemembers, Veterans, and their Family Members. While our work at Fort Lewis has been recognized by the recent DOD Mental

Health Task Force report, the Government Accountability Office, the Military Child Education Council, and positively reviewed in the press, we also recognize that we must continue to expand the services we offer and ensure that we remain committed to improving the compassionate care we provide.

Our actions must consistently honor the service of our Soldiers. Concerns regarding Soldiers separated for personality disorders, especially given the potential impact on future care for the psychological injuries of these veterans, are being addressed by the Army. The media and Congress have alleged that Soldiers have been unfairly discharged under Chapter 5–13, Personality Disorders (PD), when they should have been afforded the opportunity to undergo a Medical Evaluation Board. The acting Army Surgeon General directed a review of all Soldiers discharged for personality disorders in 2006 who had served in OIF or OEF. The results of this review still need to be presented to Army leadership, but some initial guidance for behavioral health providers has already been issued to the field.

Additionally, the Government Accountability Office (GAO) is in the process of auditing the Department of Defense with regard to the issue of administrative separation for a personality disorder diagnosis. To prepare, the GAO chose to visit Fort Lewis last month, not to address concerns, but rather to visit a positive model and consult with our psychologists, psychiatrists, and attorneys to learn about our processes in order to plan for their audit. While we strive to consistently act in the best interest of the Soldier, we agree with Army leadership that "even one misdiagnosis is too many." As our Surgeon General testified to the House Committee on Oversight and Government Reform in May, we recognize we are an imperfect organization, and are actively striving to ensure every Soldier receives the respect and outstanding care they deserve.

One of the many recognized initiatives that exemplify outstanding care to Servicemembers is Fort Lewis' implementation of the DOD's Post Deployment Health Re-Assessment, or PDHRA. The PDHRA process identifies physical and psychological health concerns for Servicemembers 90 to 180 days following redeployment. The PDHRA process at Fort Lewis is called the Soldier Wellness Assessment Pilot Program, or SWAPP. This program goes well beyond the DOD's basic mandated PDHRA process to provide a reset of the Soldier physically, spiritually, and mentally. Of particular note, every Soldier who completes SWAPP is provided the opportunity to meet that same day with a psychologist or master's level clinician. The Soldier and mental health provider work collaboratively to define needs, address concerns, assist with smooth redeployment, and connect the Soldier with any additional resources that might be needed.

After evaluating the process, we can say without question that "SWAPP works." Barriers to care fall. Every Soldier connects with a behavioral health clinician—there are no dead end referrals. As evidence of this, utilization rates for Fort Lewis' Stryker Brigade following redeployment in Fall 2005 reached the same Behavioral Health utilization rates (31 percent) in 6 months as was observed in one year in a population study completed by Colonel (Dr.) Charles Hoge and colleagues in 2006. In addition, Post-SWAPP Soldiers made an average of 5.3 visits during that time compared to an average of 3.4 visits found in the same one-year naturalistic study. Hoge, et.al, (2006) reported that only 50 percent of those who were referred based on positive PDHA responses were seen by a Behavioral Health provider, versus 100 percent of those who are seen through the SWAPP process.

Perceived stigma regarding mental health care drops when every Soldier follows the same process and meets with a behavioral health clinician. Dr. Hoge's 2004 *New England Journal of Medicine* study identified mental health stigma as the most significant barrier to care for Soldiers. Preliminary local analysis suggests that there is a drop in perceived mental health stigma for those individuals who are seen immediately after SWAPP compared to those who are seen prior to SWAPP or those who were seen later than a month after SWAPP. Additionally, SWAPP satisfaction survey data suggests that 13 percent of Soldiers seen in SWAPP were uncomfortable seeking mental health care prior to the SWAPP process, a number that was cut to less than half that following SWAPP.

SWAPP goes beyond addressing the needs of returning Soldiers. At Fort Lewis, this same process is provided to all Soldiers prior to their deployment as well. Predeployment SWAPP addresses the specific needs of Soldiers prior to their departure and seeks to buttress the resiliency of the Soldiers preparing to face the rigors of deployment. We are excited to continue SWAPP at Fort Lewis and look forward to working with the Army Medical Department to bring SWAPP to additional Army facilities.

In addition to SWAPP, Fort Lewis has many initiatives to reach out to Soldiers and their families. These include programs linking up our psychologists with the local schools to offer both programs for the students directly and training and sup-

port for the teachers and counselors in helping to deal with the effects of deployment. We are providing mental health care managers in numerous settings including our Warrior Transition Brigade to insure Soldiers have ready access to the helping resources.

We are also leveraging technology in several exciting ways. One of our efforts involves the development and deployment of an Internet based resource to reach out to all Servicemembers and their families to assist them after deployment. The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2006 authorized a pilot project of Internet-based tools aimed at identifying and treating Post Traumatic Stress Disorder (PTSD) and other mental health conditions. The Office of the Assistant Secretary of Defense (Health Affairs) has designated the Army as the project lead and I'm pleased that the Army Behavioral Health Technology Office (ABHTO) at Madigan Army Medical Center is leading the DOD project team. Partners in this very important initiative include the VA's National Centers for PTSD in Massachusetts, California, and Hawaii, the Center for Deployment Psychology, and other military organizations and sites. The web application we are developing, *afterdeployment.org*, addresses multiple critical variables in caring for the military family. The significant incidence of post-deployment mental health problems is exacerbated by limited provider availability, geographic proximity to services, scheduling challenges, and stigma. *Afterdeployment.org* offers a quality service that in many cases will provide an alternative to traditional face-to-face care. *Afterdeployment.org* is designed as a modularized and highly engaging self-care, online solution. The need for this tool has been highlighted by recent reports that a significant percentage of servicemembers and their families do not seek help despite meeting the criteria indicating a need for mental health services. *Afterdeployment.org* helps fill the gap by delivering tailored assessments and portable services available online anytime and anywhere. User anonymity is a key component, and will facilitate user comfort when engaging with the range of psychoeducational materials, self-assessment tools, and workshop exercises that the site will provide.

The programs available through the web site target the following 12 areas: (1) combat stress and triggers, (2) conflict at work, (3) re-connecting with family and friends, (4) moods, (5) anger, (6) sleep, (7) substance abuse, (8) stress management, (9) resiliency of kids, (10) spiritual guidance, (11) living with physical injuries, and (12) health and wellness. The web site design was tested in structured interviews with servicemembers in February and some modifications were made as a result of the feedback. The *afterdeployment.org* pilot version will be released for user testing in September 2007 with continuing development through FY 2008.

In order to further improve our ability to reach out to all of our beneficiaries, the AMEDD, in coordination with OSD Health Affairs (HA), is expanding our capacity to deliver tele-behavioral health care. Madigan Army Medical Center was recently approved to become a "hub" for regional telebehavioral health care and I have been asked by HA to work with them to initiate a National Center for TelePsychological Health & Technology. These services will augment the care available to our Servicemembers and Veterans and improve access to those in underserved areas.

Virtual Reality treatments for PTSD represent another area where we are leveraging new technologies in exciting ways to help our Soldiers. Building upon development efforts supported by the U.S. Army Medical Research and Materiel Command's Telemedicine and Advanced Technology Research Center (TATRC) and the Office of Naval Research we have worked collaboratively with the Institute for Creative Technology (ICT) at the University of Southern California to initiate both research and treatment programs utilizing this technology. While still in its early stages, this technology offers great promise for improving the treatments we offer our Soldiers.

Fort Lewis has consistently been a leader in Army efforts to provide the best possible care to our Soldiers. In 2005 we initiated open access mental health clinics. In an effort to insure that every barrier to care was removed, we converted our primary behavioral health clinic access for Soldiers from one that required an appointment to one that allowed Soldiers to walk-in and be seen the same day. To efficiently support this, we again leveraged technology to automate the capture of patient data via kiosks using the locally developed Automated Behavioral Health Clinic (ABHC) program which allows for more comprehensive data gathering while supporting providers in efficiently reviewing and considering this data in providing care. In 2006, we further extended this availability by opening our Soldier Readiness Clinic out of the main hospital, which made it easier for Soldiers to access. In addition, we initiated a primary care consultation model within our Soldier Family Medicine Clinics to directly support the primary care provider in their delivery of comprehensive health care and to provide an additional venue by which behavioral health care is available to our Soldiers.

Senator Murray, thank you for the opportunity to participate in this important discussion with you and the members of this Committee. Thank you for holding this hearing and thank you for your continued support of the Army Medical Department and the Warriors that we are honored to serve.

Senator MURRAY. Thank you very much. Mr. Ramsey.

STATEMENT OF ROBERT R. RAMSEY, LICSW, TEAM LEADER, TACOMA, WASHINGTON VET CENTER, READJUSTMENT COUNSELING SERVICE, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Mr. RAMSEY. Good afternoon, Senator Murray. I appreciate the opportunity to discuss the role of the Tacoma Vet Center plays in providing services within the Puget Sound Health Care System in our service area. I would like to request that my written statement be submitted into the record. The VA's authority to provide readjustment counseling to eligible veterans was established by law in 1979, and we believe that the Tacoma Vet Center was the first in the Nation to offer these services to veterans returning from Vietnam War. Readjustment counseling consists of beyond medical, a holistic system of care, that provides professional help to veterans coping with psychological traumas and other readjustment problems related to their military service. Vet Centers are located conveniently within the community and provide services tailored to the specific needs of the local veteran population.

Veterans are welcome to visit their local Vet Center any time. The Tacoma Vet Center has no waiting list, and the veteran may be seen by a counselor on his or her initial visit. Veterans immediate family members are also eligible for care at the Tacoma Vet Center and are included in the counseling process to the extent necessary to treat the veteran's readjustment issues. The Vet Center offers bereavement counseling to surviving family members of Armed Forces personnel who died while on active duty in the service of their country. The Tacoma Vet Center staff currently consists of a Team Leader, three Readjustment Mental Health Counselors, an Office Manager, a Global War on Terrorism Outreach Technician and Marriage and Family Therapists. These last two positions were recently added.

The entire staff actively engages in community in a variety of ways to increase program visibility and to access services.

We provide briefings to the Army at Fort Lewis on a weekly basis and to the Air Force at McChord Air Force base on a biweekly basis where a member of our staff presents information regarding stress management, Post Traumatic Stress Disorder and Vet Center services. Since 2003 the Tacoma Vet Center has provided outreach to nearly 5,000 veterans and clinical services to more than 800 Global War on Terrorism veterans and their family members. Our Global War on Terrorism Outreach Technician meets with local Ministerial Associations, every college and university in our area. We work closely with local community organizations such as substance abuse programs and Pierce County Sexual Assault Center.

Every week we visit the Hospitality Kitchen, a local soup kitchen in downtown Tacoma to meet with homeless veterans. We support many of these veterans there, encourage them to use the help of-

fered at our Vet Center and the services offered at VA Medical Center programs. Our Vet Center sexual Trauma counselor recently presented training for the sexual assault resource centers at both McChord Air Force Base and Fort Lewis. She also collaborates with the VA Medical Center staff to provide classes dedicated to women receiving treatment. One of our counselors, and Alaska Native, has proven very successful in reaching out to various ethnic groups, including American Indians, Pacific Islanders and Hispanic Americans. He has filled an essential role by expanding our capacity to go where our clients are, rather than waiting for them to come to us.

And our Office Manager, who is not a clinically trained person, creates a welcoming, respectful and professional environment. She works with several volunteers to ensure that they explain a full range of services offered within the VA and community social service organizations to anyone who calls. Well over 80 percent of our time is spent providing services to veterans. We are one of the busiest Vet Centers in the Nation and we are very proud of our work. Our clients report being very satisfied with our work and the services we offer. We are very fortunate to be supported by a wide array of clinical and administrative staff in the Puget Sound Health Care System. Working in a Vet Center is very intense, very rewarding and we consider it a privilege to serve combat veterans and sexual trauma survivors. Senator Murray, this concludes my prepared statement. I'm happy to answer questions you may have.

PREPARED STATEMENT OF ROBERT R. RAMSEY, LICSW, TEAM LEADER, TACOMA, WASHINGTON VET CENTER, READJUSTMENT COUNSELING SERVICE, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

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Veterans' immediate family members are eligible for care at Vet Centers and are included in the counseling process to the extent necessary to treat the veteran's readjustment issues. Vet Centers also offer bereavement counseling to surviving family members of Armed Forces personnel who died while on active duty in service to their country.

The Tacoma Vet Center staff consists of a Team Leader, three Mental Health Counselors, an Office Manager, a Global War on Terrorism (GWOT) Outreach Technician, and a Marriage and Family Therapist. This staff actively engages the community in a variety of ways to increase program visibility and access to services.

We provide briefings to the Army at Fort Lewis on a weekly basis and to the Air Force at McCord AFB on a biweekly basis. A member of our staff presents information regarding stress management, Post Traumatic Stress Disorder (PTSD) and Vet Center services.

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Our GWOT Outreach Technician meets with Ministerial Associations and every college and university in our area. We work closely with local community organiza-

tions, such as Substance Abuse programs and the Pierce County Sexual Assault Center.

Every week we visit the "Hospitality Kitchen," a local soup kitchen, to meet with homeless veterans. We support many of the veterans there and encourage them to avail themselves of the help offered at our Vet Center and services offered by other providers.

Our Vet Center Sexual Trauma Counselor recently presented training for the Sexual Assault Resource Center at both McCord AFB and Ft. Lewis. She also collaborates with VA Medical Center staff to provide classes to women receiving treatment.

One of our counselors, an Alaskan Native, has proven very successful in reaching out to various ethnic groups, including American Indians, Pacific Islanders, and Hispanic Americans. He has filled an essential role by enabling us to go where our clients are, rather than waiting for them to come to us.

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Senator Murray, this concludes my prepared statement. I am happy to answer any questions you may have.

Senator MURRAY. Thank you very much. Dr. Barrick.

STATEMENT OF G. ANTHONY BARRICK, PH.D., LICENSED MENTAL HEALTH COUNSELOR, SEATTLE, WASHINGTON

Dr. BARRICK. Senator Murray, thank you for the opportunity of addressing the important needs of mental health issues for military family members as well as the servicemembers. I am a Washington State licensed mental health counselor. I have worked in my civilian career as a government service employee with the Department of the Army, Department of the Navy and the Department of the Air Force. I mostly recently retired a month and a half ago from Naval Station Everett serving there as the Director of Clinical Services at the Fleet Family Support Center. In that position I worked with the Navy at Naval Station Everett and the region to establish what we call the IA program, the Individual Augmentee program. So frequently we're accustomed to the big units deploying and returning and services based around that, but we also have another population of people who go off one by one and are embedded in Army units or other Marine units providing services. Frequently there are military policeman or employee disposal ordinates, officers or construction battalion units.

The program that we developed was pre- and post-deployment to work with the servicemembers and their families. When the servicemember would return post-deployment, then we made sure that we met with that particular servicemember and we invited always the spouses to come in, and these were educational outreach efforts, and they were mandatory for the servicemember to attend basically before they went away on requested leave so that we could talk with them about how they were doing, what their experiences were. We had mandatory follow-ups 60, 90 and 120 days later in these employee assistance individual augmentee groups. Not surprisingly most of the IA returnees minimized and denied experiencing traumatic events. A handful, however, did share stories and current impacts on their lives such as sleeping disturb-

ances, nightmares, increased impatience and anger and relationship problems with their families. Some were experiencing symptoms of PTSD and others of traumatic stress. I've worked with the IA sailors in separate counseling when the sailors desired it, however, this was very rare. It was my experience that most active-duty sailors viewed mental health counseling to be a stigma, a stigma against their personhood and/or their military career. They were reluctant to seek mental mental health counseling. They tended to view it as a threat rather than as a tool to assist in their well-being and assist in their career.

This reticence was prevalent even within the educational part that we were doing, not just coming to counseling, but just trying to educate. That sort of reticence and stigma was prevalent there. In my 3 years with the IA program at Naval Station Everett, approximately 75 sailors were deployed and returned, and of those about 30 tended at least one of the IA returning and readjusting meetings. Three sailors requested supplemental counseling assistance. Others could have benefited from mental health counseling as a result of their deployment experiences. They declined follow-up services. I believe they were afraid of the stigma attached to seek counseling, the fear that other military members would become aware of their counseling and the fear that their military careers would be threatened, and the anxiety that most people have when they have been traumatized. That is a fear that something is wrong with them, and that is difficult to deal with, and it's, for many of those people that feel that something is wrong with them, living uncomfortably with that fear is less scary than admitting to themselves and others that something was wrong and reaching out and seeking help.

There is stress on military families and acute stress on families where the servicemember is in harm's way. Mental health services obviously can help. I would like to make some recommendations to reduce the stigma and increase the access rate of mental health counseling services:

1. Increase availability of mental health education to military members and their families, increase the education piece.

2. Increase the leadership participation in and referrals of military family members to educational programs. Leadership needs to be visible.

3. Increase leadership referrals of military members to mental health counseling when the servicemembers are exhibiting early signs of stress.

4. Increase opportunities for servicemembers to remain anonymous when seeking mental health service.

5. Allow servicemembers to go directly to TRICARE rather than through the on-base referral manager.

6. Allow TRICARE to provide marital and couples counseling. Spouses typically experience the secondary effects of their partner's trauma and may be influential in getting early treatment for their military spouses.

7. Promote congressional action to remove decision referral and supervision requirements for mental health counselors seeking TRICARE. This would increase the pool of qualified clinicians for the surge of people who are needing assistance.

8. Augment TRICARE with a specialized employee assistance program that retains some form of anonymity.

9. Rapidly implement the employment of licensed mental health counselors to be mental health professionals at veteran affairs facilities.

Finally, the process of healing is long-term. We must continue to simplify and demystify the mental health process for servicemembers and their families providing support resources and educating and planning seeds of renewal. Thank you for seeking ways to support our families.

PREPARED STATEMENT OF G. ANTHONY BARRICK, PH.D.,
LICENSED MENTAL HEALTH COUNSELOR, SEATTLE, WASHINGTON

Senator Murray and Committee, thank you for the opportunity of addressing mental health needs of military members and their families who are dealing with the stress of service in this time of war.

I am a Washington State Licensed Mental Health Counselor in private practice in Seattle. I have over 30 years of experience, including civilian service as a Supervisory Psychologist, U.S. Navy, and Counseling Psychologist, U.S. Army.

I helped establish the Individual Augmentee (IA) Support Program at Naval Station Everett, and the IA Support Program for Navy Region Northwest (NRNW). These programs provided education for Pre-Deployment Sailors and Family Members about their upcoming separation issues, potential effects of being exposed to traumatic events, and local support resources. For Post-Deployment support, we provided initial IA Returning and Readjusting Meetings (IARM) for Sailors and Family Members within 5 days of the Servicemember's return. Subsequent to the initial meeting, Sailors were required to follow-up in IARM Groups at 60, 90, and 120-day intervals, for a total of four sessions.

Not surprisingly, most of the IA returnees minimized and denied experiencing traumatic events. A handful, however, did share their stories and current impact on their lives, such as sleeping disturbances, nightmares, increased impatience and anger, and relationship problems with their families. Some were experiencing symptoms of Post Traumatic Stress Disorder (PTSD) and others Traumatic Stress. I worked with IA sailors in separate counseling when the sailors desired it. This, however was very rare.

It was my experience that most active duty sailors viewed mental health counseling to be a stigma against their personhood and/or their military career. They were reluctant to seek mental health counseling, viewing it as a threat, rather than a tool to assist in their well-being and their career.

This reticence was prevalent even within the educational IARM Groups.

In my 3 years with the IA program at Naval Station Everett, approximately 75 sailors were deployed/returned, and 30 of those attended at least one IA Returning and Readjusting Meeting. Three sailors requested supplemental counseling assistance. Others could have benefited from mental health counseling as a result of their deployment experiences. They declined follow-up services. I believe they were afraid of the stigma attached to seeking counseling, the fear that other military members would become aware of their counseling, the fear that their military careers would be threatened, and the anxiety that most people who have been traumatized have: the fear that something is wrong with them. Living uncomfortably with fear was less scary than admitting to themselves and others that something was wrong.

There is stress on military families, and acute stress on families where the servicemember is in harm's way. Mental health services can help. I would like to make some recommendations to reduce the stigma and increase the access rate of mental health counseling:

1. Increase availability of mental health education to military members and their families.
2. Increase leadership participation in and referrals of military and family members to educational programs.
3. Increase leadership referrals of military members to mental health counseling when servicemembers exhibit early signs of stress.
4. Increase opportunities for servicemembers to remain anonymous when seeking mental health services.
5. Allow servicemembers to go directly to TRICARE rather than through the on-base referral manager.

6. Allow TRICARE to provide marital and couples counseling. (Spouses typically experience the secondary effects of their partner's trauma, and may be influential in getting early treatment.)
7. Promote Congressional action to remove physician referral and supervision requirements for mental health counselors treating TRICARE beneficiaries. This would increase the pool of qualified clinicians for the "surge" in need.
8. Augment TRICARE with a specialized "Employ Assistance Program" that retains anonymity.
9. Rapidly implement employment of licensed mental health counselors to be mental health professionals at Veteran Affairs facilities.

Finally, the process of healing is long-term. We must continue to simplify and demystify the mental health process for servicemembers and their families—providing support and resources, educating and planting seeds of renewal.
Thank you for seeking ways to support our military families.

Senator MURRAY. Thank you, Dr. Barrick. Excellent suggestions, and I thank all of our panelists for testifying today. Colonel Gahm, let me start with you. Were you part of writing the study about suicide that was released yesterday?

Colonel GAHM. I was, ma'am.

Senator MURRAY. So that said that there were 99 confirmed acts of suicide. Can you tell us how many unsuccessful suicide attempts there were.

Colonel GAHM. The challenge with the question of unsuccessful—of suicide attempts is we don't—we can never know really how many people attempted suicide and didn't complete it. We do track in the Army known attempts, that is, those attempts that result in hospitalization, but other attempts where perhaps someone said, you know, yesterday I was driving and I was going to try to kill myself and just last minute swerved back, we don't know—we don't know.

Senator MURRAY. You don't know all of them, but I'm assuming that the number you gave us were suicides that occurred. Can you tell us how many were attempted that you know of.

Colonel GAHM. I don't have that number at my fingerprints tips, ma'am, but we do have that number.

Senator MURRAY. I mean, is it a large number?

Colonel GAHM. It's a larger number—the number that we track is a large number. I believe it's as many as seven times the number of completed suicides, but I don't want to—I can get you a number and I'd rather——

Senator MURRAY. I would—I would like you to get me the number. So it is possible there were 99 suicides. It could have been as many as 700 attempts?

Colonel GAHM. Most fully likely. The civilian literature has suggested that there are as many as 25 attempts for every completion, so that's just civilian population wise.

Senator MURRAY. Now, I want to ask you what I asked General Baxter in terms of those folks who are diagnosed with mood disorder or bipolar, depression. Why are we sending those people to conflict?

Colonel GAHM. Well, there are two comp—I would like to separate that from the suicide piece.

Senator MURRAY. That's fine.

Colonel GAHM. The return of individuals who have at one time had a psychiatric diagnosis to active duty and then to deployment, really it's a challenge, because as we talk about destigmatizing

mental health, and we want to ensure that people who have had mental health diagnoses can return to a fully functioning status in the military, they will then be subject to deployment. If they have a condition that is not well treated, they should not be deployed, but most of the conditions that fall into the mental health spectrum are treatable, including PTSD. And individuals who have been treated, we want them de-stigmatized and we want to include them in society, they will now be included within the population who will deploy and do other things.

Senator MURRAY. Well, Dr. Barrick, do you agree that we should consider them treated and OK'd to serve in combat?

Dr. BARRICK. That would have to be made on a case-by-case basis, yes, people who have been able to stabilize can return to combat.

Senator MURRAY. Mr. McFall?

Colonel GAHM. Again, I agree on a case-by-case basis. I certainly know individuals who were redeployed and had a positive experience for it, and to prevent them from being redeployed would have left them with guilt about abandoning their unit and so forth. And in other cases it may not be a good idea, so it really does have to be—but it's not universally the case that it's a bad idea to be deployed. In many cases we note that it's what's considered to be a favorable experience.

Senator MURRAY. Colonel Gahm, can you tell me in your opinion what accounts for the large number of soldiers who have been discharged for personality disorder.

Colonel GAHM. It's a large and obviously relative term. I believe the number you quoted was one that I have seen over te last 6 years I believe, something like 6,000——

Senator MURRAY. 5,600.

Colonel GAHM. Right, but for the million or so—we're not talking a large percentage, and if you look at—and I don't have these numbers at hand, but the percentage of individuals in society that would be diagnosed with a person who does have personality disorder, my assumption would be that it would exceed that number of individuals that we discharge from the military. The military draws from a broad spectrum of society, um, in many cases it's a good fit and individuals who may have difficulty functioning not in the military do better in the military. In other cases, the military is not a good fit and sometimes we have a number of different ways of separating those individuals.

I think personality disorder is one category that fits with that—it is a psychiatric diagnosis that has specific criteria. Those criteria do need to be followed when discharges are used that way. We are engaged in a systematic review in the Army of all of the known personality disorder discharges. I believe it was completed for the 2006 and is planned to extend further, in order to ensure that we can say with certainty what happened to those cases.

Senator MURRAY. So you have that completed for 2006? Can we get the results of that yet?

Colonel GAHM. It's actually, to my understanding, it has been completed, but it's under the review in the Army right now.

Senator MURRAY. So we can expect to see that sometime soon?

Colonel GAHM. Yes, ma'am.

Senator MURRAY. We heard a lot in the first panel about the stigma of mental health. We know that that's an issue. Yesterday when the report came out on suicide and the high number of suicides, highest in 26 years, the Army response was that broken marriages and Dear John letters were one of the main factors behind the suicides. I don't know if that came directly from the report or it was just the response. Colonel Gahm, doesn't that play into the stigma issue if we're just dismissing it as Dear John letters?

Colonel GAHM. I can't say who made those comments, but one thing that is known is that the relationship failures are one of the highest correlations of completed——

Senator MURRAY. Well, are the relationship failures as a result of post traumatic stress syndrome, Traumatic Brain Injury, other injuries along the point or the other way around?

Colonel GAHM. Right, those are all reasonable questions. I think it's not unreasonable to expect that separating spouses who have in many cases only been married for a couple of months—I mean, there are numerous cases where for different reasons people get married right before deploying, and in that case where you're gone 15 months, it's not unreasonable to expect it to stress the relationship.

Senator MURRAY. Well, I guess would it be disconcerting to give a message to people out there who are suffering from mental health care that this is just a result of a failed relationship rather than perhaps something physical occurred that you need help with?

Colonel GAHM. To my knowledge, if you are asking me is there a biological determinative of suicide——

Senator MURRAY. No, I'm asking the message that is received by military members, that perhaps the high rate of suicide as a result of Dear John letters is not a good message to them when, in fact, it's highly likely that it was post traumatic stress syndrome as a result of their service, doesn't that add to the stigma and make it more difficult for them to be able to access care if they don't want somebody to think they have a failed marriage?

Colonel GAHM. I certainly can't tell you what effect it has done on society, but I can say with confidence that that's not the intended message that went forward.

Senator MURRAY. Dr. McFall, do you have anything——

Dr. MCFALL. I don't have anything to add on that, no.

Senator MURRAY. We are way over time. I do want to ask a couple of questions, one is about family members. We heard from our first panel are men and women who are struggling with post traumatic stress syndrome, injuries, physical injuries, Traumatic Brain Injury, no support for their families, what's happening to a young kid who sees their parent going through all of this and we don't—we're not reaching out and supporting them? Should we be doing that as part of our policy in this country, Dr. McFall?

Dr. MCFALL. Yes, we should. Well, we do have structures in place to do family counseling at the VA, the Vet Center. With those structures it doesn't mean we can't do a better job.

Senator MURRAY. Well, didn't you hear all three of our soldiers today say that there was no support whatsoever for their families?

Dr. MCFALL. Yes.

Mr. RAMSEY. I would comment on that. I think the biggest problem we have is not getting the word out, and I think that's really what Vet Centers are about, doing all we can to get the word out. It's not uncommon for me to have a Vietnam veteran come into my office and tell me that the first time he's told his story is in my office after 40 years. And now these younger veterans have similar kinds of experiences where they are reluctant to come in. They don't want to participate in treatment for a variety of reasons, and so, getting the word out there that we have services available, that we can help family members, that we've recently hired someone to do marriage and family treatment at the Vet Center is difficult. And it's amazing how difficult it is to clearly communicate that to the community.

Senator MURRAY. I would assume that you'd all agree that not only—it's not just within the military, not just within the VA, but within society as a whole we have to address the stigma that is attached to mental health——

Mr. RAMSEY. Absolutely.

Senator MURRAY [continuing].—in order for people to get the help that they need to be able to be healthier. Correct?

Dr. BARRICK. Yes.

Senator MURRAY. One last question and we are going to have to adjourn for the day. I think it was Kathy Nylen on the first panel spoke about the issue of military sexual trauma. We've not heard much about that in the media, in Congress. It seems to me that there is a hidden issue here in terms of military sexual trauma contributing to much of what we're seeing today. Would any of you like to comment on whether or not my guess is correct or if we're doing anything. Is there an issue of military sexual trauma as a result of the current climate?

Dr. MCFALL. Yes, military sexual trauma does exist. There are estimates about problems of that that are published. I'll let Dr. Gahm speak from DOD's standpoint. As you know from your recent visit we do have women's trauma treatment teams at our facility that primarily address military sexual trauma in our veterans who come to us. We're also doing some other additional things to expand these efforts there as well. For example, we've just been approved to hire a new MST, military sexual trauma coordinator for our facility, and we're very excited about her pending arrival.

We also are doing screening to detect MST in the patient population that we serve through a clinical reminder system which will allow us to identify these individuals early on and get them in the hands of this MST coordinator as well as specialized PTSD mental health care if needed. And the Vet Centers are also doing good work in this area of MST as well. We work collaboratively.

Senator MURRAY. Is this an underreported issue? I see four heads nodding here, just for the record. Colonel Gahm, would you like to comment.

Colonel GAHM. On this clear greater awareness—I mean, sexual trauma is something that should not be tolerated. It's not an acceptable behavior. It's not an acceptable thing that we just want to say, well, it's OK. Is there underreporting? Most likely because you don't know what you don't know. Are we taking an aggressive approach to helping those individuals who do report and trying to

find ways that they can report and get support without—either anonymously or ensure that they go through the system? Yes, we are. So I think we're engaged in this. We're taking it seriously. I personally definitely do not believe that there is any attempts to cover this up or any huge hidden situation with us, but it's not my area of expertise and I don't want to——

Senator MURRAY. Dr. Barrick, do you want to comment.

Dr. BARRICK. Yes, in the Navy there was a considerable amount, more so than other places, of sexual assault. Over the years that I worked in that system, the attitudes began to change as the programs were implemented to address it. But it's still kind of like institutional racism, there is institutional sex that still is operating where people deny it and will not respond to it. And people are afraid to come forward because they believe they'll only be traumatized again by a system that doesn't want to hear it or will not believe them honestly. So great inroads in have been made, and the service of that I do believe we are making progress, but we need to continue to emphasize that.

Senator MURRAY. We are way over time, unfortunately we have to end now. I will have some questions for our panelists that I will submit to you and ask for your response in writing. I want to again thank all of our panelists who appeared today and participated. I know some of my questions were rather sharp, but I think we have to really find the answers to this. My job and the job of Congress is to provide the resources and the right policies, and by asking the questions we can get to that.

I want to thank all of our panelists who were here today. I want to thank all of our staff, my staff members who spent an incredible amount of time putting this together as well as our staff from the Veterans' Affairs Committee who have been here today. To the veterans again, I have a number of staff members here. There are a number of professionals here.

If you are here with an issue that you are trying to work your way through and need help, we have a lot of people around the room that are willing to help you from all of the different agencies as well as my staff, and I want to thank everybody who has come today to be a part of this and to voice your issues as well. We do have comment piece for any of you who did not have a chance obviously to speak out today, but again, thank you very, very much for your input and we will take that back to Washington, DC, to all of my colleagues.

This now ends this session.

[Whereupon at 1:45 p.m., the Committee adjourned.)

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