

S. HRG. 110-738

**VA AND DOD COOPERATION AND COLLABORA-
TION: CARING FOR THE FAMILIES OF WOUND-
ED WARRIORS**

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

MARCH 11, 2008

Printed for the use of the Committee on Veterans' Affairs



Available via the World Wide Web: *<http://www.access.gpo.gov/congress/senate>*

U.S. GOVERNMENT PRINTING OFFICE

41-917 PDF

WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON VETERANS' AFFAIRS

DANIEL K. AKAKA, Hawaii, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia

PATTY MURRAY, Washington

BARACK OBAMA, Illinois

BERNARD SANDERS, (I) Vermont

SHERROD BROWN, Ohio

JIM WEBB, Virginia

JON TESTER, Montana

RICHARD BURR, North Carolina, *Ranking
Member*

ARLEN SPECTER, Pennsylvania

LARRY E. CRAIG, Idaho

KAY BAILEY HUTCHISON, Texas

LINDSEY O. GRAHAM, South Carolina

JOHNNY ISAKSON, Georgia

ROGER F. WICKER, Mississippi

WILLIAM E. BREW, *Staff Director*

LUPE WISSEL, *Republican Staff Director*

C O N T E N T S

MARCH 11, 2008

SENATORS

	Page
Akaka, Hon. Daniel K., Chairman, U.S. Senator from Hawaii	1
Burr, Hon. Richard, Ranking Member, U.S. Senator from North Carolina	2
Murray, Hon. Patty, U.S. Senator from Washington	3
Brown, Hon. Sherrod, U.S. Senator from Ohio	4
Sanders, Hon. Bernard, U.S. Senator from Vermont	5

WITNESSES

Bunce, Col. Peter, USAF (Ret.), Father of Justin Bunce, OIF Veteran	6
Prepared statement	9
Verbeke, Robert, Father of Daniel Verbeke, OIF Veteran	12
Prepared statement	15
McMichael, Jackie, Wife of Michael McMichael, OIF Veteran	20
Prepared statement	22
Davis, Lynda C., Ph.D., Deputy Assistant Secretary of the Navy for Military Personnel Policy, U.S. Department of the Navy	35
Prepared statement (combined with Ms. Day)	38
Response to written questions submitted by Hon. Bernard Sanders	46
Day, Kristin, LCSW, Chief Consultant, Care Management and Social Work, Office of Patient Care Services, Veterans Health Administration, U.S. De- partment of Veterans Affairs	36
Prepared statement	38
Response to written questions submitted by:	
Hon. Daniel K. Akaka	48
Hon. Bernard Sanders	48
Response to questions arising during the hearing submitted by Hon. Richard Burr	60
Dulin, Jane, LCSW, Supervisor, Soldier Family Management Branch, U.S. Army Wounded Warrior Program	49
Prepared statement	51
Sayers, Steven L., Ph.D., Clinical Psychologist, Philadelphia VA Medical Cen- ter, and Assistant Professor of Psychology in Psychiatry and Medicine, University of Pennsylvania School of Medicine	53
Prepared statement	54
Response to written questions submitted by Hon. Daniel K. Akaka	55

APPENDIX

Phillips, Suzanne B., Psy.D., ABPP, CGP on behalf of the American Group Psychotherapy Association; prepared statement	65
Kerr, Pat Rowe, State Veterans Ombudsman, Director, Operation Outreach, Missouri Veterans Commission; prepared statement	73
The National Military Family Association, Inc.; prepared statement	78
Beard, Elisabeth, Mother of Army Specialist Bradley S. Beard; prepared statement	84
Henderson, Kristin, Military Spouse, Journalist; prepared statement	87

VA AND DOD COOPERATION AND COLLABORATION: CARING FOR THE FAMILIES OF WOUNDED WARRIORS

TUESDAY, MARCH 11, 2008

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 10:02 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Sanders, and Burr.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. Good morning. Aloha and welcome to all of you to today's hearing. This hearing will be in order.

One tragic effect of the ongoing wars in Iraq and Afghanistan is the toll on the servicemembers and their families. This toll will be felt for years, without any question, or entire lifetimes to come. We know that lives are disrupted, lifelong plans put on hold, and families damaged as veterans struggle to deal with their service-connected wounds.

This morning, we will hear from the fathers of two severely wounded warriors and veterans who suffered Traumatic Brain Injuries. Sadly, these parents have stories of unfulfilled expectations. They are working with a system that is often too slow to respond. They were forced to look for help elsewhere when VA failed them. Their sons are part of a relatively small group of veterans suffering from TBI. It is outrageous that they continue to face these challenges with the VA system. At this point it is not an issue of funding, it is an issue of priority and focus, and this is truly unacceptable.

Parents should not have to fight VA to ensure their children receive the therapy and care they earned and need. Spouses should have access to the tools and professional help that would hold their families together in these most trying times. I am hopeful that our second panel will be able to shed some light on the solutions to these problems.

There has been much attention placed on improving the disability process for those with injuries sustained in battle. As a Committee, we have also studied TBI and mental health programs that provide services directly to veterans. Today, our focus is on the burden of families of the veterans. The fathers, mothers, and

spouses of those who have sustained serious injury have already given so much. They cannot and should not be caring for veterans all by themselves.

In closing, VA must recognize that family support is an integral part of its mission. VA must overcome obstacles stopping it from incorporating family members into the care, rehabilitation, and recovery process. To paraphrase President Lincoln, we have an obligation to help those families who have borne the burden of the battle.

A special thanks to our witnesses, especially those who are here to share personal stories. We are deeply in your debt and we thank you for the service and sacrifices you and your loved ones have made for our great country.

In the interest of time, I will stop here and turn to Committee Members, of course, beginning with our Ranking Member, Senator Richard Burr, for his opening remarks.

Senator Burr?

**STATEMENT OF HON. RICHARD BURR, RANKING MEMBER,
U.S. SENATOR FROM NORTH CAROLINA**

Senator BURR. Thank you, Mr. Chairman, and aloha.
Chairman AKAKA. Aloha.

Senator BURR. Colonel, it is awfully good to see you again since our House days. Welcome, and I am sorry it is under these circumstances. Mr. Verbeke, thank you for your testimony, and Ms. McMichael, thank you. It is indeed an honor to have—I am proud to have—a North Carolinian here before us today. I thank you for your willingness to share what is a very difficult family story with the Committee this morning.

Jackie, your personal perspective is one of the loving wife. We will also hear the perspective of two fathers. Your stories will help us understand that being a father or mother or husband or wife in addition to being primary caregiver to an injured servicemember can be an unbelievable challenge. It is also a critical need.

If there is a common theme that I see in the first panel's testimony today, it is this: we can help families most by providing quick, hassle-free, and quality services to their loved ones.

We are about to hear three different stories of how that didn't happen, how there was a breakdown in the system, and how accountability was lacking or nonexistent. Congress has been wrestling with how best to ensure the seamless transition of the severely wounded from active duty to veteran status since this war began. Although I do believe we have made progress, the testimony today is a reminder that we still have a tremendous amount of work to do.

Families play such a crucial role in the recovery process of our wounded warriors that it is important to provide them with the proper support. As the old saying goes, and I quote, "A family in harmony will prosper in everything," unquote. We should always remember that if a spouse or a parent is feeling stressed, or if finances have caused a strain on the family, then that may negatively impact the recovery and rehabilitation of our servicemembers.

I would like to conclude with one final point, Mr. Chairman. We spend a lot of resources trying to provide the highest level of care and benefits for our injured servicemembers, veterans, and their families. In fact, we are approaching almost \$150 billion in combined VA and Department of Defense programs to help these service personnel. I highlight this to suggest that the challenges facing many veterans and family members today have as much to do with confusing bureaucratic programs operated by many different offices of the Federal Government as they do with the lack of benefit programs or the lack of resources. I don't think there is one Member of Congress who would hesitate to provide injured servicemembers and their families with every potential resource they need, but I expect and I know these families expect that these resources will be used effectively to treat their loved ones.

Quite frankly, to summarize, we must do better, period, end of sentence. I thank the Chair for convening this hearing today, and more importantly for the tremendous outreach to our witnesses today, and I welcome them once again. I yield the floor.

Chairman AKAKA. Thank you very much, Senator Burr.
Now we will hear from Senator Murray.

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

Senator MURRAY. Thank you very much, Chairman Akaka, for holding today's hearing to talk about how the VA and the DOD are working together to care for the families of our wounded warriors. I thank you and Senator Burr for holding this important hearing. I want to thank all of our witnesses for coming and sharing their personal stories with us to help us understand the true impacts of the decisions that we make here. So, thank you very much to all of you.

Mr. Chairman, it was actually Abraham Lincoln, our 16th President, who said you cannot escape the responsibility of tomorrow by evading it today. Well, there is mounting and indisputable evidence about the tremendous toll this conflict has taken on both our men and women in uniform and it has become even more evident that their families have been and will continue to pay a very high price for the service of their loved ones. We cannot afford to be complacent. The stakes are very high, and if we don't confront this issue today, many of our veterans' families are going to suffer tomorrow and many tomorrows to come.

Studies in medical literature continue to document the detrimental effects of this conflict on our warriors' families. I have personally heard, as I know everyone has, many stories from family members who are unable to cope with both the physical and mental wounds of their loved ones and who don't feel they have the adequate resources or support to give to those who have given so much to all of us.

But don't just take our words for it. Listen to the Commandant of the Marine Corps, General Conway, who said last week when he testified in front of the Senate Appropriations Subcommittee on Defense. He said, "We do have a significant issue with our families. Simply put, they are proud of their contributions to this war, but they are tired. We owe it to those families to put our family service

programs onto a wartime footing. For too long, our programs have been borne on the backs of volunteers, acceptable perhaps during peacetime, but untenable during a protracted conflict.” These are the words of the Commandant of the Marine Corps.

Mr. Chairman, when our heroes go off to fight, so do their families. This conflict has torn at the very fabric of our American families and we have to realize that protecting and providing for the families of our men and women in uniform is not only good policy, it is the right thing to do. We as a country owe it to them to make sure we do everything to make the transition of their loved ones to civilian life as smooth as possible, and that we provide every available resource to their families for the physical and mental wounds they incurred as a result of their service.

Unfortunately, today, that is not happening and too many families don’t have the resources they need; and far too many families aren’t even aware of the resources that exist. So, it is clear that the VA and DOD must not only make our veteran and active duty servicemember families a priority, but we have got to improve outreach so these families have every resource that is available to them to care for their loved ones.

So, Mr. Chairman, I very much look forward to hearing this and I want to thank our first panel, especially, for being here to share your personal stories with all of us. Thank you.

Chairman AKAKA. Thank you very much, Senator Murray.

Now we will hear from Senator Brown.

**STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO**

Senator BROWN. Thank you, Mr. Chairman. Thank you for having this hearing, and Ranking Member Burr and Senator Murray.

In the last year or so, I have conducted about 85 or 90 roundtables around the State of Ohio to hear people’s concerns about a whole host of issues and several of them have been with veterans, some of them just returning from Iraq or Afghanistan, others veterans from other wars. At the Louis Stokes VA Medical Center in Cleveland, I heard firsthand the challenges faced by families caring for recently returned veterans.

A woman in her 30’s spoke about her difficulties in finding child care for two young sons and getting time to take off work to drive her husband 2 hours to get the treatment he needs from the VA. She spoke about the challenges they face together in coping with simple everyday tasks. Her husband suffers from PTSD and TBI and he has had tremendous difficulty remembering things. When a car backfires, it sends him into a severe panic. He has all kinds of problems, obviously, he didn’t have before his service in Iraq.

These families—listening to her and her husband with her—obviously make tremendous sacrifices. We must work to ensure they get the assistance they deserve.

DOD and the Department of Veterans Affairs’ cooperation in this effort is imperative. I think we have seen progress in the last year from when we started, at least when I as a new member of the Senate, then began to be part of these discussions—with resource sharing, with collaboration, with information sharing between the two Departments and how important that is.

Also, I want to make sure that as DOD and Veterans Affairs moves forward, our men and women serving in the Guard and Reserve and their families have equal access to support necessary transition assistance. As part of the Ohio National Guard's Family Readiness Program, Ohio serves as one of 15 States currently participating in the Joint Family Support Assistance Program. The purpose of this program is to connect all branches of service—active duty, Guard, Reserve—and military families with each other and with any support and resources they need from deployment to reintegration. We must make sure that no soldier or no family falls through the cracks and this type of collaboration and inclusion is an important first step.

I thank the Chairman. I especially thank the two panels that will testify today. Thank you.

Chairman AKAKA. Thank you very much, Senator Brown.
And now we will hear from Senator Sanders.

**STATEMENT OF HON. BERNARD SANDERS,
U.S. SENATOR FROM VERMONT**

Senator SANDERS. We want to thank the families very much for coming.

I think there is no disagreement that this country is going to be looking at some very, very serious problems in terms of those who are returning from Iraq and Afghanistan. The situation in Vietnam was bad, but all of the studies suggest that the situation from Iraq is going to be a lot worse. And it is absolutely imperative that we do everything that we can to help those soldiers who are coming back to reintegrate them with their families and their communities.

Mr. Chairman, all that I will do is just make one point right now. I will tell you what we are doing in Vermont, which might be of national interest. There are two issues, and that is, number 1, making sure that we have the best treatment available for the soldiers. But, the second point, equally important, is that we make sure that we get those soldiers and their families to the treatment, because you can have great treatment, but if people don't know about the treatment or feel uncomfortable about gaining access to that treatment, it is not going to do anybody any good.

What we have tried to do in Vermont, and maybe you will discuss this later on, is develop a strong outreach program made up of veterans themselves who are doing it in an out-of-the-box, informal way. In other words, one of the symptoms of Post Traumatic Stress Disorder is that people are not particularly delighted to jump up and say, "I have a problem." That is one of the symptoms. And what we have felt is that if veterans can go out in informal settings, knocking on doors, just talking to people and say, look, how are things going. And, if they can pick up something and just calmly explain to people that what they are experiencing is being experienced by tens of thousands of people, it is not abnormal, that it is OK to come in, that it is OK to understand that if you and your wife are not getting along, you are having problems with your kids, you are having problems on the job, you are drinking too much, that is going on with a lot of people and that you can come in and there is help available.

So, I think there are two issues. We want to make sure that we have the counselors or therapists, all of the help that we need, but we want to make sure that we create a path by which people can access that help. So, that is what we are trying to do in Vermont. We have a little bit of money for a national program, as well. But getting soldiers and their families—their families, and their kids—to the help that they need seems to me terribly important.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Sanders.

I welcome the first panel. We have asked each of you to share with us your experiences. It is ironic that by being here, you have to interrupt your lives, which have already been so terribly disrupted by the sacrifices of your loved ones. But hopefully, through your contributions, we will be able to reduce the toll that military service families have. I welcome your views on how the military and VA can strengthen and improve the support provided to the families of seriously wounded.

First, I welcome Colonel, Retired, Peter Bunce. Colonel Bunce is the father of Justin, a Marine who served in Iraq and suffered a Traumatic Brain Injury. Justin is currently receiving care from the Washington VA Medical Center.

I also welcome Robert Verbeke. Mr. Verbeke is the father of Daniel, a Navy Seaman who suffered a Traumatic Brain Injury and other injuries while serving aboard the U.S.S. Theodore Roosevelt in support of the ground forces in Iraq.

And finally, I welcome Jackie McMichael, the wife of a disabled OIF veteran, who is receiving counseling from a North Carolina Vet Center. Her husband, Michael, was also injured while serving in Iraq.

I would also like to recognize the spouses of our witnesses who are so much a part of this story. Patty Bunce, will you raise your hand? Thank you, Patty. Katherine Verbeke? Thank you, Katherine. And Michael McMichael? Thank you, Michael.

I thank all of you for being here. Please accept my deepest thanks for the service and sacrifice of your loved ones. We hope that your testimony will lead to more effective programs for families. Your full statements will appear in the record of the Committee.

Colonel Bunce, will you please begin with your statement.

**STATEMENT OF COL. PETER BUNCE (USAF, RET.),
FATHER OF JUSTIN BUNCE, OIF VETERAN**

Col. BUNCE. Chairman Akaka, Senator Burr, other Members of the Committee, and, of course, your combined staff, thank you so much for the opportunity to come here and testify before you today. Thank you for holding this hearing.

There are several issues that need to be dealt with in the VA and being able to shed light on the situation that the families are experiencing with the VA, I think will go a long way to be able to at least let them know what is happening and some perspectives that are out there.

I am the father of a Marine that was wounded on his second combat tour over in Iraq. He was up on the Syrian border. There was an improvised explosive device imbedded in a cemetery wall,

and as the patrol went by, it exploded. The shrapnel wounds on the right side of his body were fairly severe, but the worst of which was it took out his right eye and shrapnel went through the front part of his brain and still resides in the left part of the frontal lobe.

The result of that is after everything else healed, he has some behavioral issues and significant short-term memory problems. The behavioral issues are common for those that have that type of brain injury.

During the course of his rehabilitation—now it has been about 4 years—he has been through a number of military hospitals, some contracted civilian care from the Veterans Administration, or actually from the Department of Defense, and then also he receives treatment now, as you said, from the VA hospital that is just located four miles north of here.

He was discharged from the United States Marine Corps in July of 2006, so we have had about a year and one-half or so out into the VA system. During the course of his treatment at the VA, he received physical therapy, also occupational therapy, and speech therapy that worked on cognitive skills, but after about a year they had run their course and the Veterans Administration hospital said, basically, we have given him all that we can give to him.

That is at the time where I said, I am not going to have my son sit at home doing nothing. I tried to look for other resources out there, and finally I had some very good friends that said, well, we will try to hire him downtown here in D.C. and see what he can do. So I took the VA up on their promise to provide for a job coach for him to be able to go and sit with him for a transition for about the first 2 weeks and then I came to realize that the VA promised it, but didn't really know how to deliver it. So, they turned, or they actually said, we can't provide this. Let us see if there is someone else who can. And that is how I stumbled on the resources that are provided by the State of Virginia by the Department of Rehabilitative Services.

Once I got into that system, they quickly assessed my son and said he is definitely not ready to even attempt to start work because of the behavioral issues. Then, they basically said, we have a whole network out there of things that we can go ahead and help your son with, and one of the first things that seemed most promising is there was a facility built during World War II for just this purpose of rehabilitation down in the Shenandoah Valley, which I had never even heard of. The VA had not referred us to the Woodrow Wilson Rehabilitative Center or any of the other services. There is a clubhouse program in Virginia called the ADAPT Program. There is a program down in Richmond called the Tree of Life.

But I was simply astonished that the VA did not know about these programs or did not refer us to them, and that is where I think one of the most glaring deficiencies that we have found with the VA right now is, and that is the lack of case management. As soon as we were referred to the State resources, the first thing that the case managers at the State did was say, let me come out to your home and let me see the environment that your son lives in. That was never, ever asked for by the VA. There is no case man-

agement. The most that they have done for us is coordinate appointments.

We have continually asked at this VA hospital just to get a single doctor to sit down and look at all the medications that our son is on to be able to evaluate how they interact because they are prescribed by different departments. The VA is very stovepiped and there is not a single doctor in charge. We found that to be true up at Bethesda, as my son was at the bow wave of the first folks coming back with these IED injuries—the signature wound of the war, Traumatic Brain Injury—but Bethesda quickly realized that they needed to put one person in charge that the family could go to to be able to say, OK, what is happening with the care of my son? Everything was fed into that doctor. The VA is unwilling to go that route.

What that stovepipe does is, it basically causes a tremendous amount of frustration for the family, because you truly do not know where to go a lot of times to be able to coordinate the care. What you get is you get a bunch of cards, business cards, handed to you by multiple doctors. There is no flow chart to say, if you have got this problem, this is where you go. There is no wiring diagram to be able to tell you how the hospital is structured. And there is not even a consolidated list of who is on your son or your daughter's care team to be able to go to. Those are simple changes that could easily be implemented until they get the system up and running, which you all in Congress have pushed for, which is to get an adequate system of case management.

Another issue, though, that I think is extremely important is there is a reluctance on the VA to go ahead and tap into the resources that are available at the State and community level. For some reason, there is an institutional feeling that if we do that, that the VA may be threatened or budgets may be threatened or that the building of the bureaucracy would be threatened. But, there is tremendous expertise out there in America for people with brain injuries. Auto accidents, snowmobile accidents, motorcycle accidents—they all cause brain injury, and all this expertise is out there and so many of the State people and some of the nonprofits that are out there dealing with brain injury have come to me and said, how do I get word to the VA that our services are available? They want to be involved. They want to lend their expertise. But the VA is unwilling or unknowing to be able to tap into those resources.

When you are involved in the VA system, that is where you go and you start to build the frustration and realize very quickly that they are not built to be able to help folks with brain injury in the current form that they are set up.

In the VA Hospital here in Washington, DC, we deal with a much older crowd—a lot of Vietnam veterans—but as you start to deal with brain injury, the expertise has not been built there.

Now, there is going to be a Center of Excellence built up at Bethesda that we know the Navy is working on. We are hoping that the VA will be able to feed in. But until that is all built, it doesn't make any sense to have these veterans in a gap, in a void of service, and that is where contracting, the fee-for-service, or the work with HEALTHNET and TRICARE and the overlapping coverage

that the Congress just provided in the recent DOD Authorization Act is very critical to be able to access those resources. And if the VA could get into a system where they know what resources are out there and how they quickly can access that, that will help the families tremendously.

So thank you, Senator. I appreciate the opportunity and I await your questions.

[The prepared statement of Col. Bunce follows:]

PREPARED STATEMENT OF PETER J. BUNCE, COLONEL USAF (RET.),
FATHER OF CPL. JUSTIN BUNCE, USMC

Chairman Akaka, Senator Burr and Members of the Committee, Thank you for the opportunity to testify before you today regarding an issue of great importance to family members and caregivers of severely wounded warriors: transitioning from active duty military to veterans status and the support provided by the department of defense (DOD) and Veterans' Administration (VA) to those providing care to our servicemen and women who are not able to adequately help themselves.

I am here today as the father of Corporal Justin Bunce, USMC (medically retired) who was severely wounded by an improvised explosive device during his second combat tour in Iraq on March 19, 2004. Rapid helicopter transfer from the battlefield in Anbar Province to a Baghdad field hospital facilitated lifesaving brain and wound surgery. Justin lost his right eye in the blast and shrapnel entered his skull just above that eye and passed through the front of his brain, penetrating the frontal lobe. The effects of this brain injury are a significant loss of short-term memory and behavioral issues commonly associated with assault to the left frontal lobe. During his rehabilitation, Justin was dealt another setback when a car accident further exacerbated the brain injury. Justin's acute and rehabilitative care while still on active duty, took him through three military hospitals, two civilian hospitals and a DOD contracted civilian therapy center.

Upon his medical discharge from the Marine Corps in July of 2006 and before his "not-so-seamless" transition into the VA system could take place, Justin had to be placed in a nursing home at our family's expense until we could purchase a home that could accommodate his physical medical needs. Justin currently lives with us and receives the majority of his medical treatment at the VA hospital in Washington, DC. However, due to the inadequacies of the VA's ability to provide tailored and consistent Traumatic Brain Injury (TBI) therapy, case management, or even basic transportation to and from the hospital, we have become ever more reliant on State and community-based brain injury resources to facilitate continued rehabilitative care.

It is with a 4-year perspective of working with the bureaucracies of DOD, TRICARE, Veterans' Administration, Social Security Administration as well as State and community-based agencies, that I address the Committee today, hopeful that in the coming years, more tailored care will be available for warriors with TBI.

UNIQUE REQUIREMENTS OF TBI CARE

Called the "signature wound" of the Global War on Terror, Traumatic Brain Injury often requires years of both in-patient and out-patient rehabilitation, regardless of the severity of the injury. In addition, the effects of TBI are felt not only by the individual suffering from the injury, but also by their family caregivers who are often left to manage a great percentage of each facet of the servicemember's/veteran's daily adult life.

As the Members of the Committee are well aware, no two brain injuries are the same, but as medical science continues to discover and explore the plasticity of the brain and its' ability to "rewire" itself, the benefits of consistent and focused rehabilitative therapy cannot be underestimated. One of the most publicized examples of these benefits can be seen in the remarkable progress that Bob Woodruff of ABC News has made when his acute military care was augmented by constant and concentrated therapy from civilian brain injury experts. Although each brain injury requires individually adaptive treatment, what is unquestionably a significant common factor about the care and therapy for TBI is that family members or caregivers for the injured have to take on a much more complex and involved role than is found with many other war related injuries, because the majority of servicemembers or veterans are not capable of managing their own care. Brain injured people often cannot remember appointments, accurately report ailments and afflictions, keep track of the day of the week or the last time they took medications. They often can-

not arrange their own transportation, or even navigate to appointment locations within a treatment or therapy facility. TBI afflicted warriors often receive a daunting flow of paperwork from the VA that must be attended to by the caregiver. Because many of these veterans are incapable of handling their personal and financial affairs, considerable time must be spent by a caregiver attending to bills, medical statements, insurance, appointment management, transportation arrangements as well as the securing and administration of large quantities of medications.

The day-to-day challenges of dealing with a loved one who has brain damage are truly daunting. The multitude of bureaucratic hoops that families are expected to jump through for services, can be the breaking point for that veteran's support system. Most families who are dealing with a veteran with TBI also have demands and responsibilities elsewhere. They often have other family members who need their attention and energy. They must hold down full time jobs and manage households. The stress of dealing with the TBI afflicted veteran cannot be understated. Without clear direction and support for both the veteran and the family, it is unrealistic to expect the best long-term outcome for the TBI veteran.

VA SUPPORT TO FAMILIES/CAREGIVERS DEALING WITH THE CHALLENGES OF A TBI VETERAN

Although there are multiple issues that the veteran with TBI and their families have to deal with, one glaring deficiency within the VA system that routinely haunts caregivers is the VA's inability to answer this question: who is the point person in charge of the veteran's case? More specifically, which professional will help the caregiver navigate this complex bureaucratic system, which professional will know how to direct the caregiver as issues arise, which professional can they call in an emergency or at points of high stress? In short, to whom can the caregiver turn to throughout the journey that few, if any, families are prepared for? A journey that is extremely complicated, emotionally charged, and far more taxing than one could ever anticipate.

Despite all the repeated promises from the VA and attention paid by Congress to providing competent case management, the extent of my family's coordinated care assistance at the Washington VA Medical Center has only been appointment scheduling. Case management has been the sole responsibility of my family. We have had to navigate ourselves through the stove-piped departmental nature of care at the VA. We have been the ones, not VA personnel, to make trips to other VA hospitals in Tampa and Milwaukee to bring back best practices for TBI therapeutic care to our local VA hospital that is ironically located in the heart of our Nation's capitol just a few miles from the Veterans' Administration headquarters. We have had to stumble onto the extensive network of brain injury expertise that resides at the State and local level that our VA hospital staff wasn't even aware of or had any knowledge of how to tap into. We have had to introduce specialists at our VA hospital in DC to the use of adaptive devices employed at other VA hospitals and push them to secure contracts with local vendors so that our son could have access to the equipment. Despite repeated requests over the past 15 months, we have yet to be directed to a medical professional at our VA hospital that will review all the medications prescribed by the various medical departments and evaluate dosages and how the medications are interacting. If a true case manager existed at our local VA, one that functioned liked the experienced professionals we have found at the State brain injury services level, the VA case manager could be of tremendous value in alleviating the all too common frustration associated with the VA communication maze, the complicated medical issues and the emotional demands that families are bound to encounter as they experience recovery and rehabilitation for their brain injured veteran.

In our experience, the VA is extremely reluctant to utilize fee-for-service to tap into the extensive network of brain injury services at the State and community level. The attitude seems to be that if adequate brain injury services are not available at a VA hospital, then accessing local services threatens the institution and/or VA funding and must be avoided. Consequently, while the VA struggles to "reinvent the wheel" of brain injury care and slowly and methodically attempts to build their own expertise, veterans needing experienced care are left in a void. Because the VA has very little knowledge or motivation to investigate what is available at the State and community level for brain injury care, it is left up to the families to discover these services on their own. In our case, the way we discovered the Virginia Department of Rehabilitative Services, the Woodrow Wilson Rehabilitation Hospital in the Shenandoah Valley, the ADAPT Clubhouse Program in Alexandria, the Tree of Life therapy center in Richmond and the extensive expertise of the private non-

profit Brain Injury Services, Inc., was purely by accident, without any referral from our VA hospital.

SUGGESTED IMPROVEMENT IN CARE FOR TBI AFFLICTED VETERANS
AND THEIR CAREGIVERS

While the Veterans' Administration creates the infrastructure to deal with long term nature of proper care and therapy for brain injured veterans, there are simple changes that could be easily implemented in the near term that can be immensely helpful to families. A wiring diagram detailing the responsibilities of the different VA team members in the various medical departments that delineates their respective roles in rehabilitation, therapy and medical care would be extremely helpful.

One source document with all of the team member's phone numbers and the various departmental extensions should be provided to each family. A fistful of business cards does not suffice when families are overwhelmed with day to day recovery, therapeutic, medical, and emotional issues. A flow chart should be created that allows a family to track where to initiate the process for appointments, referrals, access to fee for outside medical/therapy service, financial, insurance and legal assistance. If and when proper case management becomes a reality at the VA, family members should be relieved of the responsibility for locating and initiating care. However, until true case managers are in place, a flow chart is an imperative.

The VA must research, have a clear understanding of, and then communicate to family members/caregivers what outside services TRICARE and/or the VA's fee-for-service program will or will not cover for a TBI veteran seeking outside therapy and care. Particularly given the new overlapping coverage between the DOD, TRICARE and the VA provided by Congress in the recent DOD Authorization Act, it is essential that the VA not require families to interpret the provisions and rules applying to outside care on their own.

Therapeutically speaking—whether occupational, physical, cognitive or speech—the family/caregivers need to be more active participants in both short and long term goal setting. It is common knowledge and common sense that when people are stakeholders in any process the outcome is better. Therefore, active program participation on the part of the injured veteran and their support system needs to be increased. VA medical professionals must break out of the mindset that they can inform a brain injured veteran about follow-on care instructions, home exercise routines, or future appointments and the veteran will remember what was said to him or her. A system must be instituted where a designated family member/caregiver is immediately informed through the telephone or e-mail whenever instructions or appointments for a brain injured veteran are passed.

Team meetings that include the veteran and their family members should be held initially and then augmented with regular follow-up meetings throughout the veteran's programming to facilitate communication, common goal setting and better understanding of the needs of both the veteran and the family. If functional outcomes and environmental independence are priority goals for the brain injured veteran, then it is imperative that home visits are a part of each therapist's treatment responsibilities. How else can each therapist accurately assess the veteran's environmental and functional needs outside of the clinical setting of the VA? Returning to and gaining the highest level of independent function should logically be the goal for each TBI veteran. If returning to the home environment as independently functioning as possible is the ultimate goal, then all of the team therapists need to be knowledgeable about the nuances, both physical and emotional, that the veteran with TBI is dealing with in their living environment. Simply stated, a comprehensive and supportive rehabilitative and therapeutic program can only be created when the VA health care professionals have first hand knowledge about the home environment surrounding where that veteran is living.

Most of the VA brain injury evaluations and assessments conducted on our son Justin have relied on his own personal reporting. Throughout the process of rehabilitation, Justin's report on his own condition, both past and current, has often been taken as fact and recorded as such. As a result of his extensive brain injuries, fact and fiction are often mixed and when coupled with a distorted sense of time, the result is an inaccurate reality. Therefore, if conclusive recommendations and treatment options are based on a TBI veteran's self-reporting, the result will be less than accurate and ultimately less effective. Confirmation of information from reliable sources such as family members and caregivers is vital to verifying the accuracy of information that becomes a part of that veteran's permanent file and is integral to his or her treatment plan.

Finally, the belief by some that either DOD or each and every VA hospital must create a center of excellence for brain injury must be carefully weighed and evalu-

ated against the availability and expertise with brain injury that exists at the State and community level. There is virtually no hope that a brain injured servicemember or veteran will ever return to active duty. Therefore, does it make sense to surround them during their rehabilitation with the military culture? If the goal is to reintegrate the brain injured warrior into civilian society as rapidly as possible then it is only logical to contract for services wherever local experience and expertise already exists. In our son's case, we believe that continued exposure to the language, habits and behavior that is commonplace in the military and within the veterans' administration hospital environment that is clearly not acceptable in the civilian workplace, actually hampers and delays his ability to reintegrate with civilian society. It is my opinion that when brain injury expertise exists at the State and community level, the VA should do all it can to contract for that expertise rather than attempt the long process of creating in-house brain injury expertise.

SUMMARY

Over the past 4 years, my wife and I have attempted to provide the best rehabilitative care for our son and pass on our "lessons learned" to the families of those heroes like him suffering from TBI. During this process we have had to call on friends and call in favors from what we call our "legion of angels" on Capitol Hill, at TRICARE-HEALTHNET, in the military and at the VA to work the system for us to get the care our son needs. We also have utilized our own financial resources to make the right things happen for Justin. We have the blessings and good fortune of being able to call upon these resources to help our son, but we are not representative of the thousands of family members that cannot rely on "connections" and who are overwhelmed with the responsibility of caring for their loved ones with TBI. Waiting for the DOD or the VA to build the infrastructure to deal with TBI while simple standard operating procedures can be established and local resources tapped into for TBI veteran care today, should be considered unacceptable. It is my hope that by drawing attention to support provided for families caring for our warriors with TBI, you will spur the VA into action.

Chairman Akaka, Senator Burr and Members of the Committee, thank you for the opportunity to testify before you today and I look forward to answering your questions.

Chairman AKAKA. Well, thank you very much, Colonel, for your remarks.

Now we will hear from Mr. Verbeke.

STATEMENT OF ROBERT VERBEKE, FATHER OF DANIEL VERBEKE, OIF VETERAN

Mr. VERBEKE. Mr. Chairman and Members of the Committee, thank you for this opportunity to testify. I appreciate your time and interest in my experience with the military and the VA, and my views on what can be strengthened and improved. My immediate thoughts upon receiving the invitation are that there are many areas of care and support that are severely lacking.

It is important to note that my needs for support are directly tied to my son's needs, that is, take care of Dan's needs and most of my needs will be met. Dan's experiences are my experiences.

My son was injured on December 5, 2005, during combat operations in Operation Iraqi Freedom. He sustained critical and life-altering injuries, which included a head injury, collapsed lung, fractured vertebrae and fractured ribs. Dan has progressed with the healing of his physical wounds, but suffers from severe TBI. He has steadily improved over the course of the past 27 months. He does not have functional use of his arms or legs. He cannot eat, drink, or speak, though he has begun to vocalize basic words. He is able to express emotions of anger, sadness, and to laugh. He attempts to use his left hand to help brush his teeth and shave. He communicates very reliably through eye movements and blinking and he has a great smile.

Immediately after Dan's injury, he was flown to Kuwait and moved to Balaad in Iraq. In Balaad, there was a craniotomy performed on him. From Balaad, he was moved to Landstuhl and placed in a German hospital. From there, he was then medevaced to Bethesda, and after a four or 5-week stay in Bethesda was moved to the Richmond VA Medical Center.

My experiences with the military have been superb. Dan has received a tremendous amount of ongoing support from his shipmates. There are numerous visits and interactions, and in each case they perk him up. He really enjoys being with his shipmates.

But, I have to say, my experiences with the treatment at the Richmond VA Medical Center cannot be characterized as good. In fact, they are not good at all. For the most part, the people who treated Dan were very nice and caring people that I became acquainted with in my 4-month stay with them. But, what I learned immediately upon leaving there, however, was they didn't know what they didn't know. And that is: their skills, capabilities, resources, staffing, treatments, therapies, and therapy techniques all fell extremely short of what we experienced at the Bryn Mawr Rehabilitation Hospital.

I have to say that my decision to move my son from VA care was the best decision I have ever made for him. The medical treatment that Dan received after we moved from the VA center to the private sector also dramatically changed. Immediately after entering the Bryn Mawr Rehabilitation Center, my son was treated by numerous specialists. The specialists that treated him treated him because he needed that level of care.

Just a couple of quick examples. One, there was an open wound on his foot for 5 months in the VA center. In private care, they solved that problem and healed it in less than a month.

Very shortly after moving Dan to Bryn Mawr Rehab, he was seen by a physician that specializes in tone management. Tone is the elasticity or tension of Dan's muscles. His injury resulted in tone problems, that is, certain parts of his body muscles tightened up and would not move freely. I clearly remember the physician's words when he first saw Dan. His words were, "Who did this to him?" That physician is also a member of the Armed Forces and has served in Iraq. He was angry at how my son had been treated.

The Richmond VA Medical Center quickly scaled down Dan's therapy and for some disciplines discontinued it altogether. They stopped therapy at a time where therapy and stimulation were most important to him. Candidly, my conclusion is they didn't know how or what to do to really help my son. They didn't know what they didn't know.

In September of 2006, Dan's neurologist and rehabilitation doctor advised me that we should begin to consider moving Dan home. Therapists from the rehab evaluated our home and began to make architectural plans for modifications based on the recommendations. About that same time, I raised my concerns of moving Dan from the rehab with Congressman Jim Gerlach's office. I subsequently met with another VA representative in November of 2006. During this meeting, I explained my concerns and desires for my son. The VA representative listened and suggested he take me on a tour of the Coatesville VA Hospital. I agreed and he proceeded

to take me there and showed me a ward where Dan would be placed. He wanted to place my son in a dementia ward. That is not what he needed and it indicates an appalling lack of understanding of TBI patient needs.

Also in March of 2007, we decided to proceed with the home modifications and requested approval of the VA Adaptive Housing Grant. The grant required Dan's name be placed on the deed of our home, and because we did not agree, we received a very limited sum of \$14,000. Construction began in May 2007 with VA knowledge of our plan and intent.

On October 15 of 2007, I advised the Philadelphia VA that it was my intention to move Dan home on November 20. I requested their assistance in funding Dan's required ongoing therapy and in providing the necessary supplies, medications, and assistance in the home. November 20 came and went and I did not have the supplies or medications, nor did I have a transition plan.

After applying regular pressure—I should say, after me applying regular pressure on the VA—I finally received the last of the initial supplies and medication items on February 21 of 2008. It took more than 4 months for me to receive these items. I have a process of reordering them, but the VA has no suitable plan for Dan to receive newly prescribed medications.

My experience with the Philadelphia VA is they are unresponsive. They ignore primary physicians' orders regarding in-home care and assistance. They are unable to provide newly prescribed medications. They are unable to establish and execute action plans and unwilling to fund his therapy needs. They are already backing off any type of long-term therapy commitment, which is contrary to what a TBI patient needs.

I almost forgot. I also learned from them one day that it is illegal for them to work past 4 p.m.

It is clear to me that the focus should be on what is best for Dan and his needs. His needs for medications, supplies, therapy, and everything else should be paramount in everyone's mind. Instead, the concern is where he can be shoehorned into the system and what an item or service or therapy will cost and whether the VA or TRICARE should fund the expense.

It should be noted that since leaving the Richmond VA Medical Center, all of Dan's costs for care have been funded by TRICARE, with Dan paying out-of-pocket costs for copays and shares.

I am dealing with VA personnel who have known for more than a year of our plans to move Dan home, as recommended by his physician and his neurologist. They have had a very long time to help and assist in this plan. In all honesty, I regret getting them involved. They have turned a very simple transition into a complete debacle.

I have worked for a major corporation for many years and fully understand the requirement to have policies, processes, and procedures that can be leveraged across organizations and businesses. But there are always the big deals that come along that require exceptions and actions that are not the norm. That is why the procedures and policies are there, to handle the norm and to recognize when exceptions are necessary. The exceptions require a program office approach with a person or persons who have responsibility

and authority to make very quick decisions and shifts in accountability. It results in the big deals moving quickly and smoothly.

Dan and others like him are big deals. They are the exceptions. There are not many who have been injured like my son. The VA can't cope with his needs and there is certainly no coordination within the VA departments and organizations. Complicate this with the inclusion of the private care element, TRICARE and Medicare, and the systems and processes break down immediately.

For more than a year, Dan's condition has been such that his neurologist and primary care physician believe it is best for him to be at home. To accomplish this required extensive modifications to our home and a huge out-of-pocket expense for the family.

The problems and experiences clearly point to major systemic issues of support that must be addressed. Dan is a big deal, but he is not alone. The problems are not unique. They demonstrate major gaps and breakdowns in the level of care and complete failure to support their unique needs.

My son and others like him served their country proudly. The focus must be on what they need. Instead, the VA has made and continues to make financial decisions. Those decisions are totally unacceptable, if we care about the health and life of my son and those like him. They are the big deals. They need a different level of care and attention. They need regular stimulation and appropriate therapies delivered by people experienced with this type of injury.

The level of care is complex and needs immediate dramatic change, but the issues we face are not. I constantly reinforced with the VA to do something for me—don't give me more to do. Yet they failed to understand. Give my son and those like him the in-home care they need: medication, nursing, ongoing therapy, stimulation, respite assistance, training, family compensation for caring for their injured loved ones, and relieve the huge family financial burdens. We shouldn't have to fight for these things, yet we do.

Remember, one of the VA's first responses was that Dan should be in a dementia ward. In a very recent communication, the VA insulted me with a statement that they expected family participation in his care. Just what did they think was going on? They really don't understand.

My belief is the best way is to help the families dramatically improve the care for the injured: stop scrimping on care costs. Provide ongoing assistance to the families in terms of helping them.

Thank you for allowing me the opportunity to share my experiences with the military and VA and my views on what can be strengthened and improved. I hope you understand my only concern and priority is Dan and his care. I am not alone. Each of these injuries is unique and demand flexibility in care, and cannot be served adequately with rigid processes and systems. The burden is placed entirely on the family because we don't trust the system to take care of our injured. Thank you.

[The prepared statement of Mr. Verbeke follows:]

PREPARED STATEMENT OF ROBERT VERBEKE, FATHER OF DANIEL VERBEKE

Mr. Chairman and Members of the Committee, Thank you for this opportunity to testify.

My son and I have a unique association with this Committee as Dan was born in 1983 in Illinois and we have been residents of the Commonwealth of Pennsylvania since 1988. We both have served in the U.S. Navy.

I appreciate your time and interest in my experiences with the military and the VA and my views on what can be strengthened or improved. My immediate thoughts upon receiving the invitation are that there are many areas of care and support that are severely lacking. It is important to note that my needs for support are directly tied to Dan's needs. That is, take care of Dan's needs and most of my needs will be met. Dan's experiences are my experiences.

My son, ABE3 Daniel R. Verbeke, was injured on December 5, 2005, during combat operations in Operation Iraqi Freedom while serving aboard the USS Theodore Roosevelt, CVN-71. Dan sustained critical and life-altering injuries, which included a head/brain injury, collapsed lung, fractured vertebrae and fractured ribs. Dan has progressed with the healing of his physical wounds but suffers from severe Traumatic Brain Injury (TBI). He has steadily improved over the course of the past twenty-seven (27) months. He does not have functional use of his arms or his legs; he cannot eat, drink or speak though he has begun to vocalize basic words "Hi," "Uh-Huh," "Yea" and most recently "No." He is able to express emotions of anger, sadness and he will laugh. He attempts to use his left hand to help in brushing his teeth and shaving. He is able to communicate very reliably through eye movements and blinking. Oh, he has a great smile too!

Immediately after Dan's injury he was flown to Kuwait and then moved to Balaad in Iraq. It was in Balaad where a craniotomy was performed that resulted in saving his life. Days later he was flown to Landstuhl and then immediately moved to a private German Hospital, as there were no neurosurgeons at Landstuhl. He then was moved to Bethesda NNMC and subsequently to the Richmond VAMC polytrauma unit. While at the Richmond VA location I became unsettled with the type and level of care my son was receiving. I subsequently removed him from VA care to a private care facility that specializes in and has years of experience in Traumatic Brain Injury Rehab. We soon learned that this decision was the best decision I have ever made for my son.

My experiences with the military have been superb. Dan has received a tremendous amount of ongoing support from his shipmates. There have been numerous visits and interactions and in each case they have served to "perk him up." He really enjoys being with them. There is a very real bond with them that will never go away. I would also like to point out that his ship's Captain, Captain Haley, has been a big supporter and I thank him. Immediately after Dan's injury Captain Haley authorized and dispatched a CACO who joined us in Germany and remained with us until after Dan had been medivac'd to Bethesda. Senior Chief LeTourneau was exemplary in her role supporting us. I would also like to mention that the ongoing assistance from Navy Safe Harbor has been invaluable. I have many words of praise for LCDR Ty Redmon and the team working with him. The military has acted and continues to act as part of our extended family.

My experiences with the treatment at the Richmond VAMC can be characterized as not good—not good at all. For the most part, the people who treated Dan were nice and caring people. What I learned immediately after leaving there, however, was they didn't know what they didn't know. That is, their skills, capabilities, resources, staffing, treatments, therapies and therapy techniques all fell extremely short of what we immediately experienced at the Bryn Mawr Rehabilitation Hospital. The Richmond VAMC was not accomplished in coma emergence and severe TBI and did not have the cutting-edge experience with a case as severe as Dan's.

The VA therapists and physicians had little or no experience with patients of the condition of Dan. The level of therapy and the techniques cannot be compared to the therapy Dan received while at the Bryn Mawr Rehab. The Bryn Mawr Rehab therapists are much higher skilled; they focused on stimulation constantly while performing therapy. The techniques in each of the disciplines of Physical, Occupational and Speech Therapy are far more advanced. Although the Speech and Physical Therapists at Richmond tried, they just did not have the expertise and they were very lacking in the techniques and resources that Dan received immediately upon transfer to Bryn Mawr Rehab. The Richmond Occupational Therapist is another story. Recovery from a TBI is about therapy and stimulation. While this therapist treated Dan she very rarely spoke to him, I continually witnessed sessions that would last longer than 45 minutes where she would not say more than a few words to him. When I commented on this, the VA reaction was to shift Dan's therapy sessions to a time when I could not be present. They didn't fix the problem—they ignored it! I escalated the issue to the attending physician, but there were no changes.

After we returned to Pennsylvania I learned that while at Richmond VAMC, Dan was misdiagnosed on a medical condition that resulted in receiving medications that

masked a very serious condition. He was ignored while in significant pain with the explanation that it was “tone.” He was unable to get blood work done over a weekend to properly treat him following a seizure and we were told they could not have the results analyzed over the weekend as people were “off.” Private care hospitals across this country perform these routine tests 24x7 and within minutes. He had an open wound that penetrated all the way to the bone on his right foot the entire time at Richmond (4-5 months) where the condition worsened and was only treated by a nurse. Immediately after being placed in private care, he was treated by a doctor specializing in wound care and under his treatment the wound closed in one month. Dan was in pain the entire time at Richmond.

The medical treatments and diversity of physicians treating Dan dramatically changed when we arrived at Bryn Mawr Rehab. At Richmond, Dan was treated by the resident physician and the attending. No specialists treated my son other than the neurosurgeon who performed his cranialplasty just before we left Richmond. Immediately after arriving at Bryn Mawr Rehab Dan was seen and treated by numerous specialists. It was a real eye opener and completely different level of care and aggressive effort invested in my son’s accurate diagnosis, treatment and recovery.

Very shortly after moving Dan to Bryn Mawr Rehab he was seen by a physician specializing in “tone management.” Tone is explained as the elasticity or tension of Dan’s muscles. His TBI injury resulted in tone problems, that is, certain parts of his body muscles tightened up and would not move freely. It is a by-product of the great condition his body was in at the time of his injury. I clearly remember the physician’s words when he first saw Dan. His words were, “Who did this to him?” That physician is also a member of the Armed Forces and has served in Iraq. He was angry at how my son had been treated.

The Richmond VAMC personnel very quickly scaled down Dan’s therapy and for some disciplines discontinued his therapy sessions. They stopped therapy at a time when therapy and stimulation were most important in helping him progress, despite my efforts to persuade them to continue these treatments.

Quite frankly, the VA personnel were much more concerned about training the family than treating my son. Just one of the far too many examples is the very first meeting that was held to update me that occurred about two weeks after Dan arrived at Richmond. The entire agenda was to discuss family participation and training. I was with Dan and helping the staff nine to twelve hours each day—seven days a week. During that meeting I challenged them and asked why weren’t we talking about what they would do to help my son. I stressed that should be the priority. My conclusion was they didn’t know what to do or how to really help Dan. They simply did not have the knowledge, experience, skills, and resources.

On many occasions there were comments about cost and what items cost. Dan’s care and treatment should not have been compromised by cost. Yet, it certainly was—time and time again. I learned that lesson very quickly when I experienced his treatment plan outside the VA system.

I am prepared to provide many more examples far too much like these.

Dan was treated at Bryn Mawr Rehab until December of 2006. He emerged from vegetative state and progressed to a minimally conscious state. He was inconsistently responding and a decision was made to move him to a skilled nursing facility while awaiting surgery to correct contractures of both ankles. While in the nursing facility he continued to receive therapy.

While at Bryn Mawr Rehab I was contacted by the local Philadelphia VA and met with them to discuss Dan’s status and possible future plans.

In September of 2006, Dan’s neurologist and rehabilitation doctor advised me that we should begin to consider if we wanted to move Dan home because he felt we would soon need to move Dan from Bryn Mawr Rehab either to home or to a skilled nursing facility. Therapists from Bryn Mawr Rehab evaluated our home and we began to make architectural plans for modifications based on their recommendations. A representative from the Philadelphia VA was involved and their recommendations were included in the plans.

At this time I raised my concerns of next steps and my deep concern of suggestions of moving Dan from the rehab to skilled nursing with Congressman Jim Gerlach’s office. I subsequently met with another VA representative in November of 2006. During this meeting I explained my concerns and desires for my son. The VA representative listened and suggested he take me on a tour of the Coatesville VA Hospital Facility. I agreed and he proceeded to take me there and showed me a ward where Dan would be placed. It was a “locked” dementia ward. He was quite proud of the facility and mentioned that because of my son’s injury he would have a private room—when one became available. The entire ward stunk of odor from patients who needed to be cleaned. He wanted to place Dan in a dementia ward, indicating an appalling lack of understanding of the needs of a TBI patient. Imme-

diately upon leaving the Coatesville VA facility I vowed my son would never be placed in a VA center again.

Dan had surgery to correct his ankle contractures and returned to the Bryn Mawr Rehab for two weeks in early March of 2007. The short stay was to confirm the surgery would enable the therapists to begin standing him. Standing has been found to help a TBI patient in their recovery and it has helped Dan. Following that stay he was moved to the Manor Care facility. Manor Care is a skilled nursing and rehabilitation center. The vast majority of the patients there are very aged people.

In March 2007, we decided to proceed with the home modifications and requested approval for a VA Housing Grant. The VA confirmed the strict requirements of the grant, which included that Dan's name be placed on the deed of the home. Because I declined, we subsequently had to settle for the very limited amount of \$14,000. Construction began in May 2007 with the VA knowledge of our plans and intent.

My experiences with the Philadelphia VA are extensive and uniformly quite frustrating. Every interaction with them has been arduous and verging on combative at times. They continually demonstrate their inability to establish and execute plans. They have been completely unable to meet Dan's needs.

During the spring of 2007, I met with a representative of the Independent Living and Vocational Rehabilitation and Employment group to discuss what opportunities that group had to help my son. During that meeting and in later interactions, I was advised by the VA person that she could approve financial assistance and was confident she could get a higher amount approved by the Philadelphia VA. She then decided that she could get a greater amount approved if she filed for a grant to the Washington office. The recommendation was that we halt the construction on our home until the approval was obtained for the grant. I refused and suggested that she expedite the approval process. At the time I also asked her to just get the Philadelphia financial assistance approved. She decided instead to proceed with the grant request from Washington. I waited five months until we received the decision that the assistance had been denied. Clearly my decision to proceed with the home construction was the proper decision. If I had waited, we would have significantly delayed the preparations for our home. The end result is Dan received nothing! There was no assistance. My conclusion is she either did not know what she was doing or she should have followed my direction and gained the Philadelphia approval.

On October 15 of 2007 I had a conference call with the Philadelphia VA and advised them the modifications to our home were nearing completion and that I intended to move Dan home on November 20. I requested their assistance in funding Dan's required ongoing therapy and in providing the necessary supplies and medications. Keep in mind they had full knowledge of the intent and had been in the loop on the home modifications since the preceding year. This call was to advise them of the planned date. I very quickly learned they had no concept of how to establish even the most basic plan of action to transition Dan home. On multiple occasions following the call I asked for an executable plan—I'm still waiting. They could not tell me what actions they would take, when the plan would be complete or even who was responsible. November 20 came and went and I did not have the supplies or medications nor did I have a transition plan. It is inexplicable to believe they could not plan and execute. I have personally witnessed similar patients while at Bryn Mawr Rehab who were transitioned home in a matter of days yet the VA has not been able to accomplish this in many months.

After applying regular pressure on the VA, on February 21, 2008, I finally received the last of the initial supplies and medication items. It took more than four months to get these items. There were multiple instances of the wrong item or quantity being shipped, which required additional interactions with the VA. Why does it take four months to get items that are readily available?

During many conversations with them I requested a plan to re-fill Dan's medications and to obtain newly-prescribed medications. I still do not have an acceptable plan for newly-prescribed medications. The VA "solution" will take longer than 24 hours at best. It is completely unacceptable to wait that long. When I challenged them to deliver a more adequate plan their response was it was my fault because I had not identified a full service pharmacy for them to use. Their position consistently is that it is my fault. How can it be my fault that they cannot provide what my son needs? They can't plan or execute, they have known of our plans for more than a year. The only logical conclusion is that they just don't care.

After months I still have not received a transition plan for therapy and in-home assistance. They have received full evaluation reports on Dan's therapy needs and have received detailed orders from his physician about the type of care he needs and they continue to ignore them.

I could go on and on as I have numerous examples. Essentially my experience with the Philadelphia VA is:

- Make statements and do not live up to what they say
- Unresponsive—months to get transition plan in place
- Unwilling and unable to provide skilled care recommended by doctor
- Unable to fill supplies requests timely—takes many months
- Unable to provide medications STAT—takes more than 24 hours—they have no capability to meet an immediate need once he is transferred home. Their solution requires out-of-pocket cost for Dan
 - Every decision that is made is based on cost impact—not what my son needs
 - They ignore primary care physician’s orders
 - I have been informed by VA personnel that it is against the law for them to work past 4 pm.
 - Unable to establish and execute a simple plan—they can never tell me what, when and who is going to take actions. No dates—no commitments. All they tell me is they are moving as quickly as they can.
 - They are already backing off any type of long-term therapy commitment—contrary to neurologist order
 - Unwilling to fund his therapy needs—pushing the responsibility to private insurance
 - Payment of his van to the dealer required my personal involvement and took three months after it had been previously approved by the VA
 - Owe Dan money for reimbursement—more than 90 days—no one follows up
 - No ownership. No one owns a problem to resolution
 - Unprofessional—comments, can’t plan, can’t execute

It is clear to me that the focus should be what is best for Dan and what he needs. His needs for medications, supplies, therapy, etc. should be paramount in everyone’s mind. Instead, the concern is where he can be shoehorned into the “system” and what an item or service, such as therapy, will cost and whether the VA or TRICARE should fund the expense. It should be noted that since leaving the Richmond VAMC all of Dan’s costs for care have been funded by TRICARE with Dan paying the co-pays and cost shares. The VA has not participated in absorbing any of Dan’s medical costs. That includes everything—surgeries, rehab, nursing, transportation, medications, disposable items, etc. I’m dealing with VA personnel who have known for more than a year of our plans to move Dan home, as recommended by his physician. They have had a very long time to assist with a plan for transition. Quite frankly, I regret getting them involved. They have turned a very simple transition into a complete debacle.

I have worked for a major corporation for many years and fully understand the requirement to have policies, processes and procedures that can be leveraged across organizations and businesses. But, there are always the “big deals” that come along that require exceptions and actions that are not the norm. That’s why the procedures and policies are there—to handle the norm and recognize when exceptions are necessary. The exceptions require a program office approach with a person or persons who have the responsibility and authority to make the quick decisions and direct the organizations on what is to be done. It requires a delegation of authority and shifts in accountability. It results in the “big deals” moving quickly and smoothly. Dan and others like him are “big deals.” They are the exceptions. There are not many who have been injured like my son. The VA can’t cope with his needs and there is certainly no coordination within the departments and organizations of the VA. Complicate that with the inclusion of the private care element and TRICARE and the systems and processes just break down.

For more than a year Dan’s condition has been such that his neurologist and primary care physician believe it best for him to be transitioned home. To accomplish this required extensive modifications to our home and a huge out-of-pocket family expense. When this decision was made (in very early 2007) I engaged with the Philadelphia VA for assistance and once again I have experienced the inability of the VA at essentially every turn to execute even the smallest task without painstaking involvement and rework. They are not in the least bit concerned about serving and meeting my son’s needs. They have repeatedly demonstrated they are unwilling and unable to assist.

Dan wants to and should come home. Yet, the VA has demonstrated they are unable to assist. This is unacceptable.

The problems and experiences clearly point to major systemic issues that must be addressed. Dan is a “big deal,” but he is not alone. These problems are not unique. They demonstrate major gaps and breakdowns in the level of care and complete failure to meet their unique needs. My son and others like him served their country proudly. The focus must be on what is best for Dan, the type of care he needs, deserves and earned in service to this country. Instead the military and VA have made and continue to make financial decisions. Those decisions are totally un-

acceptable if we care about the health and life of my son and others like him. They are “big deals.” They need a different level of care and attention; they need regular stimulation and appropriate therapies, delivered by people experienced with this type of injury.

The level of care is complex and needs immediate and dramatic change but the issues we face are not. I constantly reinforce with the VA to do something for me don't give me more to do. Yet, they fail to understand. Their idea of help was to send me the link to a brain injury web site. Give my son and those like him the in-home care they need—timely medication availability, nursing, ongoing therapy, stimulation, respite assistance, training, compensation for caring for their injured loved ones and relieve the huge financial burdens. We should not have to fight for these. Yet we do. Remember, one of the VA's first responses was that Dan should be in a dementia ward. Their most recent plan insulted me with a statement that they expected family participation in his care. Just what do they think has been going on? They really don't understand and quite frankly their attitude is appalling.

My belief is that the best ways to help the family is to dramatically improve the care for the injured. Stop the scrimping on care cost. Provide ongoing assistance to the families in terms of helping them—do things for them.

Thank you for the opportunity to share my experiences and my views on what can be strengthened or improved. I hope you understand that my only concern and priority is Dan and his care. I am not alone. Each of these serious injuries is unique and demand flexibility in care and cannot be served adequately with rigid processes and systems. The burden is placed entirely on the family because we do not trust the system to provide for our injured. Our experience has taught us that.

I'm asking for your assistance.

Thank you for allowing me to speak today.

Chairman AKAKA. Thank you, Mr. Verbeke.
Now we will hear from Ms. McMichael.

**STATEMENT OF JACKIE McMICHAEL, WIFE OF
MICHAEL McMICHAEL, OIF VETERAN**

Ms. McMICHAEL. Mr. Chairman and Members of the Committee, thank you for this opportunity to speak with you today. My name is Jackie McMichael. I am the proud wife of Lieutenant Michael McMichael of the North Carolina National Guard.

Before September 2003, I had everything—an adorable 2-year-old little boy, another little boy to be born at any minute, and a wonderful husband. My husband came back from Iraq. He walked off the plane. He smiled. He was a little skinny, but otherwise healthy looking. But after a while, there were noticeable and dramatic changes. My story is one I never thought I would have, but I can't tell you my story without first tell you Mike's.

While in Iraq, my husband survived not only the constant stress of being on a hit list, but survived several blasts that have left this once outgoing, vibrant, strong, consistent, dependable man with many physical and psychological challenges we will be coping with for the rest of our lives. Mike must now walk with a cane. He has frequent migraines as well as hand and body tremors. He rarely sleeps through the night, as many veterans do not. He has frequent hallucinations. His memory issues cause him to be dependent on a Palm Pilot issued to him by the VA to complete daily tasks. He no longer has the ability to comprehend how to manage money—an apparent symptom of his TBI. In 4 months, he ran up debts so substantial he is on the verge of bankruptcy.

Mike went from making slightly less than \$70,000 a year to losing three jobs because of difficulty transitioning back to civilian life and now makes \$10,000 a year in VA disability. He is unable to work because of his PTSD, TBI, and various physical issues. Mike went from being a star employee at Progress Energy of Carolina to

getting fired for no longer being able to cope with the job responsibilities—responsibilities he excelled at before Iraq.

Mike has had numerous breakdowns resulting in three hospital stays. After one incident, we admitted Mike to a civilian mental health facility because of the stigma attached to the VA. At that facility, they wanted to treat Mike with shock therapy. I did not let this happen. I would not let that happen.

He has made poor decisions, including leaving his family last year. The pressure of dealing with the normalcy of family life and losing his job was overwhelming.

My children have seen their daddy in emotional moments they were too young to understand. All they know is their daddy was a soldier. He put bad guys in time out, but the bad guys gave their daddy a head boo-boo.

None of these events happened to Mike alone. They happened to me, to my 6-year-old son, my 4-year-old son, Mike's mom, and my family. I saw the man of my dreams, my heart, become so detached he no longer cared about anything—not his children; not even living.

I thought I was more prepared than most to deal with all of this. I have a Master's degree in counseling. I practically grew up in the VA Center in Durham, North Carolina. My mother worked there for 20 years. I am educated, resourceful, and tenacious, and I was completely lost. Existing initiatives are out there, but they are hard to find and typically can only afford to focus on just the veteran.

Since Mike's return, I have experienced severe depression and stress so great, I had a grand mal seizure last June. I had not had a seizure of this magnitude in over 10 years and had not had to be on medication for that long, as well. I was left experiencing generalized seizures and had to be out of work for 6 weeks. With my history of epilepsy combined with all the recent events, the doctors related this recurrence directly to stress and fatigue. I never would have thought at 34 years old, with the professional, well-paying job that I have, that I would have to go to my father and ask for money to help pay for my mortgage.

My children are too young to understand all the specific events, but they are not too young to express anger and frustration to the point it affects their normally happy, outgoing spirits. You cannot take one player off the team, train and educate only him or her on the game, and expect to win a championship. You must train the entire team. There is a great need for whole family education and resources. Collaborative rehabilitation is absolutely critical. This is absolutely critical for our success. I believe many veterans see their transition as theirs alone.

It took us over a year and a half to get connected with a team of professionals that we had to coordinate on our own—professionals from the Durham VA Medical Center, the Raleigh Vet Center, and the Wounded Warrior Project. They have truly saved Mike's life and our family.

I would have benefited from earlier awareness of resources for citizen soldier families, in particular. Being the wife of a National Guard officer, I was not immersed in the military culture, and again, at times was lost just in the vocabulary. The Raleigh Vet Center's "Eight Habits of Highly Effective Marriages" and couples

counseling resources have been invaluable. However, I want more. I want a lot more.

Education on PTSD, TBI, legal issues, coping skills, transitioning the family back to a two- or single-parent household, setting boundaries, relationship counseling, personal counseling, and navigating the benefits labyrinth are absolutely essential. On top of the emotional and psychological concerns we have had to deal with, the financial impact is a crushing blow.

These are just a few topics with sustainable benefits to the veteran and the family. I would like to see this information advertised. It may already exist, but how do families find it? Often, only the veteran can initiate the first contact and they will not speak to the family until they speak to the veteran first.

I would like to see doors open to families even though their veteran may not be ready to cope emotionally with their injuries yet. This may require a reeducation of our medical community on how to do this effectively, both civilian and military.

I would like to see the VA leverage the relationship and love we have for our wounded warriors to help us all heal and teach us all how to be a family again.

I greatly appreciate this opportunity to speak with you today and thank you very much for your time.

[The prepared statement of Ms. McMichael follows:]

PREPARED STATEMENT OF JACKIE MCMICHAEL, WIFE OF MICHAEL MCMICHAEL

Mr. Chairman and Members of the Committee, Thank you for the opportunity to testify. My name is Jackie McMichael and I am the proud wife of Lt. Michael McMichael of the North Carolina National Guard. Before 6:45 pm on September 6, 2003, I had everything. An adorable 2-year-old little boy, another little baby boy to be born any minute and a husband who was truly the best friend I have ever had. After the phone rang alerting my husband of his activation I knew my life would change, but I had no idea how much. My husband came back from Iraq on January 7, 2005. He walked off the plane. He smiled. He was a little skinny, but otherwise healthy looking. He looked happy. After the euphoria of Mike being home began to wear off, the changes in him were noticeable and dramatic.

To say the last 3 years have been challenging is an extreme understatement. My story is one I never thought I would have, but I can't tell you my story without telling you Mike's.

While in Iraq my husband survived not only the constant stress of being on a hit list but survived several blasts that have left this once outgoing, vibrant, strong, consistent, dependable man with many physical and psychological challenges we will be coping with for the rest of our lives.

Physically Mike has been impacted in the following ways:

- Mike must walk with a cane now due to a crushed vertebra sustained during an IED blast in November 2004. We have been working on getting physical therapy and just recently received word that he will begin in April.
- He has frequent migraines that are debilitating and at times have lasted for days. In 2006 he was hospitalized for a week because they wanted to make sure he wasn't having a stroke.
- Like many Vets he rarely sleeps through the night. When he does, he tosses and turns. He talks in his sleep and suffers from terrible nightmares.
- Mike has had frequent hallucinations about people and characters being around him. He's had conversations and interactions with them.
- His memory is so bad he can often not recall conversations, decisions, events, etc. He can not consistently remember directions to familiar locations such as his mother's house and therefore depends on a GPS that was given to him by a fellow Veteran.

• Even on a good day he has hand and body tremors.

Financially Mike has been impacted in the following ways:

- He no longer has the ability to comprehend how to manage money, an apparent symptom of his TBI. This inability combined with issues of depression then mania

and sudden distrust of authority figures lead Mike to leave his family claiming to want a divorce and attempt to go in to business on his own. In 4 months he ran up debt so substantial he is on the verge of bankruptcy.

Many people think many different things about his actions during this time. But they did not really know Mike before Iraq. He would have never put his family in financial jeopardy. When we first met he owned his own house, his own truck. He had a good paying job. Before Iraq he knew how to manage money, how to save, how to make sound decisions. Upon his return from Iraq all of that was gone, leaving me to wonder what had happened to him.

- Mike went from making slightly less than \$70k a year to losing 3 jobs because of difficulty transitioning back to civilian life and now makes \$10k a year in VA disability. He is unable to work because of his PTSD, TBI and various physical issues. We are still awaiting news on a requested increased award.

Emotionally Mike has been impacted in the following ways:

- Mike went from being the star employee to getting fired for no longer being able to cope with the job responsibilities. Responsibilities he excelled at before Iraq. He was faced with men and women everyday who remembered and expected the "Old Mike." He was told he should be "cured" of his PTSD after his second Short-Term Disability ended, and a few months later he was fired. Now, on top of all the emotional challenges, the financial challenges are added on and alone these can kill even the best marriage under normal circumstances.

- Overall, Mike has had numerous breakdowns resulting in 3 hospital stays for mental health reasons since June 2005. He has attended a 6 week in patient PTSD clinic in Salem, Virginia as well.

- Since returning from Iraq his anger has reached levels I have never seen before. After one incident we admitted Mike to a civilian mental health facility. He refused to go to the VA. Although there was never physical violence, I believe he came incredibly close that night.

- His emotional issues have lead to poor decisions including leaving his family last year. The pressure of dealing with the normalcy of family life and losing his job was overwhelming. He began isolating himself from everyone including his children and it was only getting worse. He stopped seeing his doctors and stopped attending counseling at the Raleigh Vet Center.

- My children have seen their Daddy in emotional moments they are too young to understand. All they know is their Daddy was a Soldier. He put bad guys in time out. The bad guys gave Daddy a head boo-boo and now sometimes he gets sad and mad.

None of these events happened to Mike alone. They happened to me, to my 6-year-old son, my 4-year-old son, Mike's mom and to my parents and my brothers. We were left to watch as Mike self-destructed not knowing what to do to help him or ourselves. We had no clue what was wrong with him and he was, at times, completely uninterested in finding out himself. He said over and over again, "I know guys who lost limbs and they are OK."

I expected things to be difficult. I did not expect this struggle. I saw the man of my dreams, my heart, become so detached he no longer cared about anything—not his children not even living. I came in to this new reality more prepared than most (I thought). I have a Master's Degree in Counseling. I practically grew up in the Durham VA Medical center as my mother worked there for 20 years. I am educated, resourceful and tenacious and I was completely lost.

I believe there are a lot of good initiatives out there but they are either hard to find or typically can only afford to focus on the Veteran. Because of confidentiality the family often feels excluded in the current traditional system. I equate our situation to treating someone with a drug addiction. The issues are not isolated to just the addict. The whole family must be educated to support the continued healing process.

Since Mike's return I have experienced severe depression and stress so great I had a grand mal seizure last June. I had not had a seizure of this magnitude in over 10 years. I was left experiencing generalized seizures and had to be out of work on short term disability for 6 weeks. With my history of epilepsy combined with all the recent events the doctors related this recurrence directly to stress and fatigue. I never would have thought at 34 years old, with a professional, well paying job, I would have to borrow money from my Dad to help pay the mortgage so we don't lose our home. My children are too young to understand all the specific events, but they are not too young to express anger and frustration to the point it affects their normally happy spirits. Mike's issues are not just his own. You can not take one player off a team, train and educate only him or her on the game, and expect to win a championship. You must train the whole team.

There is a great need for “Whole Family” Education and resources. Educating the Vets on the importance of a Collaborative Rehabilitation is critical. I believe many Vets see their transition as their issue alone. Mike was very resistant to me talking to his Doctors or telling me anything about what he was working on. This is understandable as I am very aware of HIPAA regulations and confidentiality. But I was losing my husband and I was seeing things I knew they could not have been aware of. I called his doctors and told them “You don’t have to say anything about Mike, just listen to me. This is what I am seeing at home.” All I wanted was to know what to look for, what to expect, what to do, how to help. It took us about a year and a half to get connected with them, but we are now blessed to have a collaboration of professionals from the Durham VA, the Raleigh Vet Center and the Wounded Warrior Project to help us. They have truly saved Mike’s life and our family.

MY HUMBLE OPINION:

I would have benefited from earlier awareness of resources for both active duty and citizen soldier families. (Being the wife of a National Guard officer, I was not immersed in the military culture and at times was, again, lost). The Raleigh Vet Center’s “8 Habits of Highly Effective Marriages” and couples counseling resources are examples of invaluable offerings we have gladly taken advantage of, but I want more. Education on PTSD, TBI, legal issues, coping skills, transitioning the family back to a 2 or single parent household, setting boundaries, relationship counseling, personal counseling and navigating the benefits labyrinth (on top of all the emotional and psychological concerns we have to deal with, the financial impact is a crushing blow. I can not express this enough). These are just a few topics with sustainable benefits to the Vet and the family. I’d like to see this information advertised. It may already exist, but how do families find out about them? Often the Vet must initiate first contact.

I’d like to see doors open to families even though their Vet may not be ready to cope emotionally with their injuries yet. This may require a re-education of our medical community on how to do this effectively without jeopardizing the regulations they must follow while still meeting the needs of the Veteran. I’d like to see the VA leverage the relationship and love we have for our wounded warriors to help us all heal and teach us how to be a family again.

I greatly appreciate the opportunity to speak with you today and thank you for your time.

Chairman AKAKA. Thank you very much, Jackie McMichael, for your remarks here.

I would like to ask Senator Burr to begin with his questions, and I will ask Senator Murray to follow.

Senator BURR. Thank you, Mr. Chairman, and thank you to you three. I am not sure that I could as calmly go through some of the things you have described as a parent, as a husband.

We spend every day up here trying to make sure that what we learn is converted into changes within the system that, hopefully, makes sure somebody else doesn’t go through the learning curve and the challenges that each one of you have. I truly do believe today that this gives each one of us a renewed commitment to make some of these changes faster. The reality is that every day that we delay, we have people that come into the system that will experience maybe not the same challenge that you have experienced, but one that affects their long-term recovery in a very similar way to your sons and your husband.

So, let me ask some very quick questions, if I can. Mr. Verbeke, you stated that you thought that the VA made financial decisions, and I just want a clarification. Do you believe that they made financial decisions, that those decisions limited your son’s ability to recover, or did they make financial decisions that affected the type of procedures that they make available to all who come in with similar injuries?

Mr. VERBEKE. Senator Burr, I believe it is both. I personally witnessed—and I don't know if I can say this, but—I was able to witness the type of care that Dan got in the Richmond Polytrauma Unit, in the TBI center there, and I saw what happened there. Then, within days I saw what happened in the private sector, and I will tell you, they were dramatically different, as I mentioned in my statement.

I would also state that while I was at Richmond, there was always, always a discussion about cost and what things cost. I can tell you that in the private sector, I have yet to hear—and I have been there since June of 2006 now—I have yet to hear anyone question cost. Decisions are based on what my son needs.

Senator BURR. Colonel, does Justin have a Recovery Coordinator now?

Col. BUNCE. Sir, I received a call from a Recovery Coordinator yesterday. I would suspect that it is probably because I was testifying up here today. But that was the first time that I had heard from one. Now, I understand that they have just stood up the program here. Also in the last few weeks, I received a call from the Wounded Warrior Regiment from the United States Marine Corps, so there was that channel that is also working.

I asked a simple question. I said, I just want to try to find a behavioral type of psychiatrist—and I have heard that they are out there in the country—to be able to try to do some intense therapy and address some of the behavioral issues, because obviously the ultimate objective is to get him working and get him out interacting with the civilian workforce.

Senator BURR. Clearly, we are tremendously grateful to Senator Dole and Secretary Shalala, who identified this as part of their Commission's recommendations. I think VA understood the benefit and has tried to roll the Recovery Coordinators out as quick as they can. But, clearly, for somebody with the types of injuries that your son has had and many others who come in with similar ones, the ability to have one person that coordinates their care—both in how it is delivered and also in the dissemination of information and the answering of questions—is absolutely valuable to the caregivers and family members.

Jackie, how soon after Mike returned did he seek any mental health services?

Ms. MCMICHAEL. It took him a while. It was about—well, the first initial time was about 6 months. He had his first breakdown after he found out two of his men that he worked with in Iraq were killed when they got home; just accidents. One had a heart attack. So, that really caused him to have a breakdown. We called Military OneSource to ask for references and they gave us a civilian psychiatrist.

She was very nice, but the civilian side was not prepared to deal with the combat-related PTSD. So, we worked with her for a little while. At this time, Mike, because of the stigma of the VA and the macho thing, I guess, was kind of acting against him. He didn't want to go to the VA. We paid for this with our insurance, our personal insurance. So, it took about a year—over a year—to get him to just go to the VA and get signed up to become a part of the system. But again, the civilian side was completely unprepared in Ra-

leigh to handle it. They wanted to do shock therapy on him and that was the last straw.

Senator BURR. Jackie, is there anything that could have made a difference in getting Mike the mental health services that he needed at an earlier point?

Ms. McMICHAEL. I think at some point, I believe that they had conversations with the guys. I think they had education while they were still in Iraq. OK, you are going home. These are some things you are going to need. That is not the right time to give them that information. They are too excited to get home.

They might have given him stuff after he got home, but they are not in that frame of mind. They get off the plane. In Mike's case, he felt fine. Oh, I have got a little twinge in my back, and every time a car backfires, I get a little shaky, but that will go away. I can't sleep at night. It just started to progress more and more. They are still in that euphoric state. They don't understand.

So, I think having like a buddy system almost, or that education early on, making that contact with the families, as well, so that we can encourage—as I said, I was completely thinking, oh, I am so qualified to take care of this and I can take care of it because I have got a Master's in counseling. I was completely unprepared to deal with all of his issues alone. It would have been nice to have a buddy system or better education while he was gone.

Senator BURR. Thank you very much. I thank the Chair.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Murray?

Senator MURRAY. Thank you very much, Mr. Chairman.

Thank you all for coming and testifying, but more importantly, for helping us understand what you are going through. It is so overwhelming to listen to you. We sit through committee hearings after committee hearings. We hear report after report. We work to provide additional resources and dollars. We try to change policies. And to hear that you are still going through this is a reminder that we haven't gotten to where we need to be yet, and I really appreciate your sharing that, because we have got to be motivated here.

It is frustrating because these are issues that I don't think Congress has ever dealt with. Certainly, we have dealt with wars before and returning soldiers and different issues, but the issues that all of you talked to us about are pretty unique to this war.

You all kind of come from different circumstances, but it occurs to me, we have a cultural problem today within the VA and the DOD on understanding the mental health care. To hear the words you talk about, dementia, shock therapy, doesn't even touch the reality, I think, of what our soldiers are suffering from when it comes to TBI and Post Traumatic Stress Syndrome.

So, I assume you would all also encourage us, beyond what you talked about in terms of families, is getting the research to really know how to treat these and give these men and women everything we can give them to bring them back as far as we can bring them back with the best kind of research. I would assume that would be part of what you think we are really lacking in today, correct?

[Nodding heads.]

Senator MURRAY. Ms. McMichael, your husband was in the Guard?

Ms. MCMICHAEL. Yes.

Senator MURRAY. And you said that when he came home, he walked off the plane smiling and you didn't know until some time much later?

Ms. MCMICHAEL. Correct. About 6 months later was when it was very noticeable. Before that, it was the smaller things that I thought was just an adjustment period. I didn't let him drive for about a month just to—because he was used to driving big vehicles and going over things, so we wanted to make sure that he was a little safe—

[Laughter.]

Senator MURRAY. Not doing that.

Ms. MCMICHAEL. Exactly. So, we wanted to make sure—and cars going by him. That still is a bother to him.

Senator MURRAY. And I hear that a lot from families.

Ms. MCMICHAEL. Yes.

Senator MURRAY. Now, when he came home, were you—as a family—given any information about what you might be looking for or any kind of help that you should be—

Ms. MCMICHAEL. We had a Family Readiness Group, and I want to say it was around November or December, a time when they knew they were going to be coming home within a few weeks, we all got together and they gave us information. It was basically tidbits or kind of helpful hints, more so. It wasn't anything on what to expect. It was things like, you know, you might not want to redecorate your house, because when your veteran comes home, he won't have any sense of familiarity. Well, it was already December. If I had gone crazy with the house and already redecorated, then I was out of luck. That wasn't very helpful to me.

Senator MURRAY. But it wasn't things like watching—

Ms. MCMICHAEL. Exactly.

Senator MURRAY [continuing]. For memory loss or those kinds of things.

Ms. MCMICHAEL. Temper. He had a very quick temper and he was never like that before. He was very easy going before—

Senator MURRAY. It seems to me one of the things you would recommend is support for families to understand the issues that may be coming home?

Ms. MCMICHAEL. Exactly, and what to look for, where to go for help if you have any questions. I don't think we should be handing out TBI pamphlets when they get off the plane, but going to the families and talking to them, these are some things that you might see. If you have any questions, this is where you could go. It is almost like at a college, you have an admissions counselor or a guidance counselors, someone they can go to and for that particular incident. All three of us have different needs for our loved one, and what is going to work for me isn't going to necessarily work for those families.

Senator MURRAY. I think that was really apparent in listening to all three of you—very different circumstances in how they were injured, when they came home—

Ms. MCMICHAEL. Right.

Senator MURRAY [continuing]. When you knew the injuries, what kind of treatment they need, and it isn't one-size-fits-all, but you are in an institution where they think that way.

Ms. MCMICHAEL. Right.

Senator MURRAY. So, I think we really have to start focusing and really pushing our VA and DOD to look at the injuries coming home from this war in many pathways rather than just in boxes, as I think all of you have described you have dealt with. Is that correct?

Mr. VERBEKE. Right.

Ms. MCMICHAEL. And given the stigma of the VA to the guys—they don't trust the VA. They have been to VAs, and our VA is right next to the Duke University Medical Center—

Senator MURRAY. They don't trust the VA?

Ms. MCMICHAEL. They don't trust the VA.

Senator MURRAY. Because?

Ms. MCMICHAEL. Bad stories. Some VAs are worse than others and they should be the same across the board.

Senator SANDERS. Do you see contrasts between Duke and the VA?

Ms. MCMICHAEL. They do, absolutely; because Duke doctors go over to the VA to train. When I volunteered there, I would see Duke doctors come in and it was almost like they were experimenting. Now, 20 years later, it is a lot different than that. And Duke—because of individuals like Mike's psychiatrist—he has taken the initiative to start working with Duke and their head trauma unit.

Ms. MCMICHAEL. And Mr. Verbeke talked about the VA Polytrauma Center in Richmond, Virginia. How long ago was your son there?

Mr. VERBEKE. We left there early in June of 2006, very early.

Senator MURRAY. So about a year and one-half ago?

Mr. VERBEKE. A year and one-half.

Senator MURRAY. And your experience at that time was not the proper kind of care?

Mr. VERBEKE. I didn't know that until I left.

Senator MURRAY. Yes.

Mr. VERBEKE. When we were at the VA Polytrauma Unit, there were therapies being done on my son. They discontinued them earlier than I thought were appropriate, and I just had a general unsettled feeling. I was fortunate because while I was there, my wife was at home and she did some research locally. And, literally, in our back yard, found this Bryn Mawr Rehabilitation Hospital that had a very highly-ranked Traumatic Brain Injury rehab center.

So, she visited there. She had been down to Richmond almost every weekend to make sure that I was doing all right, and, I mean, her story that came back to me was, "We have to get him out of there. We have to get him out of Richmond and get him to a place that can really help him."

Senator MURRAY. Well, I would hope that at some point in the near future, no one feels they have to get them out of there, because our VA centers are where most of our soldiers are going to be treated. And they need to be the absolute best for everyone

there, not just for the ones whose families are as active as yours are—every single one of them.

We do need to support our families. We do need to do a better job. Thank you for reminding us of that. We will continue to work with you to try to make that happen; so thank you.

Chairman AKAKA. Thank you very much, Senator Murray.

Senator SANDERS?

Senator SANDERS. Thank you, Mr. Chairman, and thank you very much. We all understand that it is not easy for you to come up here and do this, but your discussion of your issues reflects probably many, many thousands of people's experiences, so we very much appreciate your being here.

As Senator Murray indicated, all three of your experiences are different, and I could tell, Colonel Bunce, that a couple of years ago, I was invited to speak to the Traumatic Brain Injury Association in the State of Vermont. There was a luncheon. I thought there would be about 20 people there. The place was full. I mean, there were hundreds and hundreds of people there—often automobile injury-related and so forth. But your point is, there is a lot of knowledge out there and a lot of expertise out there and certainly we should be reaching into that community—into the private sector, the nonprofit sector—to learn what they have experienced and vice-versa.

Ms. McMichael, it seems to me that you are up against bureaucracy and isolation. Would it have been easier if there had been a location where Mike might have had the opportunity to maybe meet with other veterans who are returning home to understand that maybe what he was experiencing was not unique, on an ongoing basis? Did you have the opportunity to meet with other wives or other family members?

Ms. MCMICHAEL. No.

Senator SANDERS. Would that have been helpful, do you think?

Ms. MCMICHAEL. Absolutely. We actually are now going to the Raleigh Vet Center and they have groups, but the majority of gentlemen there are Vietnam veterans. The basic core experiences are the same—the feelings, the PTSD are the same—but, I think it would have been very beneficial. We have actually talked to the Vet Center about potentially getting something like this going—having groups where it is just OIF or Iraqi veterans just to share, and then other groups where everybody is in the same environment and sharing information. That would have been incredibly helpful on the wife side—just sharing, just getting it out.

Senator SANDERS. You are not the only wife who has gone through this experience.

Ms. MCMICHAEL. Exactly. Exactly. I am not the only one. I represent thousands of wives and family members; mothers. You have single veterans out there and they have got mothers and fathers, brothers and sisters—

Senator SANDERS. But there was no support system—

Ms. MCMICHAEL. No.

Senator SANDERS [continuing]. That you could walk into?

Ms. MCMICHAEL. No. And the support system we have now, we had to connect them: Mike's psychiatrist; his psychologist; other Iraqi veterans. We had to get them together and talking together,

because I didn't want his psychiatrist over here teaching him to do this, prescribing certain drugs, and his psychologist not know about those, because the drugs had—it took about a year and one-half to get his drugs correct and get a good cocktail going, if you will.

Senator SANDERS. Michael, did you want to—

Mr. MCMICHAEL. Yes, sir. I don't mean to take you off the panel, sir, I know that is kind of the process. But, you have got to remember also, veterans are stubborn and we don't like going to these Vet Centers, initially. So, also as part of that, we need to find some way to outreach these veterans and get them to the centers.

Senator SANDERS. That is exactly right. It gets back to culture and so forth. And I think if in some ways—I don't know how to say this—if someone came back without an arm or a leg, it is, in a sense, easier, right, because the injury is very visible.

Mr. MCMICHAEL. Exactly. I have said that myself. I wish sometimes, I have told her, I wish I came back with something more visible.

Senator SANDERS. But the truth of the matter is, the injuries, the other types of injuries are quite as real; and I think what we as a society, and what the VA has not recognized is that they are as real.

Mr. MCMICHAEL. Correct.

Senator SANDERS. Probably the VA is maybe the best institution to treat people in terms of amputations and those types of things, but I think we have a long way to go to understand that brain injuries, emotional injuries are absolutely as devastating, absolutely as real. But, there has been a hesitancy for many, many years to jump into that. So, I think there is a lot to be learned about the injuries from this war. We have so many people who are going to need that kind of help, we need to do it.

All I would say, Mike, and I say this back in Vermont, is the courage of the men and women who have served is without question. What you have experienced, what you guys have gone through—the explosions and the PTSD—there is nothing to be ashamed of. It is as real as an amputation and we have got to go forward, all of us together, to provide the positive care that you guys need. As others have said, you have served your country and now it is time that your country responds appropriately.

Thank you, Mr. Chairman.

Ms. MCMICHAEL. Thank you, Senator.

Chairman AKAKA. Thank you very much, Senator Sanders.

Ms. McMichael, you testified that you have been very pleased with the family counseling provided by the Raleigh Vet Center. Can you please describe how you first became aware of what they had to offer? Building on what Senator Sanders said, how would you characterize the effectiveness of VA's outreach to families to let them know these services are available?

Ms. MCMICHAEL. Well, I first found out about it—Mike's psychiatrist at the VA recommended the Vet Center and I called them. Mike was having an incredibly difficult time and he refused to call. At that time, he had been to the psychiatrist but wasn't continuing this therapy. I called and was told that they couldn't talk to me, that they had to initiate contact with the veteran first. I basically

used my tears, and I begged and pleaded, and told them that he is not going to call you. You have to talk to me.

I have had to do that many times. I just called up his doctors and said, I know you don't have to say anything about Mike and his care. You don't have to violate any HIPPA regulations. Just listen to me. This is what I am seeing at home. This is what is going on.

At the Vet Center, I would say in the past 6 months to a year, they have started doing more and more with families. There is a counselor there who facilitates "The Eight Habits of Highly Effective Marriages," and we signed up for the 16-week course. There are two other couples in there with us out of thousands of people who would benefit.

There is not a lot of advertising going on for these. We just happened to fall into it. A lot of the time, it is who you know; and you have to find those people continuously. The Vet Center, we are hoping to work with them even more to get more resources—a family counselor. But it was hard going. It was hard to find them and it took a long time.

Chairman AKAKA. Yes. I would like to hear from Colonel Bunce and Mr. Verbeke about any remarks you have on this, on the outreach to families by the VA. Colonel?

Col. BUNCE. Well, Mr. Chairman, as far as outreach is concerned, what we found is it is basically a pull system, not a push system. So if we—we have to go in and say, this is what we specifically need and then we will either get some reluctance or we will be referred to someone. But just knowing where and what the point of entry to ask for is—why this care coordinator or case manager—I think would be very important.

But, I think to some of the earlier comments about an in-processing system, I mean, all these young men and women came out of the military that have very good in-processing and out-processing systems. It is not very hard, I think, to be able to import a system into the VA with the expertise that is out there in the military that says, this is what you do when you come into this system.

Now, I know that you and the other Members of Congress have put a lot of attention on this seamless transition and there are efforts underway to be able to do that, to have this Joint Medical Board. But in the case with my family, I found there was not even a CAT scan done of a brain-injured Marine coming into the VA system. So, consequently, about 9 months into the process when he started having headaches, they wanted to give him an MRI, which is magnetic resonance, which would start to move the shrapnel that was in his head. And when I told—fortunately, he remembered. There was a little spark in there had he said, "I don't think this is good. Call my dad." When I talked to them, I said, you can't do that. Then I had to prove to them that he had shrapnel in his head. So, I had to then coordinate with Bethesda and make them demonstrate that, yes, he still has shrapnel in his head, because they had not done a CT scan.

So, that is just a story to emphasize the fact that having some type of in-processing system and trying to get this big bureaucracy in the VA to adapt to the new reality out there, I find that the mili-

tary hospitals are much more flexible. They are able to morph themselves and adapt. And that is really what Bethesda did as they started to get this large in-rush of wounded, especially as it went up to the Fallujah campaign. They did a lot of changes up there.

And you all know when you hire new staffers up here on the Hill and you give them a task and say, get smart on this, it is amazing what they can come up with and just how quickly they can come up to speed. I think that adaptability and that ability to go and pick an expert and say, listen, you need to get smart on what outside resources are available so if we don't have it here in this VA hospital, we know how to access it quickly. You could get someone up to speed very quickly, but you have to have the will to want to adapt.

Chairman AKAKA. Mr. Verbeke?

Mr. VERBEKE. Senator, in all honesty, I am not familiar with the outreach program. It may have been something that was in a piece of literature or a brochure or e-mail or correspondence, but I am not familiar with it. Our focus has been entirely on supporting our son and helping him move forward so that he can transition home.

Chairman AKAKA. Thank you. Let me call on Senator Murray for a second round.

Senator MURRAY. I just had one quick question and it came to me actually from a soldier that I have known now for 4 years with TBI who has been through a lot of what you have been through. He suggested to me—and the MRI issue is what reminded me. He suggested to me that our soldiers with TBI and PTSD get some kind of bracelet or something that can identify them in the community. If you have lost your legs, people normally assume, you are a young person, that is what happened to you. But if it is TBI, there is no way walking down the street, or if a medical situation occurs, they may not know. Is that something any of you have talked about or thought about or heard about?

Ms. MCMICHAEL. I have not heard about it.

Mr. VERBEKE. I have not, no.

Col. BUNCE. Yes, and that is, I think, a very smart thing. Even tracking the medications—if they are ever in a position where the caregiver is not around to be able to let folks know what medications they are on becomes very important, because a lot of these brain medications are—it is important that they are consistent and that they don't have an interruption.

Senator MURRAY. Thank you. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Murray.

This question is for all of you at the table, and I look upon this as asking questions about what the goals should be, and also since you mentioned a seamless transition, this plays in this question. In an ideal or at least a fair world, what services would you expect to receive from DOD and, subsequently, from VA, as your loved one was receiving care from each of these departments? Can you respond to that, Colonel?

Col. BUNCE. Sir, I think that is a very interesting question because it is our sons or a husband here that went to war, and they come back and now the thrust of the care is put on the family. Now, families are willing to do it because they love their country

and they love their loved one, but this is something that is put on the family that the family never put their hand up and volunteered for.

So, when you take a look at TBI—and of course it is expensive because it is such long-term care—when you look at these American heroes that have gone over there and gotten hurt, it is, I think, the obligation of the country to say we are going to give whoever is taking care of this person whatever resources we need to get him as far along as possible. And that is where, as Mr. Verbeke was talking about, the limitation of the sense that, OK, we don't have that in-house, we are not willing to go and pay for it out in the civil sector, is very concerning to me because then the only other option is to throw it back onto the family.

You know, there are some that are willing or that have the financial resources to be able to pay for that, but as Ms. McMichael pointed out, when her financial situation is put into a case where it is jeopardizing the rest of her family, now you have to start to make choices. And is that choice fair that the rest of the family has to sacrifice to be able to adequately take care of the loved one who was wounded in combat, and that is when you get into the fairness issue. That is part of it that concerns me.

Chairman AKAKA. Mr. Verbeke?

Mr. VERBEKE. I think that the real issue still needs to focus back on what the injured person needs, for example, for my son. And whether it is provided by DOD or whether it is provided by VA, it is a matter of what do they really need, and then sourcing what that need is.

Each of these cases is the same, but they are different. They are individuals and their care and needs are different. The families' needs and support are different. And I think that is one of the frustrations I have had, is that we keep trying to be put into a system that has certain rules and policies and procedures, and they really don't fit these cases. They are different.

And so, I think that what we really need is more flexibility. We need an understanding that these are unique; they are different. You have to look at each case, as serious as they are, and determine what is best for that individual's needs—all right, my son's, the Colonel's son's, Ms. McMichael's husband—and then determine what is best for them; and then also look at the family and say, OK, what does the family need? As I mentioned, this is totally a burden on the family and it should not be that way. It should not be that way.

Chairman AKAKA. Ms. McMichael?

Ms. MCMICHAEL. I absolutely agree. I think taking care of Mike is one of the biggest honors that I can have in my life and I wouldn't have it any other way. The last 3 years have been very difficult and I believe that we all have a hierarchy of needs. At the very bottom of the hierarchy, we have food and shelter. Then as you move up, you have got spirituality and friendship and things like that. We can't afford to even—and health. We can't afford to think about health if we've got financial issues. I have got to think about food and shelter for everybody in my family and I can't afford, at this point, to worry about Mike. And that is what I want.

I want to know what, specifically, Mike's needs are; and then train me how to be a better wife, mother for my entire family so that we can better support each other; and get him onto the path to healing so we can all be on the path to healing. I shouldn't have to worry—none of us should have to worry about the logistics of care. We should just be focused on how we can all improve. We have all changed. Mike was gone for a year and a half, 10 months in Iraq, and we both changed. Just if there were no other issues, no PTSD, no TBI, there still would be a need for counseling and that transition back to family life. When he left, we had a newborn. He came back and our youngest son was walking and talking, talking back. So that was a big transition for him.

I think the continued care that needs to happen—we shouldn't have to worry about the logistics. That should be seamless. It should just fall into place so that we can focus on what we need as a family and what the individual veteran needs.

Chairman AKAKA. Well, thank you very much, Ms. McMichael.

I want to thank all of you on the first panel for your responses and your statements. Without question, this will be helpful to the Committee in what we try to do to improve our system here for our veterans. I also want to thank all of you for being here. I also want to thank the VFW, by the way, for helping Ms. McMichael to come here to this hearing. So, thank you very much to the first panel.

Col. BUNCE. Thank you.

Mr. VERBEKE. Thank you.

Ms. MCMICHAEL. Thank you.

Chairman AKAKA. And now I welcome our second panel of witnesses. I have asked our first three DOD and VA witnesses to discuss current programs and services available to the families of wounded warriors as well as any existing or planned initiatives to improve these programs.

Dr. Lynda Davis is the Deputy Assistant Secretary of the Navy for Military Personnel Policy and the DOD lead for care management for the Joint DOD and VA Senior Oversight Committee.

Ms. Kristin Day is the Chief Consultant for Care Management and Social Work for the Veterans Health Administration and the VA lead for care management for the Senior Oversight Committee.

Ms. Jane Dulin is the Supervisor of the Soldier Family Management Branch of the Army's Wounded Warrior Program.

And finally, Dr. Steven Sayers, a clinical psychologist at the Philadelphia VA Medical Center and a faculty member at the University of Pennsylvania School of Medicine, will discuss his research of family problems among recently returned veterans.

I want to thank all of you for being here today. I look forward to hearing what we can do to take better care of the families of our wounded warriors. Your full statements will appear in the record of the Committee.

Before I call on the second panel for your testimony, I would like to note for the record that the joint testimony of Ms. Davis and Ms. Day was delivered late and lack of advanced testimony hampers us in our ability to prepare for a hearing. It is also a violation of committee rules, by the way. Parents of gravely wounded warriors were able to get their testimony to this Committee on time. It is unacceptable that the Department of Veterans Affairs and the De-

partment of Navy, with their vast resources, cannot do the same. The excuse, it was stuck at OMB, may be true, but it means that OMB is being disrespectful not just to the Committee, but to the other witnesses and I just want you to know that I am disappointed that your testimony was late. I hope that this will be the last time I have to comment on this subject. So, please relay my views to OMB.

Dr. Davis, will you please begin.

STATEMENT OF LYNDA C. DAVIS, PH.D., DEPUTY ASSISTANT SECRETARY OF THE NAVY FOR MILITARY PERSONNEL POLICY, U.S. DEPARTMENT OF THE NAVY

Ms. DAVIS. Thank you, Mr. Chairman. It is a privilege to be here with you and Ranking Member Burr. I am glad I have had an opportunity to talk to both of your staffs, additionally, and I regret that our testimony was late. I speak to you also as a former soldier and as the mother of a soldier who wants to make sure that our system is working as best as it possibly can beyond that, not only for our current wounded ill and injured servicemembers, but those who will come in the years to come.

We have heard some very strong and moving statements from our fathers on the panel before us and from Ms. McMichael and I appreciate their sharing their candor with us. It is a privilege for me to serve with my colleague, Ms. Kristin Day, as the DOD lead on our case care management reform effort.

I want to tell you just a little bit about what we are doing on the areas of care, management, and transition support, and what we are doing separately at DOD, and then move out to our plans for the future.

Currently, our DOD line of action has a Case Management Working Group. It cuts across the military services and our two agencies. It works very closely with other Federal agencies like the VA and with our partners in the private sector—the VSOs; the VBOs; the National Military Family Association; groups like the Case Management Society of America—to try to understand what is truly needed for our servicemembers and their families, and our veterans, and to make the best practices available.

In doing so, we on the DOD side use our military Wounded Warrior Programs as the base for the care of our servicemembers who are injured. Those include the Wounded Warrior Transition Units of the Army Medical Action Plan, the Army AW2 Program, the Navy's Safe Harbor Program, the Marine Corps' Wounded Warrior Regiment, and the Air Force Wounded Warrior Program. Jointly, they serve about 3,500 wounded, ill, and injured servicemembers right now with non-clinical case management for them and for their family members.

These programs reflect the specific culture of the service, but they do have some common features. All of our Wounded Warrior Programs now in the DOD have a capability to have a 24/7 call center or a hotline that is available to family members and servicemembers. We have family reunion programs planned primarily by the chaplaincy. We have a needs assessment done on the wounded warrior and the family. We have non-medical case managers assigned, sometimes called advocates or liaisons, assigned to the fam-

ily members. I know that, Dan Verbeke had a Safe Harbor case manager that was very beneficial in working with the family, even if they weren't able to solve all the problems.

We have transition preparation provided through these Wounded Warrior Programs and information, problem solving, and long-term outreach. These service programs now will track and stay with the wounded servicemember and the family up to 5 years after they have been medically retired. Currently, the Marines alone are tracking over 8,000 former Marines. I guess you are never a former Marine, you are always a Marine.

I know Ms. Day will go into a little bit more detail about our new joint Federal Recovery Coordination Program that was mentioned—what we have been able to initiate in the last 6 months—that was recommended by the Dole-Shalala Commission. I would like to highlight a couple features that go with that program in addition to the Recovery Care Coordinators and the Federal Individual Recovery Plan.

We will have a National Resource Directory. What we heard our family members say is, we need one place where we can search and integrate all the information. We will have, this summer, a national web-based yellow book that will be used by the servicemembers, the families, all of their care providers, all the private sector. It will allow us to search by geographic location, military service, diagnosis, and type of service that is needed. Anybody in the American public will be able to go there and find or contribute to the kind of services and resources that are needed for our wounded, ill, and injured.

We are also preparing a family handbook that is hard copy and web-based for the family member that will have everything from benefits and compensation to the other services that are available for the family. It will be introduced to them by a personal coordinator, not just a reference with a business card or instruction to go to a Web site. We will also have a customized “My E-Benefits” site where the family member can essentially keep their own pay, benefits and compensation records.

My time is up. I haven't been able to refer specifically to the service injured programs, but those are in the testimony, sir. I look forward to answering your questions.

Chairman AKAKA. Thank you very much.

And now we will hear from Ms. Kristin Day.

**STATEMENT OF KRISTIN DAY, LCSW, CHIEF CONSULTANT,
CARE MANAGEMENT AND SOCIAL WORK, OFFICE OF PATIENT
CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS**

Ms. DAY. Good morning, sir.

Chairman AKAKA. Good morning.

Ms. DAY. I, like Ms. Davis and my VA colleagues, heard very compelling testimony this morning. We stand ready to correct any errors that were made and we look forward to serving our servicemembers and our families that we heard from this morning.

Mr. Chairman, Ranking Member Burr, and distinguished Members of the Committee, I am pleased to be here with my colleague, Dr. Lynda Davis, to discuss the support for families in the care,

management, and transition of the wounded and ill servicemembers and recovering servicemembers.

As you have noted, we prepared a joint statement which has been submitted for the record. My oral statement will focus on areas where VA is currently supporting families and some areas where we may be able to do more.

By statute, VA can provide limited services to family members, which includes members of the immediate family, the legal guardian of the veteran, or the individual whose household the veteran certifies an intent to live. VA can provide care and services to the families of certain veterans through the Civilian Health and Medical Program of the Department of Veterans Affairs, better known as CHAMPVA, a comprehensive health care program in which VA furnishes health care services and supplies to a defined list of eligible beneficiaries.

VA's voluntary service program continues to provide needed support and guidance. Generous donations by Veterans Service Organizations, businesses, and other organizations allow VA to assist families with temporary lodging, free or discounted meals, transportation, or even entertainment for veterans' family members.

VA is authorized to include family members in several areas, such as our polytrauma system of care or mental health services, and does so whenever it is possible and in the interest of the veteran. Our Vet Centers can provide family counseling for military-related problems that negatively affect the veteran's readjustment to civilian life.

Families are central to the combat veteran's care and family members are usually the first to realize the effects of possible war-related problems. Effective intervention through preventive family education and counseling helps many returning veterans stabilize their post-military family lives.

VA actively supports caregivers in hospice and respite care. Between 2004 and 2006, VA tripled the number of veterans receiving VA-paid home hospice care and those receiving care in VA inpatient hospice units. While we are proud of these accomplishments, we still have much room to grow. Two new initiatives, a volunteer home respite care program and a medical foster home program, work out very well for the family, the veteran, and the community, particularly in rural areas. In many areas, there are simply no other providers available. This voluntary home respite program helps address an important need and may particularly help veterans who are isolated.

In August 2007, VA selected eight caregiver assistance pilot programs across the Nation at a total cost of approximately \$5 million. The goal of these pilots is to explore options for providing support services for caregivers in areas where such services are needed and where there are few other options available. These programs are located across the country, and while most of them are intended to serve a broad population, they will also increase the caregiver support services available to OEF/OIF veterans in the immediate future and the long-term.

In October 2007, VA partnered with DOD to establish the Joint VA and DOD Federal Recovery Coordination Program, which will identify and integrate care and services for the most severely

wounded, ill, and injured servicemembers, veterans and their families through recovery, rehabilitation, and community reentry. VA has hired a Federal Recovery Coordinator Director, a Federal Recovery Coordinator Supervisor, and eight Federal Recovery Coordinators, who were deployed in January of 2008.

We have come to appreciate the importance of support to family caregivers whose severely injured loved ones transition to VA care. We have several opportunities for enhancing care, including providing health care for family members who are away from home and caring for their loved ones; broadening training opportunities for family caregivers to improve their effectiveness and resilience while reducing the need for outside caregivers; expanding existing programs, such as our bowel and bladder care and spinal cord injury for caregivers to reach caregivers for certain severely injured individuals; and financially enabling family caregivers to accompany their seriously injured loved ones from VA to another treatment facility to receive care.

As I conclude, it is important to remember that seamless transition is not a straight path. Veterans and servicemembers often move back and forth between DOD and VA facilities and the different statutory authorities result in different levels of support and care.

Mr. Chairman, I thank you for the opportunity, for your support and interest, and we look forward to your questions.

[The combined prepared statement of Ms. Davis and Ms. Day follows:]

PREPARED STATEMENT OF DR. LYNDA C. DAVIS, DEPUTY ASSISTANT SECRETARY OF THE NAVY FOR MILITARY PERSONNEL POLICY, DEPARTMENT OF DEFENSE; AND MS. KRISTIN DAY, CHIEF CONSULTANT, CARE MANAGEMENT AND SOCIAL WORK, DEPARTMENT OF VETERANS AFFAIRS

Good morning. Mr. Chairman, Ranking Member Burr, distinguished Members of the Committee, we deeply appreciate your steadfast support of our military servicemembers and veterans and welcome the opportunity to appear here today to discuss improvements implemented and planned for the care, management, and transition of wounded, ill, and injured servicemembers and recovering servicemembers. We are pleased to report that, while much work remains to be completed, meaningful progress has been made through improved processes and greater collaboration between the Department of Defense (DOD) and the Department of Veterans Affairs (VA).

The Administration has worked diligently—commissioning independent review groups, task forces and a Presidential Commission—to assess the situation and make recommendations. Central to our efforts, a close partnership between our respective Departments was established, punctuated by formation of the Senior Oversight Committee (SOC) to identify immediate corrective actions and to review and implement recommendations of the external reviews. The SOC continues work to streamline, de-conflict, and expedite the two Departments' efforts to improve support of wounded, ill, and injured servicemembers' and veterans' recovery, rehabilitation, and reintegration.

Specifically, the SOC has endeavored to improve the Disability Evaluation System, established a Center of Excellence for Psychological Health and Traumatic Brain Injury, established the Federal Recovery Coordination Program, improved data sharing between the DOD and VA, developed medical facility inspection standards, and improved delivery of pay and benefits.

SENIOR OVERSIGHT COMMITTEE

The driving principle guiding SOC efforts is the establishment of a world-class seamless continuum that is efficient and effective in meeting the needs of our wounded, ill, and injured servicemembers, veterans and their families. The SOC is composed of senior DOD and VA representatives and co-chaired by the Deputy Sec-

retary of Defense and Deputy Secretary of Veterans Affairs. Its members include: the Service Secretaries, the Chairman or Vice Chairman of the Joint Chiefs of Staff, the Service Chiefs or Vice Chiefs, the Under Secretaries of Defense for Personnel and Readiness and Comptroller, the Under Secretaries of Veterans Affairs for Benefits and Health, the Office of the Secretary of Defense General Counsel, the Assistant Secretary of Defense for Health Affairs, the Director of Administration and Management, the Principal Deputy Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Veterans Affairs for Policy and Planning, the Deputy Under Secretary of Defense for Plans, and the Veterans Affairs Deputy Chief Information Officer. In short, the SOC brings together, on a regular basis, the most senior decisionmakers to ensure wholly informed, timely action.

Supporting the SOC decisionmaking process is an Overarching Integrated Product Team (OIPT), co-chaired by the Principal Deputy Under Secretary of Defense for Personnel and Readiness and the Department of Veterans Affairs Under Secretary for Benefits and composed of senior officials from both DOD and VA. The OIPT reports to the SOC and coordinates, integrates, and synchronizes work and makes recommendations regarding resource decisions.

MAJOR INITIATIVES AND IMPROVEMENTS

The two Departments are in the process of implementing more than 400 recommendations of five major studies, as well as implementing the Wounded Warrior and Veterans titles of the recently enacted National Defense Authorization Act (NDAA), Public Law No. 110-181. We continue to implement recommended changes through the use of policy and existing authorities. For example, in August 2007, the Secretaries of the Military Departments were directed to use all existing authorities to recruit and retain military and civilian personnel who care for our seriously injured warriors. This morning, we will focus on the major initiatives underway to reform care/case management.

CARE/CASE MANAGEMENT

Since the beginning of Operation Enduring Freedom (OEF) in October 2001, the DOD, the Military Services, and VA have undertaken significant efforts to identify and support the full range of medical and non-medical needs of the wounded, ill, and injured servicemembers, veterans, and their families.

The joint DOD/VA reform of care/case management falls under the auspices of SOC Line of Action Three (LoA 3), Care/Case Management, which is tasked with designing a system to provide continuity of quality care and service delivery for wounded, ill, and injured servicemembers, veterans and their families from recovery to rehabilitation and reintegration. At the core of this reform effort are two fundamental convictions: First, that it is our honor and duty to help all wounded, ill, and injured servicemembers, veterans, and their families go beyond "survive" to "thrive." Second, that the creation of a truly integrated process involves inter-Service, inter-agency, intergovernmental, public, and private collaboration in the development and application of policies, procedures, programs, and professionals that serve and support those we honor.

VA is able to provide limited services to family members, which includes members of the immediate family, the legal guardian of a veteran, or the individual in whose household the veteran certifies an intention to live. The law provides, in general, that the immediate family members of a veteran being treated for a service-connected disability may receive counseling, education, and training services in support of the veteran's treatment. Likewise, if a veteran is receiving hospital care for a non-service-connected disability, VA is authorized to provide those services, as are necessary in connection with that treatment, if the services were initiated during the veteran's hospitalization and their continuation on an outpatient basis is essential to permit the discharge of the veteran from the hospital. Outside of our hospital system, VA's Vet Centers also provide family counseling to family members to further a post-combat veteran's successful readjustment to civilian life.

In addition, VA is proactively assisting veterans and active duty servicemembers with specific service-connected disabilities in using their benefits under the Specially Adapted Housing Grant Program (SAH). These grants are used to construct an adapted home or modify an existing home to meet veterans' or servicemembers' housing accessibility needs. The goal of the grant program is to provide a barrier-free living environment. VA's SAH agents closely and personally work with each veteran who applies for a grant to ensure a smooth process and that the veteran has a home that provides a level of independent living that the veteran would likely not otherwise enjoy. Another area VA provides care and services to the families of certain veterans is the Civilian Health and Medical Program of the Department of

Veterans Affairs (CHAMPVA), which is a comprehensive health care program in which VA furnishes health care services and supplies to eligible beneficiaries. Beneficiaries include the spouse or child of a veteran who: (1) is rated permanently and totally disabled due to a service-connected disability; (2) who died as a result of a service-connected disability or who at the time of death had a total disability permanent in nature resulting from a service-connected disability; or (3) who died in active service in the line of duty, so long as the veteran's family members are not eligible for DOD TRICARE benefits.

We have come to appreciate the importance of support to family caregivers whose severely injured loved ones transition into VA health care. Providing health care for family members who are away from home and caring for their loved ones; broadening training opportunities for family caregivers to improve their effectiveness and resiliency while reducing the need for outside caregivers; expanding existing programs such as our bowel and bladder care in spinal cord injury for caregivers to reach caregivers for certain severely injured veterans; and financially enabling family caregivers to accompany their seriously injured loved one from VA to another treatment facility to receive needed care are opportunities to enhance care.

Through LoA 3, new comprehensive practices for better care, management, and transition are being implemented. These efforts are in response to the recommendations of the various Commissions and Reports, as well as the requirements of the NDAA for fiscal year 2008. Progress is being made toward an integrated continuity of quality care and service delivery with inter-Service, interagency, intergovernmental, public, and private collaboration. But it is important to remember that seamless transition is not a straight path; veterans and servicemembers often move back and forth between DOD and VA facilities.

In October 2007, VA partnered with DOD to establish the Joint VA/DOD Federal Recovery Coordinator Program (FRCP), as recommended by the President's Commission on Care for America's Wounded Warriors (Dole-Shalala Commission). The FRCP will identify and integrate care and services for the seriously wounded, ill, and injured servicemember, veteran, and their families through recovery, rehabilitation, and community reintegration. VA hired an FRCP Director, an FRCP Supervisor, and eight Federal Recovery Coordinators (FRCs) in December 2007. The FRCs are currently deployed to Water Reed and Brook Army Medical Centers, as well as National Naval Medical Center at Bethesda. Two additional FRCs are currently being recruited and will be stationed at Brook Army Medical Center and Balboa Naval Medical Center in San Diego.

VA has established a new Caregiver Support National Program in the Veterans Health Administration, Office of Care Management and Social Work Service. The Office will serve as the focal point for policy development and coordination. This program will ensure there is a systemic approach to serving caregivers and will develop educational tools and training modules to assist VA staff in supporting our caregivers as they support our veterans.

The FRCP is intended to serve all seriously injured servicemembers and veterans, regardless of where they receive their care. The central tenet of this program is close coordination of clinical and non-clinical care management for severely injured servicemembers, veterans, and their families across the lifetime continuum of care.

The FRCP will develop and implement several web-based tools, including a Federal Individual Recovery Plan (FIRP) and a National Resource Directory (NRD). The NRD is for wounded, ill and injured and recovering servicemembers, veterans and their families as well as for all care providers and the general public. The NRD identifies and delivers the full range of medical and non-medical services. In addition to hiring, training, and placing the eight FRCs, the Departments have developed a prototype of the FIRP distributed, with the Military Services, educational/informational materials to FRCs, Multi-Disciplinary Teams, servicemembers, veterans, families, and caregivers.

For wounded, ill, and injured servicemembers, veterans, and their families enrolled in the FRCP, a FIRP, or transitional "life map," identifying personal and professional goals is developed to identify and track clinical and nonclinical services across locations of service and phases of recovery, rehabilitation, and community reintegration.

The FIRP provides one uniform tool to help the FRC and Multi-Disciplinary Teams provide the wounded, ill, or injured servicemembers, veterans, and their families with a life map for recovery. The uniform comprehensive plan for recovering servicemembers will also fulfill this purpose by providing an individualized, integrated, longitudinal, clinical/non-clinical service plan through return to duty or retirement. Both the FIRP and the comprehensive plan will include information on support and resources for providers and the wounded, ill, or injured servicemembers, veterans, and recovering servicemembers.

We are also in the process of developing the prototype of the National Resource Directory (NRD) in partnership with the Department of Labor and other Federal agencies, State, and local governments and the private/voluntary sector (e.g., Veterans Coalition, National Military Family Association (NMFA)), with public launch this summer; producing a Family Handbook in partnership with relevant DOD/VA offices; and developing demonstration projects with States such as California for the seamless reintegration of veterans into local communities.

Since its formation in May 2007, the SOC has conducted several outreach efforts to ensure consultation with representative organizations of the wounded, ill, and injured servicemembers, veterans, recovering servicemembers, and their families. In July 2007, all LoAs met with and briefed representatives of the Veterans Service, Benefits and Advocacy Organizations, as well as NMFA. A second outreach meeting was held in November 2007.

In addition to these joint VA/DOD outreach efforts, each LoA meets regularly with organizations and subject matter experts on policy, procedures, and practices under its jurisdiction. For example, in June 2007, LoA 3 hosted a Summit on Non-Clinical Case Management of Wounded, Ill, and Injured Service Members and Their Families at the DOD that reached over 300 Federal, State and local government and private, non-profit, and professional organizations from throughout the country. Wounded, ill, and injured servicemembers, veterans, and their families shared their firsthand experience with DOD/VA care, management, and transition services at this event.

SUPPORT TO FAMILY MEMBERS

The critical role family members play in the ability of a wounded, ill, or injured servicemember or veteran to not only heal but thrive, has long been recognized by the Departments and the Military Services. We are enhancing many existing programs and adding new ones in recognition of the challenges that families face when they have a loved one who has been injured. For example, a joint VA/DOD Family Handbook and web site is under development to provide the wounded, ill, and injured servicemembers, veterans, and their families a roadmap for the process of recovery, rehabilitation, and reintegration. This handbook will provide information on benefits and services available to wounded, ill, and injured servicemembers, veterans, and their families.

Another program DOD and VA are jointly developing is My e-Benefits, in accordance with the recommendation of the Dole-Shalala Commission. This web site will serve as a single, customizable, inclusive source for the wounded, ill, and injured servicemembers and veterans, including recovering servicemembers, and their families to get information about benefits and support programs.

The families of wounded, ill, or injured servicemembers and veterans benefit considerably from the comfort provided through the Fisher Houses™. Because members of the military and their families are stationed worldwide and must often travel great distances for specialized medical care, Fisher House™ Foundation donates “comfort homes,” built on the grounds of major military and VA medical centers. These homes enable family members to be close to a loved one at the most stressful times—during the hospitalization for an unexpected illness, disease, or injury. There is at least one Fisher House™ at every major military medical center and at nine VA medical centers across the country to assist families in need and to ensure that they are provided with the comforts of home in a supportive environment.

VA's Voluntary Service program continues to provide needed support and guidance. Generous donations to VA Voluntary Services by Veterans Service Organizations, businesses, and other organizations allow VA to assist families with temporary lodging, free or discounted meals, transportation, and entertainment for veterans' family members, among other services.

A number of caregiver and family support groups also meet with family members at VA facilities to address caregiver burnout or depression. In so doing, they help address the individual counseling needs of family members that fall beyond VA's caregiver authority. Many veterans are able to remain independent in the community when neighbors, friends, and others provide assistance when family members cannot.

VA actively supports these efforts and is looking for new areas where we can do more. We must continue to adjust to clinical advances, as well as demographic ones. The aging of our veteran population also represents challenges, and we are working with community-based resources to respond to their needs.

In August 2007, VA selected eight caregiver assistance pilot programs across the Nation at total cost of approximately \$5 million. The goal of these pilots is to explore options for providing support services for caregivers in areas where such serv-

ices are needed and where there are few other options available. These programs are located across the country, and while most of them will serve a broad population, they will also increase the caregiver support services available to OEF/OIF veterans in the immediate future and the long term. Among the key services provided to caregivers are transportation, respite care, case management and service coordination, assistance with personal care (bathing and grooming), social and emotional support, and home safety evaluations. Education programs teach caregivers how to obtain community resources such as legal assistance, financial support, housing assistance, home delivered meals, and spiritual support.

VA also actively supports caregivers in hospice and respite care cases. Between 2004 and 2006, VA tripled the number of veterans receiving VA-paid home hospice care and those receiving care in VA inpatient hospice units. While we are proud of these accomplishments, we still have room to grow. VA recently adopted two innovative programs to aid families in their homes: a volunteer home respite care program, which recruits and trains volunteers to provide a few hours of respite care a week in the homes of veterans who live in their community; and a medical foster home program, which identifies families in the area who are willing to open their homes and care for veterans who need daily assistance and are no longer able to remain safely in their own home, but do not want to move into a nursing home. VA calls this, "Support at Home—Where Heroes Meet Angels."

Both of these arrangements work out very well for the family, the veteran, and the community, particularly in rural areas. Concerned citizens often express an interest in helping veterans, but they live too far away from a facility to participate easily. These programs offer them a chance to help serve American veterans in their city or town by either visiting the home of the veteran or opening their own. VA trains and certifies all individuals who participate for the safety of our patients. VA also provides up to 4 weeks per year of inpatient respite care so family members can take a break from their duties. Furthermore, VA pays for home respite when necessary and currently provides these services to nearly 300 veterans every day. In many areas, there are simply no providers with whom we can contract. This voluntary home respite program helps address an important need, and may particularly help veterans living in rural areas.

VA provides caregiver support services for the families of veterans receiving VA Home-Based Primary Care (HBPC) and hospice care. Veterans in HBPC typically have chronic, disabling diseases, and the burden of care often falls on the veteran's family. HBPC provides home care to over 14,000 of our most frail veterans every day. VA also recently adopted a new quality indicator, which helps us determine the level of strain and fatigue on our family caregivers. By the end of 2007, VA assessed the caregivers of 67 percent of these veterans, and offered guidance or support to 97 percent of those identified with caregiver strain.

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2008

The recently passed fiscal year 2008 NDAA provides several requirements in relation to care/case management, some of which are highlighted below:

- Standardize training for Medical Care Case Managers and Non-Medical Care Managers, Recovery Care Coordinators, and other health care professionals;
- Provide training on the detection, notification and tracking of Post Traumatic Stress Disorder (PTSD), Suicide, Homicide, and other mental health issues.
- Establish a uniform program for assignment of Recovery Care Coordinators;
- Establish uniform standards for the development of Care Recovery Plans for each servicemember; and
- Establish uniform procedures among the Services to measure family member satisfaction with quality of health care services provided to recovering servicemembers.

We are presently in the process of implementing these requirements in a thorough and timely manner. To that end, we are aggressively collaborating with the various Service Wounded Warrior Programs and are planning a Joint Wounded Warrior Program working session for the middle of March.

DEPARTMENT OF VETERANS AFFAIRS PROGRAMS

VA is authorized to include family members in several areas and does so whenever it is possible and in the interest of the veteran. For example, family members of patients in our Polytrauma System of Care are actively engaged by VA clinicians and staff regarding treatment decisions, discharge planning, and therapy sessions, as appropriate, so they can help their loved one learn to be as independent as possible when he or she returns home. The designated Traumatic Brain Injury and Polytrauma case manager assigned to every veteran and active duty service-

members receiving care in VA's Polytrauma System of Care coordinates support-efforts to match the needs of each family.

Over the past few years, VA Mental Health Services included families in over 500,000 units of service, specifically mental health evaluations, participation in treatment planning, and collaboration in monitoring treatment outcomes. VA can see families when their involvement is included in a treatment plan designed to benefit the veteran, as discussed above. One example is family psycho-education, an intervention providing information to families about the patient's illness and training on how to respond to symptoms and problem behaviors. Although the intervention is with the family, research strongly supports the benefits to the veteran.

Another important resource for veterans, servicemembers, and their families is VA's National Center for PTSD. The PTSD Information Center contains in-depth information on PTSD and traumatic stress for a general audience. The center answers commonly asked questions about the effects of trauma, including basic information about PTSD and other common reactions.

Vet Centers, administered by VA's Readjustment Counseling Service, provide family counseling for military-related problems that negatively affect the veteran's readjustment to civilian life. Indeed, within the context of the Vet Center service model, families are central to the combat veteran's care. Family members are usually the first to realize the effects of possible war-related problems, especially among National Guard and Reserve soldiers. Effective intervention through preventive family education and counseling helps many returning veterans stabilize their post-military family lives.

Veterans who served in a combat theater are eligible for readjustment counseling, even if they have not enrolled for health care benefits. Family services at our Vet Centers are not time limited and are available as necessary for the veteran's readjustment throughout the life of the veteran. Vet Centers have full latitude to professionally include family members in the treatment process as long as this is aimed at post-war readjustment for the veteran. Spousal counseling groups are conducted at many Vet Centers to help spouses cope more effectively with the veteran's war-related problems, including PTSD, substance use, depression, anxiety disorders, grief, anger management, social alienation, unemployment, or other conditions.

Professional family readjustment counseling at Vet Centers is provided by licensed social workers, psychologists, and nurse psychiatric clinical specialists with additional professional training for marriage and family counseling. These providers do not issue prescriptions, and will make a referral to the nearest VA medical center in the event medication is deemed necessary. In locations where a Vet Center does not have staff with expertise in family counseling, our teams provide clinical assessments, preventive behavioral health education, basic counseling, and referrals to local VA or other qualified family counselors in the community. These Vet Centers are well-networked with local human service providers.

In the event a servicemember dies while on active duty, Vet Centers provide bereavement services to the surviving family members. Between 2003 and the end of fiscal year 2007, Vet Centers have assisted 1,713 family members and 1,136 families of fallen servicemembers, 807 (71 percent) of whom were in-theater casualties in Iraq or Afghanistan.

DEPARTMENT OF DEFENSE PROGRAMS

The DOD has initiated many key outreach efforts to disseminate information to wounded, ill, and injured servicemembers and veterans, including recovering servicemembers, and their families. Family Support Programs for military servicemembers, veterans, and their families are available through a wide variety of resource networks. Several examples of these family support programs include:

- Military Homefront which serves as the official DOD web site for reliable Quality of Life information designed to help troops and their families, leaders, and service providers;
- The DOD Military Assistance Program providing a web site with information and interactive resources for assisting in relocations, money management and job searching at a new location;
- The Military Spouse Resource Center which is designed to assist the spouses of U.S. total force military personnel by providing easy access to information, resources and opportunities related to education, training, and employment;
- The Military Child in Transition and Deployment that serves as the official source of education information for the DOD;
- The Federal Occupational Health Family Support Center Program which provides a range of customized support services to military and civilian personnel at installations nationwide;

- The *PDHealth.mil* web site which provides information and guidance for servicemembers and their families about the servicemember and family support services that are available from the military, VA, and the private sector;
- The Veterans and Families Deployment Health Clinical Center (DHCC) which serves to improve deployment-related health by providing caring assistance and medical advocacy for military personnel and families with deployment-related health concerns. DHCC serves as a catalyst and resource center for the continuous improvement of deployment-related health care across the military health care system.
- The Military Spouse Career Center which is a resource site for spouse services. This site addresses the unique challenges of being a military spouse such as shopping at the commissary and moving to foreign lands; and
- The Military Spouse Career Advancement Initiative that was created to help spouses overcome some of their financial barriers. Funding enables eligible candidates to receive Career Advancement Accounts in the amount of \$3,000 for 1 year, and renewable a second year for an additional \$3,000. This money can be used to pay for expenses directly related to post-secondary education and training to include tuition, books, necessary equipment, and credentialing and licensing fees in nationally identified high-growth, portable career fields such as education, health care, information technology, construction trades, and financial services.

The DOD Office of Military Community and Family Policy (MC&FP) has partnered with 15 States (beyond the six States directed by the NDAA for fiscal year 2007, Section 675), to operate Joint Family Support Assistance Programs in order to meet the needs of Active Duty, Guard, and Reserve Component family members. MC&FP and the Department of Labor have undertaken a collaborative effort to support military spouses in career development. The Military Spouse Career Advancement Account is an initiative underway in eight States to provide education and training to spouses to develop a career in a portable field. The collaborative effort has also created the Military Spouse Career Center, an online resource which “aims to support spouses and families by providing access to career opportunities, training information and education options.”

DEPARTMENT OF THE ARMY PROGRAMS

The Army has developed the Soldier Family Assistance Centers (SFAC) at Walter Reed Army Medical Center and Brooke Army Medical Center to coordinate resources and act as a point of contact for patients and their family members. The SFACs have created a toll-free hotline available 24 hours, 7 days a week to help resolve medical issues and provide an information channel of soldiers’ medically-related issues directly to senior Army leadership to improve how the Army serves the medical needs of wounded, ill, or injured servicemembers, veterans, recovering servicemembers and their families.

The Army also has several web tools including: Army Families Online, an integrated systems approach composed of seven specific sub-objectives (Pay and Compensation, Health Care, Housing and Workplace Environment, Family Support, Education and Development, Cohesion, and Operational and Special Interest); MyArmyLifeToo, a web site sponsored by the Army Family and Morale, Welfare and Recreation Command Family Programs Directorate, which carries the mission to maintain the readiness of individuals, families and communities within America’s Army by developing, coordinating and delivering services which promote resiliency and stability during war and peace; and the Army’s USAREUR G1 Human Dimension Resources, which provides Pre- and Post-Deployment resources for soldiers, civilians, and family members.

DEPARTMENT OF THE NAVY PROGRAMS

The Department of the Navy has operationalized family support programs to better empower Sailors, Marines and their families to effectively meet the challenges of today’s military lifestyle. The Navy’s Safe Harbor non-medical care managers assess each severely wounded, ill, or injured Sailor and their family to determine the needs for family member support. All wounded, ill, or injured Sailors, regardless of the severity of their condition, receive the support the family members need. The Marine Corps has assigned Family Readiness Officers at the unit level to enhance Marine Corps Family Team Building. In partnership with Pennsylvania State University, they developed a Pilot Course to train recreation professionals on Inclusive Recreation for Wounded Warriors to ensure Marines and their families can create the “new normal” as soon as possible. The Marine Corps Wounded Warrior Regiment has a Wounded Warrior Battalion on each coast to provide better continuity

of care for wounded Marines and Sailors and their families, providing a location to recuperate and transition in proximity to family and parent units.

The Department of the Navy also has Navy Fleet and Family Support Programs that provide unified, customer-focused, consistent, and efficient programs and services to support sustained mission and Navy readiness. The Navy Lifelines Service Network, Answers for Sailors, Marines and Their Families is the Official Quality of Life delivery network of the Department of the Navy, serving Sailors, Marines, and their families. The Marine Corps Community Services program supports basic and quality-of-life needs for members of the Marine Corps and their families.

DEPARTMENT OF THE AIR FORCE PROGRAMS

The Air Force Survivor Assistance and Air Force Wounded Warrior Program provides assistance for each Airman's case on a one-on-one basis to help ensure their needs are fully met. A Family Liaison Officer is assigned a Community Readiness Consultant by the Airman and Family Readiness Center and/or an Air Force Personnel Center Wounded Warrior staff member through all phases of the process, as needed. They can contact the Survivor Assistance program staff 24 hours a day, 7 days a week.

In addition, the Air Force Family Advocacy Program FAPNet serves the mission to build healthy communities through implementing programs designed for the prevention and treatment of child and partner abuse. It is accessible through Air Force Crossroads, the Official Community web site of the United States Air Force. The Air Force Aid Society, the official charity of the United States Air Force, provides worldwide emergency assistance, sponsors education assistance programs, and offers a variety of base community enhancement programs that improve quality-of-life for Airmen and their families.

THE NATIONAL GUARD

The National Guard Family Program focuses on providing programs that encourage continued well-being and an increased quality-of-life. These programs include the: State Advocacy Program; Exceptional Family Member Program; Emergency Placement Care; Family Member Employee Assistance Program; Relocation Assistance Program; Emergency Financial Assistance; Food Locker; Family Referral and Out Reach; and Consumer Affairs and Financial Assistance.

THE RESERVE COMPONENTS

The Services, including their respective Reserve Components, have comprehensive deployment support programs to help families cope with the demands of military life and separations. The Services strive to ensure services (education, training, outreach, and personal support) are available during the entire deployment cycle. These programs assist unit commanders, servicemembers, and families affected by deployment and mobilization.

Family assistance centers serve as the primary delivery system for military family support programs, including deployment support, return and reunion, and repatriation. With increased demands of military life, Active and Reserve Component family support is critical to readiness and morale. These centers have met the short-notice "surge" mission requirements to date. A long-term sustainment strategic plan that provides for further integration of DOD resources that support a strong personnel and family readiness posture during ongoing contingencies is being developed. A number of pilot programs and initiatives are being fielded to all military members and their families to include the Joint Family Support Assistance Program required by the NDAA for fiscal year 2007, Section 675, and the Yellow Ribbon Reintegration Program required by the NDAA for fiscal year 2008, Section 582.

The Yellow Ribbon Reintegration Program will provide Reserve Component members and families with information, services, referral, and proactive outreach opportunities throughout the entire deployment cycle. The Office of the Assistant Secretary of Reserve Affairs is establishing the program office with assistance from other Department agencies and the Services and their components. The goal is to have the program implemented as quickly as required resources are confirmed and in place.

THE COAST GUARD

The Coast Guard Morale, Well-Being, and Recreation Program oversees the quality-of-life programs for members of the Coast Guard and their families. The Coast Guard Work-Life Program, located within the Health and Safety Directorate, sup-

ports the well-being of Active Duty, Reserve, civilian employees, and family members.

CONCLUSION

The SOC, OIPT, and LoAs continue to work diligently to resolve the many outstanding issues while aggressively implementing the recommendations of the Dole-Shalala Commission, the NDAA, and the various aforementioned task forces and commissions. These efforts will expand in the future to include the recommendations of the DOD Inspector General's report on DOD/VA Interagency Care Transition, which is expected shortly.

One of the most significant recommendations from the task forces and commissions is the shift in the fundamental responsibilities of the Departments of Defense and Veterans Affairs. The core recommendation of the Dole-Shalala Commission centers on the concept of taking the Department of Defense out of the disability rating business so that DOD can focus on the fit or unfit determination, streamlining the transition from servicemember to veteran.

While we are pleased with the quality of effort and progress made, we fully understand that there is much more to do. We also believe that the greatest improvement to the long-term care and support of America's wounded warriors and veterans will come from enactment of the provisions recommended by the Dole-Shalala Commission. We have, thus, positioned ourselves to implement these provisions and continue our progress in providing world-class support to our warriors and veterans while allowing our two Departments to focus on our respective core missions. Our dedicated, selfless servicemembers, veterans and their families deserve the very best, and we pledge to give our very best during their recovery, rehabilitation, and return to the society they defend.

Mr. Chairman, thank you again for your generous support of our wounded, ill, and injured servicemembers, veterans, and their families. We look forward to your questions.

RESPONSES TO WRITTEN QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO
LYNDA C. DAVIS, PH.D., DEPUTY ASSISTANT SECRETARY OF THE NAVY FOR MILITARY PERSONNEL POLICY, U.S. DEPARTMENT OF DEFENSE

ADAPTIVE HOUSING GRANTS

Question 1. In your prepared testimony you mentioned the importance of the adaptive housing grants provided by the VA for veterans and servicemembers. As you know, veterans with certain severe service-connected disabilities are entitled to specially adapted housing grants of up to \$50,000. These can be used to construct or modify a home so that it can accommodate a veteran's needs. Veterans with service-connected blindness only or with loss or loss of use of both upper extremities may receive a grant of up to \$10,000. The authors of the Independent Budget note that increases in this program's grant amount have been sporadic despite the increases in real estate costs. Many families and servicemembers find that this program just does not cover enough of the costs to make these improvements. There is currently a proposal before the Senate, that I worked on with my colleagues here on the Committee, to increase the benefit by \$10,000 for those veterans eligible for the \$50,000 grant and \$2,000 in additional benefit for those veterans eligible for the current \$10,000 grant. The approximate cost for this change in fiscal year 2009 is \$6 million. Does the VA support making this change to this mandatory program and increasing the benefit?

Response. The Department of Veterans Affairs (VA) administers the Adaptive Housing Grants program. Therefore, the Department of Defense defers to the VA's response to this question.

YELLOW RIBBON REINTEGRATION PROGRAM

Question 2. As you mentioned in your prepared testimony, Congress included as part of the fiscal year 2008 Defense Authorization bill direction for DOD to create the Yellow Ribbon Reintegration Program (Public Law 110-181, Section 582) to establish a program to help National Guard and Reserve soldiers and their families with the process of pre-deployment, deployment, and post-deployment. However, the President's budget for fiscal year 2009 contains no targeted funds for this program for servicemembers and their families. Several States in including Vermont, Minnesota, and Missouri have unique reintegration and outreach programs that they have developed in part using federally directed spending. However, many other

States do not have such resources and returning servicemembers and their families are suffering from this lack of services. This is particularly true for States that are without a large active duty component and military installations. Since National Guard and Reserve are being called up to do a Federal mission, the Federal Government must help these servicemembers reintegrate back into their communities and this program could help to do just that. Can you explain why the President and the DOD have not requested any funding for this program in this year's budget? When will funding be made available for this program and when will it be up and running?

Response. The President's 2009 budget request was delivered to Congress on February 4, 2008. The Yellow Ribbon Reintegration Program was enacted as part of the fiscal year 2008 National Defense Authorization Act (NDAA) (Public Law 110-181) on January 28, 2008, well after the President's 2009 budget was finalized. While the Yellow Ribbon Reintegration Program was mandated in the fiscal year 2008 NDAA, no funds were appropriated to establish and support the program.

To address the funding shortfall, the Department has worked with the Services to identify programs that are not being fully executed in order to redirect funds to support the 2008 Yellow Ribbon Reintegration Program requirements. We have also requested funding for the program in the global war on terror supplemental budget requests for 2008 and 2009. The Department is developing the President's 2010 budget request and funding for this program is being addressed for that request.

While much work lies ahead, the program is up and running now. The Department's Yellow Ribbon Reintegration Program Office was established on March 17, 2008. It has a Director and Deputy Director and each Service has contributed staff. The Department plans to publish policy guidance to implement the Yellow Ribbon Reintegration Program in July 2008.

The support services provided under the Yellow Ribbon Reintegration Program are being delivered to all States through a combination of the Joint Family Assistance Program (required by section 675 of the fiscal year 2007 NDAA), the Services and their Reserve components, and Federal, State and local agencies.

FAMILY ASSISTANCE CENTERS (FACS)

Question 3. You mentioned in your prepared testimony the importance of Family Assistance Centers (FACs) that provide a full range of service for the National Guard and Reserve and family members. I couldn't agree more. When I talk to people in Vermont they tell me that there is not enough dedicated funding for these programs and that the funding that they do get does not last long enough. The current formula for allocating funds for this program gives increased funding when a deployment is announced but then that funding expires a short time after a unit returns from serving overseas. This does not make sense because the needs of the families and servicemembers increase not decrease when servicemembers return from deployment. I believe the funding should stay at elevated levels for at least 2 years after a unit returns.

a. Can you tell me whether the DOD is looking at reviewing this program, the funding allocation formula, and how long the money is available?

b. Is the DOD considering funding the FACs and other Deployment Cycle Support Programs from a dedicated stand alone account rather through multiple accounts from which many other programs drain funds, as is currently the case?

c. Will the DOD be changing the funding formula so that each State receives a minimum level of FAC and Deployment Cycle funding and staffing? If so, will this minimum level of funding take into account the unique geographic and other circumstances of the State such as how far the nearest military base is?

d. Is the DOD examining how to make authorized and appropriated funds for FACs and Deployment Cycle Support Programs coded as "purple" so that they are not restricted to providing assistance to only one branch of the Armed Forces?

Response. The Department plans to review the Army National Guard (ARNG) Family Support Center Program as one of the elements to be considered by the Department of Defense Yellow Ribbon Reintegration Program Center of Excellence established by Section 582 of Public Law 110-181.

Currently, the ARNG provides additional resources 6 months before mobilization and 6 months after mobilization but works with each State as needed if a Family Assistance Center (FAC) needs to stay open longer. The Department is not considering "fencing" funds for FACs or any other deployment cycle programs since this limits the flexibility of the Department to address such needs.

The statutes governing appropriations are very specific and they require that the funds are provided to each of the Services. The formula for allocating funds is a Service decision but part of that decision can take into account unique cir-

cumstances as part of the analysis in budget and program process. The ARNG, with full support from the Active Army, has increased their base number of FACs from 162 to 249 as a “steady State.” The ARNG will continue to provide additional resources for additional personnel and FACs (currently 345) based on mobilization levels, geographic dispersion as well as State specific challenges (mountains, islands, etc.).

There is no “purple” funding stream for the FACs, but they are not restricted to who they serve or their Service affiliation. In providing services to members, the staffs at FACs are instructed not to turn anyone away. They currently serve all Services and all components, Active, Guard and Reserve. There is no intent to change this practice, but they plan to enhance services for all Servicemembers and their families.

QUESTIONS FOR THE RECORD SUBMITTED BY HON. DANIEL K. AKAKA TO MS. KRISTIN DAY, LCSW, CHIEF CONSULTANT, CARE MANAGEMENT AND SOCIAL WORK, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Dr. Davis and Ms. Day’s written testimony stated that caring for families is essential to caring for veterans, but that VA can provide only certain services for families due to legal limitations. What statutory changes do you believe are necessary, and do you have any idea when Congress can expect a legislative package to make these changes?

Response. In general, the Department of Veterans Affairs (VA) has legal authority to provide limited counseling, education, and mental health services to a veteran’s immediate family members, the legal guardian of a veteran, or the individual in whose household the veteran certifies an intent to live, when such services are needed to treat the veteran’s condition.

VA is also able to provide care and services to the families of certain veterans through the civilian health and medical program of VA (CHAMPVA), a comprehensive health care program in which VA furnishes health care services and supplies to a defined list of eligible beneficiaries. Additionally, VA may provide treatment to non-veterans on a humanitarian basis. These services are billed to the patient.

Expanding VA’s authority to provide more comprehensive family support services and limited treatment services to family members or designated caregivers would require legislation. VA is considering possible new authorities but these concepts require further development and analysis.

Question 2. Justin Bunce and Daniel Verbeke were both recently assigned Federal Recovery Coordinators after years of having to rely on their families to help them navigate the DOD and VA systems. Is the FRC program making a concerted effort to reach back and find other veterans who were injured years ago but could still benefit from the program’s services?

Response. The Federal recovery coordinators (FRC) actively started working with patients January 28, 2008. FRCs develop Federal individualized recovery plans (FIRPs) for severely wounded, ill and injured servicemembers or veterans who meet the FRC program (FRCP) criteria. Phase One of the FRCP, scheduled to be completed in May 2008, targeted those catastrophically wounded ill or injured arriving from theatre to the military treatment facility. The second phase of the FRCP is scheduled to start in June 2008, and will include “look backs” to those severely wounded, ill and injured servicemembers, veterans, and families injured prior to the start of the FRCP. Identification of this population will be conducted through a review of VA rehabilitation, to include spinal cord injury and blind rehabilitation, along with the polytrauma patients. In tandem, the Department of Defense (DOD) will work through TRICARE in an effort to identify the same population for potential inclusion into the FRCP. Staffing support has already been initiated to support this expansion effort. A (centrally-positioned) additional registered nurse is already being recruited to champion this effort along with additional field-based FRCs who will be placed according to geographic location of need.

QUESTIONS FOR THE RECORD SUBMITTED BY HON. BERNARD SANDERS TO MS. KRISTIN DAY, LCSW, CHIEF CONSULTANT, CARE MANAGEMENT AND SOCIAL WORK, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Veterans with certain severe, service-connected disabilities are entitled to specially adapted housing grants of up to \$50,000. These can be used to con-

struct or modify a home so that it can accommodate a veterans' needs. Veterans with service-connected blindness only or with loss or loss of use of both upper extremities may receive a grant of up to \$10,000. The authors of the Independent Budget note that increases in this program's grant amount have been sporadic despite the increases in real estate costs. Many families and servicemembers find that this program just does not cover enough of the costs to make these improvements. There is currently a proposal before the Senate, that I worked on with my colleagues here on the Committee, to increase the benefit by \$10,000 for those veterans eligible for the \$50,000 grant and \$2,000 in additional benefit for those veterans eligible for the current \$10,000 grant. The approximate cost for this change in fiscal year 2009 is \$6 million.

Does VA support making this change to this mandatory program and increasing the benefit?

Response. The specific proposal referred to in the question is contained in section 501(a) of S. 1326, which would increase the maximum dollar amounts available under the specially adapted housing (SAH) program. VA supports enactment of subsection (a) with the following clarification and subject to Congress' enactment of legislation offsetting the costs associated with such increase in these amounts. Since the existing statutory limit on grants made pursuant to section 2101(a) is an aggregate that includes grants made under section 2102A, an authority which is due to expire June 14, 2011, an ambiguity may arise at the time of expiration with regard to the amount of assistance available under section 2101(a). To avoid such an effect, VA recommends amending the introductory paragraph of section 2102(a) by adding a maximum dollar amount allowable for grants authorized under section 2101(a).

Chairman AKAKA. Thank you very much, Ms. Day.
Now we will hear from Jane Dulin. Ms. Dulin?

**STATEMENT OF JANE DULIN, LCSW, SUPERVISOR, SOLDIER
FAMILY MANAGEMENT BRANCH, U.S. ARMY WOUNDED WAR-
RIOR PROGRAM**

Ms. DULIN. Thank you. Chairman Akaka, distinguished Members of this Committee, thank you for the opportunity to talk today on behalf of the U.S. Army Wounded Warrior Program. AW2 provides personalized assistance to the Army's most severely wounded, ill, and injured soldiers and their family and is an integral part of the Army's commitment to serve and support these wounded soldiers and families.

In April 2004, the Department of Army introduced an initiative to enhance the care and support of severely wounded soldiers and their families. This initiative was known as the Disabled Soldier Support System, or DS3, and was designed to support and guide soldiers and families from evacuation through treatment, rehabilitation, and transition back into the civilian community.

In November 2005, the name changed to the U.S. Army Wounded Warrior Program to reflect that our wounded warriors and their families are self-sufficient, contributing members of our military and civilian communities living and espousing the warrior ethos rather than simply being disabled.

An AW2 soldier is one who sustains injuries or illness incurred after September 10, 2001, in support of the Global War on Terrorism. The soldier has received or is expected to receive a 30 percent rating for one or more severe injuries rated by the Physical Disability Evaluation System. Many wounded soldiers do not meet our criteria. However, AW2 is committed to ensuring that all wounded warriors receive quality care. AW2 will assist and refer the non-AW2 soldier and family to appropriate Army, VA, and local resources that can assist that soldier.

AW2 provides the Army's wounded soldiers and their families with the life cycle of care, from initial hospitalization to transition into continued military service or medical retirement. AW2's personalized services are not limited by physical location and are not restrained by recovery time lines. AW2 will provide services and support to active, National Guard, and Reserve soldiers and their families for as long as it takes. All components receive the same level of service.

When I joined AW2 in April 2005, I was one of only four Soldier Family Management Specialists assisting approximately 340 severely wounded soldiers and their families. The challenges faced by the soldiers and families were daunting and the challenges of a new organization attempting to incorporate and integrate several existing programs to serve them were many and equally daunting. Much of the work involved reaching back to help resolve pre-existing problems facing our soldiers and families.

Many of our soldiers were already out of the Army and enrolled in the VA but still had unresolved Army issues. The Army had no centralized program to track a wounded soldier from the point of injury through treatment and transition into the VA system, so AW2, together with the VA, had to develop one. Our former Director once said, AW2 is building its plane while flying it. We were reactive rather than proactive.

Today, AW2 is currently tracking and assisting over 2,500 severely wounded soldiers and their families, and unfortunately, that number continues to grow. We have 80 Soldier Family Management Specialists working throughout the country at military treatment facilities and installations. With the support of the Department of Veterans Affairs, AW2 has SFMSs working within VA medical centers and at the Level 1 polytrauma centers. We now have four regional supervisors ensuring that our SFMSs are providing quality services to our soldiers and families. As one of those supervisors, I oversee the SFMSs working at Walter Reed, Brooke Army Medical Center, and at the four VA polytrauma centers. Our SFMSs work closely with the military liaisons and the VA staff at the polytrauma centers to proactively mitigate soldier and family issues.

AW2 cuts through red tape and assists our soldiers and families in navigating Federal, State, and private benefit systems. AW2 links soldiers and families with selected financial, educational, employment, legal, and medical resources. AW2 is utilizing lessons learned to enhance and improve our service delivery to our wounded warriors and their families.

In conclusion, after having worked as a social worker at the Department of Veterans Affairs during a time when the collaboration between the DOD and VA was not as strong as today, I can assure you of the benefits that this partnership is producing. AW2 remains committed to working in conjunction with the Department of Veterans Affairs to ensure that the soldiers and families who have placed their lives on the line receive the full range of services and benefits for which they are entitled.

I thank you for the opportunity to appear before you today and I look forward to your questions.

[The prepared statement of Ms. Dulin follows:]

PREPARED STATEMENT OF MS. JANE DULIN, SUPERVISOR, SOLDIER FAMILY MANAGEMENT SPECIALIST BRANCH, UNITED STATES ARMY WOUNDED WARRIOR PROGRAM

INTRODUCTION

Chairman Akaka, Distinguished Members of this Committee, Thank you for the opportunity to talk today on behalf of the United States Army Wounded Warrior Program.

WOUNDED WARRIOR PROGRAM

On April 30, 2004, the Department of the Army introduced an initiative to enhance the care and support of severely Wounded Warriors and their Families. This program identified the requirement for the Army to respond to the needs of the seriously wounded Soldiers from Operations Iraqi Freedom and Enduring Freedom. Initially, the name of this initiative was the Disabled Soldier Support System, known as DS3. It was designed as a system of support to guide Wounded Warriors and Families from evacuation through treatment, rehabilitation, and possibly to return to duty or military retirement and transition into the civilian community. When I was hired as a Soldier Family Management Specialist in April 2005, I assumed duties as one of four Soldier Family Management Specialists assisting the Army's most severely wounded Soldiers and their family members.

In November 2005, the name changed to the United States Army Wounded Warrior (AW2) Program. This change occurred to recognize that the Army's Wounded Warriors did not consider themselves to be "disabled" but rather self-sufficient, contributing members of our communities. The United States AW2 Program embodies the Warrior Ethos "we will never leave a fallen comrade."

The personalized support that is provided by a Soldier Family Management Specialist to a Wounded Warrior and his/her Family is not limited by geography or physical location and is not constrained by recovery or rehabilitation timelines. A Soldier Family Management Specialist will provide services to that Soldier and Family for as long as it takes.

To be eligible for the United States AW2 Program, a Soldier must suffer from injuries or illnesses in support of the Global War on Terror sustained after September 10, 2001. He or she must receive, or expect to receive a 30% or greater Army disability rating for one or more injuries by the Physical Disability Evaluation System. These injuries include categories such as: loss of vision/blindness; loss of limb; spinal cord injury/paralysis; permanent disfigurement; severe burns; Traumatic Brain Injury; Post Traumatic Stress Disorder and other fatal/incurable disease.

Through the expert leadership of the United States Wounded Warrior Program, our mission is to cut through red tape and assist our Soldiers and their Families as they navigate Federal, State and private benefit systems. Soldier Family Management Specialists are the "boots on the ground" linking Wounded Warriors and Families with selected financial, educational, employment, legal and medical resources. We strive to be effective change agents, continually implementing lessons learned to adjust policy and increase the responsiveness and effectiveness of our medical and benefit systems and partners.

The United States AW2 Program's footprint is now throughout major Army Military Treatment Facilities, Veterans Affairs Polytrauma Rehabilitation Centers and VA Polytrauma Network Sites. In less than three years, the United States AW2 Program has expanded to 80 Soldier Family Management Specialists throughout the United States. As of November 2007, AW2 has four regional SFMS supervisors.

In March 2007, the Program initiated and deployed the Wounded Warrior Accountability System (WWAS), which is the "gold-standard" and has no peer in the military or civilian sectors. WWAS is a system that has combined data from 12 Legacy systems and provides AW2 Soldier Family Management Specialists with the ability to track, monitor and manage our Soldiers and Families. The Soldier Family Management Specialist documents all interactions with AW2 Soldiers and their Families in the call log capability of WWAS.

The United States AW2 Program worked with Army G-1 to develop the AW2 Benefits Calculator which provides AW2 Soldiers a financial comparison of continued military service versus medical retirement. This tool is one of many utilized by the Soldier Family Management Specialist to assist the transitioning Soldier and Family.

The United States AW2 Program and Soldier Family Management Specialists were instrumental in establishing and training the Wounded Soldier Family Hotline for all Army wounded, injured and ill Soldiers; utilizing lessons learned and experience gained from working with the Army's most severely injured. AW2 has participated in many of the Army's transformation initiatives such as the Physical Dis-

ability Evaluation System transformation, the Army Medical Action Plan (AMAP) and the OSD Senior Oversight Committee Lines of Action. As we implement all pertinent aspects of the 2008 NDAA including improvements to case management and supporting the PDE pilot program, AW2 SFMS's will continue to improve the treatment of Soldiers and Families across the continuum of care.

In June 2006, AW2 held its first symposium, based on the well-established Army Family Action Plan. This forum allowed AW2 Soldiers and Family Members to identify and prioritize systemic issues, some of which are the basis for many of the transformation efforts. Two additional symposiums followed with a fourth symposium scheduled for June 2008.

The level of service provided by the Soldier Family Management Specialists ranges from assisting a severely wounded Soldier to obtaining a full restitution from the Army Board for Correction of Military Records in less than six months to assisting a wounded warrior and Family find the resources to pay an electrical bill. Typical achievements by Soldier Family Management Specialists include assisting medically retired Soldiers with TSGLI appeals. In some case these resulted in a \$50,000 award to the Soldier. Additionally these critical SFMSs assist medically retired Soldiers, some with severe Traumatic Brain Injuries to negotiate and be released from binding monetary liability contracts. They have assisted in initiating financial audits resulting in discoveries of erroneous Survivor Benefit Plan deductions for single Soldiers and then coordinated with the Retirement Service Office to reimburse the entire amount back to the Soldiers. These Specialists have met with Families of AW2 Soldiers as they faced difficult end-of-life decisions for the Soldiers. They have coordinated Homecoming Celebrations for multiple AW2 Soldiers, assisted with Social Security applications and appeals for AW2 Soldiers, coordinated Purple Heart Ceremonies for medically retired, comatose Soldiers at their homes and countless other services for our most severely wounded warriors.

As of January 2008, we have 26 Soldier Family Management Specialists working within Veterans Affairs Medical Centers, providing AW2 services to the Army's most severely wounded Soldiers and Families. We thank the Department of Veterans Affairs for providing us office space and support to continue our mission.

We plan to increase the number of Soldier Family Management Specialists at VA facilities as our AW2 population grows. In addition, we plan to further improve our training program, utilizing lessons learned to enhance our service delivery to our Wounded Warriors and their Families. We will continue to oversee the program qualities and efficiencies for our Soldiers and Families to obtain the benefits and services for which they are entitled. We will never leave a fallen comrade.

From April 2004 onward, the United States AW2 Program has been and remains a vital and growing program. It is the Army's official program for providing advocacy and support to our most severely injured and ill Soldiers and their Families. Currently, the program is tracking more than 2500 Soldiers and remains relevant and critical to our Army. AW2 assisted 59 Soldiers to Continue on Active Duty or in an Active Reserve Status (COAD/COAR). In conjunction with the Soldier's Career Managers at the Army Human Resources Command, Soldier Family Management Specialists have helped in developing a 5-Year Plan for each COAD/COAR Soldier. Finally, AW2 and the Soldier Family Management Specialists are actively engaged in the implementation of a Pilot Program with the National Organization on Disabilities (NOD). This program will align an employment expert with a Soldier Family Management Specialist enhancing their ability to assist our Soldiers seeking employment.

The Army is grateful for the support it has received throughout the Department of Defense and from other Federal agencies to improve the care, treatment, and services provided for our wounded warriors and their families. While much progress in this noble effort has been made, more can and should be done. The Army supports the initiatives to include the proposed Dole-Shalala legislative reforms to help our wounded warriors as they transition from DOD to VA.

In conclusion, the AW2 Program is vital and necessary to our most critically injured Soldiers. As someone involved in the program from its earliest inception, without hesitation I can assure you it is heading in the right direction and for the right reasons. I thank you for your time and look forward to your questions.

Chairman AKAKA. Thank you very, Ms. Dulin.
Now we will hear from Dr. Steven Sayers.

STATEMENT OF STEVEN L. SAYERS, PH.D., CLINICAL PSYCHOLOGIST, PHILADELPHIA VA MEDICAL CENTER, AND ASSISTANT PROFESSOR OF PSYCHOLOGY IN PSYCHIATRY AND MEDICINE, UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE

Mr. SAYERS. Thank you. Mr. Chairman, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to testify. I am going to frame some of the needs of the veterans from the conflicts in Iraq and Afghanistan and their family members by describing for you some of the research that we have recently conducted with these veterans. I am going to focus my comments on married military veterans with mental health issues, since my research and experiences as a VA-based university faculty member and clinician have dealt primarily with these veterans.

Returning veterans face a number of challenges in reintegrating into their family. Upon their return from deployment, military servicemembers find that they have changed, their family members have grown and changed, and in some cases they are meeting their newborn children for the first time. It is anticipated that veterans and their family members will go through a process of reintegration and it is also common for them to need to renegotiate their role in the family because the spouse has picked up most of the household responsibilities in his or her absence. It is also common for returning veterans to feel like a guest in their own home and perceive a lack of connection and warmth from their children.

But the limited available research evidence suggests that most veterans work through these experiences relatively successfully because family members can be a source of support and comfort, but where misunderstanding and conflict occurs, there is potential for less success in reintegrating the veteran into the family. Previous survey studies done with Vietnam-era veterans suggested that veterans experiencing mental health problems would be the most vulnerable to problems with reintegration.

Our first research task was to understand what kind of family problems were most associated with mental health issues from which these veterans are suffering. Our results were drawn from a total sample of 199 veterans who had recently returned from Iraq and Afghanistan, 43 percent of whom were married or living as married, 24 percent were recently separated, with a total of 67 percent who were married or recently separated. And these veterans had been referred from a primary care provider for a mental health evaluation and they agreed to answer additional questions for us about their family problems.

The first thing to say about the results is that family reintegration issues in this particular sample were especially common, and those with symptoms of major depressive disorder or PTSD were more likely to report feeling like a guest in their home than if they didn't have one of those disorders. Also, those with depression were less sure about their role in the household and those with PTSD were more likely to report that their children acted afraid or did not act warmly toward them.

The most disruptive psychiatric symptoms appear to be feeling emotionally numbed and emotionally cutoff from others, as well as having an exaggerated startle response or being hyper-alert. In ad-

dition, mild to moderate conflict involving shouting, pushing, or shoving was fairly common, over 50 percent among those with a current or recent partner. And over a quarter reported that their partner was afraid of them.

Now, what these specific findings tell us is that reintegration of the returning servicemember into the family can really become very complicated, conflicted, and less successful when one is dealing with the disruptive symptoms associated with depression and/or PTSD. And the findings also indicate that it is important to intervene on these reintegration problems with family members when a veteran has mental health issues. Family members are very aware of the mental health needs of their veteran and often have needs related to unresolved reintegration into the family and unresolved reintegration problems after a deployment independent of whether the veteran chooses to seek services within the VA system.

This is an important area of research for our investigators and our research, the VA research in this area is really growing. Examples of projects related to family are studies of caregiver involvement and depression and online family education and serious mental illness. Overall, there have been projects and solicitations on access and barriers to care, relative to telemedicine initiatives, collaborative care and other care models, and related economic issues.

So, thank you again, Mr. Chairman, for inviting me today and I am ready to take your questions.

[The prepared statement of Mr. Sayers follows:]

PREPARED STATEMENT OF STEVEN L. SAYERS, PH.D., ASSISTANT PROFESSOR OF PSYCHOLOGY IN PSYCHIATRY AND MEDICINE, UNIVERSITY OF PENNSYLVANIA, AND CLINICAL RESEARCH PSYCHOLOGIST AT THE PHILADELPHIA VETERANS AFFAIRS MEDICAL CENTER

Chairman Akaka, Ranking Member Burr, and Members of the Committee, Thank you for the opportunity to testify. I will frame some of the needs of veterans from the conflicts in Iraq and Afghanistan and their family members by describing for you some of the research that we have recently conducted with these veterans, as part of the VISN 4 Mental Illness Research, Education and Clinical Center (MIRECC). I will focus my comments on married military veterans with mental health issues since my research and experiences as a VA-based University faculty member and clinician have dealt primarily with these veterans.

Returning veterans face a number of challenges in reintegrating into their family. Upon their return from deployment, military servicemembers find that they have changed, their family members have grown and changed, and in some cases they are meeting their newborn children for the first time. It is anticipated veterans and their family members will go through a process of reintegration. It is common for veterans to need to renegotiate their role in the family because the spouse has picked up most of the household responsibilities in his or her absence. It is also common for returning veterans to feel like a guest in their own home, and perceive a lack of connection and warmth from their children. Most existing research suggests that during this reintegration period there are both positive and negative emotional effects of deployment on veteran and family; however, there is little evidence of an overall effect of deployment on the stability of marriages. The limited available research evidence suggests that most veterans work through these experiences successfully.

Our research grew out of the desire to understand what type of family problems returning servicemembers have that may complicate their reintegration into their family and community. Family members can be a source of support and comfort, but where misunderstanding and conflict occurs, there is potential for less success in reintegrating the family member into the family. Previous survey studies done with Vietnam era veterans suggested that veterans experiencing the mental health problems would be most vulnerable to problems with reintegration. Our first research task was to understand what kind of family problems were most associated with the

mental health issues from which these veterans were suffering. These results were drawn from a total sample of 199 veterans who had recently returned from Iraq or Afghanistan, 43 percent of whom were married or living as married; an additional 24 percent had recently separated. These veterans had been referred from a primary care provider for mental health evaluation and they agreed to answer additional questions about family problems.

Among those recently returned veterans with symptoms of depression, PTSD, or another anxiety disorder, we found that family reintegration problems were especially common. Those with symptoms of Major depressive Disorder or PTSD were more likely to report feeling like a guest in their own home. Also, those with depression were less sure about their role in the household. Those with PTSD were more likely to report that their children acted afraid or did not act warmly toward them. The most disruptive psychiatric symptoms appear to be feeling emotionally numbed and cutoff from others, as well as an exaggerated "startle" response or being hyper-alert.

We also asked about relationship conflict, including domestic abuse, among those veterans with current romantic partners or who were recently separated. Mild to moderate conflict involving shouting, pushing or shoving was common (53 percent) among those with a current or recent partner. Over one quarter reported that their partner was afraid of them.

My general findings are as follows: it is not uncommon for family problems to occur along with mental health problems, regardless of the cause. What these specific findings tell us, however, is that the reintegration of the returning service-member into the family may become complicated, conflicted, and less successful when one is also dealing with the disruptive symptoms associated with depression and/or PTSD.

The findings also indicate that it is important to intervene on reintegration problems with family members when a veteran has mental health problems. Family members are very aware of the mental health needs of their veteran and often have needs related to unresolved reintegration problems after a deployment, independent of whether the veteran chooses to seek services within the VA system. This is an important area of research. VA research in this area is growing. Examples of projects related to family are studies of caregiver involvement in depression and on-line family education in serious mental illness. Overall there have been projects and solicitations on access and barriers to care, relevant telemedicine initiatives, collaborative care, other care models, caregivers and related economic issues.

Thank you again, Mr. Chairman, for inviting me today. At this time, I will answer any questions you or other Members may have.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO STEVEN L. SAYERS, PH.D., ASSISTANT PROFESSOR OF PSYCHOLOGY IN PSYCHIATRY AND MEDICINE, UNIVERSITY OF PENNSYLVANIA, AND CLINICAL RESEARCH PSYCHOLOGIST AT THE PHILADELPHIA VA MEDICAL CENTER

Question 1. Your research has found that veterans' families are often the first to notice and experience the changes in veterans with depression and PTSD upon their return home. How can VA prepare families and provide additional support to ease veterans' reintegration to the family?

Response. The Department of Veterans Affairs (VA) is required to provide eligible family members with such consultation, professional counseling, training, and mental health services as are necessary in connection with that treatment. For veterans receiving treatment for a non-service-connected disability, VA is authorized to provide family counseling support if those services were initiated during the veteran's hospitalization and the continued provision of those services on an outpatient basis is essential to permit the discharge of the veteran from the hospital. Family members are aware of the mental health needs of their veteran, and educational outreach efforts directed toward family members are used to help them encourage the veteran to seek services when needed. VA will implement more outreach to educate and inform family of mental health risks and services available to address those risks.

Question 2. Please describe how the Mental Illness Research, Education & Clinical Center (MIRECC) will work to integrate your research findings into clinical practice.

Response. Our goals will be to broaden existing outreach efforts to the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans and their family members. We plan to work with existing network OEF/OIF outreach staff to develop additional outreach focused on engaging family members directly. We plan to pilot

a program that will engage family members to educate them about VA services, provide brief support consistent with our limited authority under the law, and offer the possibility of directed problem solving therapy, which is a type of cognitive behavioral therapy that helps family members constructively respond to a veteran's mental health conditions. A critical role of the MIRECC is to examine the effectiveness in improving veteran and family member outcomes using this outreach. We will rely on our existing strengths in telephone-based clinical evaluation, including the Behavioral Health Laboratory developed in Philadelphia, as a major component of evaluation and triage in these outreach efforts. We have made multiple presentations on Dr. Sayers' research findings to professional audiences, most recently to clinicians at the VA Medical Center in Durham, NC, on March 25, 2008. We will make additional presentations of this type to other audiences in VA. The findings are under review at a professional journal, which will provide a larger dissemination of this research.

We plan to evaluate our outreach efforts, and use the findings to tailor additional outreach efforts at the Philadelphia Medical Center and throughout the Veterans Integrated Service Network (VISN) 4. Additional dissemination of these methods, based on our evaluation, will target clinicians at VA and other professional conferences, and other training opportunities for VA clinicians developed through our MIRECC in VISN 4.

Chairman AKAKA. Thank you very much, Dr. Sayers.

My first question is to Dr. Davis and Ms. Day. We heard from Colonel Bunce and Mr. Verbeke about their struggles with the bureaucracy. I understand that Daniel Verbeke was just appointed a Federal Recovery Coordinator. How is that program going to help him? What can you tell his father today about how his responsibilities will be diminished by this program?

Ms. DAY. Yes, sir. Thank you.

Chairman AKAKA. Ms. Day?

Ms. DAY. I think the testimony that we have heard here from the family members reflects the reality of our complex care and the fact that many of our most severely wounded servicemembers receive care, clinical care and non-clinical care, by a myriad of people. In fact, the Navy did a lean Six Sigma and they determined that over 30 well-meaning case managers come to the bedside of a Marine offering assistance and care, get a card, as we have heard, get a pamphlet, and yet the servicemember and the family go home confused, isolated, and by themselves.

So, while it seems counterintuitive that you would need another individual, there is a missing role and that is the coordinator. And for me, the easiest metaphor to explain the concept is an air traffic controller. There is no plan at this point for these individuals. No one has sat down with these servicemembers and these families and said, what are your goals, what are your immediate priorities, and engage them in a partnership, regardless of where you get your care—whether you go to TRICARE or whether you go to VA or the private sector.

The Federal Recovery Coordinator will work with the servicemember and the family to map out, if you will, using a couple of key tools that we will talk about, how to meet their goals in a reasonable way. These families are quite understandably overwhelmed, given what has happened to them and to their loved one, and they need a partner from the beginning to move forward with them.

So, the Federal Recovery Coordinator will have a couple of unique tools. One, as Dr. Davis mentioned, is a national directory of resources. Nobody can know about all of the resources that are available in this country from Federal, State, and local, private sec-

tor, public sector resources; and, therefore, we need to leverage our technology and develop a resource directory that the Federal Recovery Coordinators can then customize, if you will, to meet the specific goals of the individual—to show them and work with them the Federal resources, the local resources, the State resources—just as our families have indicated this morning. They have not had a partner to help them do that, based on their unique set of circumstances.

So, back to the air traffic control metaphor, they won't be providing the care. They won't be flying the planes in and out. But they know which ones are supposed to be there at what time.

We also know, and our families have reinforced for us this morning, that hand-offs and transition of care are very vulnerable times for these individuals and their families. So, the Federal Recovery Coordinator will be especially focused on those areas which are predictably delicate.

The first eight Federal Recovery Coordinators now have 46 severely injured that they are working with. They have been at their duty stations for approximately a month. And they will follow these individuals that they have developed a plan with for the course of a lifetime, regardless of where that individual goes, should they move from Walter Reed to a polytrauma center to a TRICARE provider. Regardless of where they get their care or where they are, we will be leveraging, again, technology—the old-fashioned telephone, the Internet, as well as e-mail—to maintain contact with them as their needs for support wax and wane into the future.

Chairman AKAKA. Thank you. Ms. Davis?

Ms. DAVIS. I would only like to add, sir, that in the 2008 NDAA, Congress, in its wisdom, helped us out again by supporting some of these same services for the less seriously injured, so that now there will be a Recovery Care Coordinator and a Comprehensive Recovery Plan that we will have for every wounded, ill, and injured servicemember.

So, our Wounded Warrior programs that currently exist, will be enhanced further with a plan that captures all the medical and non-medical needs for the servicemember and the family. We hope in that way to avoid some of the challenges that we heard from the families about lack of information and having to be searching for what is available out there. It won't be the servicemember and the family's responsibility. As Mr. Verbeke said, "Do something for me. Don't just give me more to do." We will be doing more for them.

Chairman AKAKA. Ms. Day, before I pass it on to our Ranking Member, let me ask you, using a metaphor that was used by Ms. Day on the air traffic controllers, these airplanes might be crashing, as well. What can you do today when you get back to your office to get them headed in a safe course?

Ms. DAVIS. I am sorry, Mr. Chairman. Are you asking—would you like me to respond to that?

Chairman AKAKA. Yes. What will you do today when you get back to the office?

Ms. DAVIS. One of the things that we are fortunate to be able to do is to make sure that we have had an opportunity to talk to Mr. Bunce and Mr. Verbeke, and really listen to the needs that they have had as we, on the DOD side, work with their representatives,

and the Wounded Warrior Regiment for the Marine Corps, and the Safe Harbor for the Navy, to hand them off warmly to their new Federal Recovery Coordinators. So, it is incumbent upon us on our side not to assume that our VA counterparts have all the information they need about how best to care in this transition period. We need to do a better job of planning for that transition phase. That is one thing that we are doing, sir.

We have a Family Council on DOD that is poised now and meeting this week to implement all the new requirements of the NDAA for the family members, which includes: training on things like the PTSD; making sure all resources are available; additional medical care for non-eligible family members like parents and older dependent children; making sure that they are well aware of the respite care and resources and the pay and compensation and benefits that are available to them; making sure there is a comprehensive program to assess family satisfaction with the services that they are receiving. We are implementing those things right now, Mr. Chairman.

Chairman AKAKA. I believe that among the seriously wounded veterans of OIF and OEF, there are hundreds if not thousands of stories like the ones we heard today. This is not a question, but I am concerned that the very limited resources will become rapidly overwhelmed and so we are looking forward to your further planning.

Senator Burr?

Senator BURR. Mr. Chairman, I have some remarks and then I will ask one question, if I may. I intend to ask the Chair, and I don't think the Chair will disagree with this, that we invite the VA in either a formal or informal capacity to address the three cases we have heard about today, to share with us the changes that have been made that would give us some assurance that were a similar servicemember to walk through the door or to be carried through the door tomorrow, the outcome would be different, and it is my hope that we will, in fact, do that.

Chairman AKAKA. Let me add at this time I certainly would want that to happen, yes.

Senator BURR. I thank the Chair.

Dr. Davis and Ms. Day, thank you for sharing with us some of the changes that have been made both at DOD and VA. One of the challenging things as a Member of this Committee is that I think we have a responsibility to try to comfort three families that are here today in our assurance that VA is listening. I think we have to assure them that government is learning, and more importantly that DOD and VA are changing and are responsive to the needs and the recovery of their loved ones and anybody else's.

I join the Chairman when I say, and I want to make it perfectly clear, if you can't produce the testimony in the time line of the Committee Rules, if you can't show respect to—and I don't say this to you two personally, please understand that—but if the agencies can't show respect to these families that come up here, many times using their own money, sharing very personal stories about the frustrations of dealing with Federal agencies, that the well-intended did not meet the needs of their family members who have sacrificed so much—I won't ask you to carry the message back to

OMB. I will carry it back to Director Nussle personally, but this is unconscionable that we would continue to do this.

Now, having said that, Ms. Day, I listened to you describe the number of additions that we have made, and I am sure that all of them have a very appropriate role in the enhanced outcomes that we expect in the future. But let me summarize what I heard from the families before.

One, services the warriors needed were either not available or not offered within VA.

Two, VA only looks at a slot to insert these warriors into but lacks the ability to assess improvement. In other words, it is a time line that we look at. You have been in this amount of time. Whether you have completed what we think is the satisfactory progress or the progress a family member or service personnel expects to complete, time is up. We will try something else. But all slots are predetermined.

Health professionals didn't recognize the benefit of early intervention. Now, you can't find anywhere in the private health care system today that early intervention is not the gold standard of medical treatment. Yet, we have got the most severely injured coming back where early intervention, especially on the mental health side, is nonexistent. The recognition in one of these cases that there was such a focus—probably because of the parents' insistence to address the TBI—that an open wound could go unattended for 5 months until the private sector got a hold of a patient, it is unconscionable in today's VA delivery system.

There is no coordination of care. Dr. Davis, I think the Recovery Coordinators—I am just surprised it took us so long to recognize that we needed this and I hope it is a silver bullet, one that will begin to solve the problem. But if you listen to what Mr. Verbeke said, I think, or maybe it was the Colonel, there is not even anybody to coordinate the care of prescriptions when you have got multiple delivery points of health care for these veterans. The wrong combination of prescription drugs can have a tragic, possibly permanent, outcome.

So, to be totally candid, my assessment is the VA doesn't see the human face behind the patients they are treating. These are individual patients with no face. If they had a face, we would do something different. We wouldn't stop at the points we have stopped with many of these men and women. Now, I know that is a very cold statement to make, but this is not the first hearing like this that we have been through.

So, my question, Ms. Day, is, what do you say to Mr. Verbeke as it relates to VA's inability to get 6 months' notice that his son is going to go home and the supplies—it is not in question as to whether it is available to him—don't get there for his son's return; and now—3 months later—the last pieces are getting there. How do you explain it?

Ms. DAY. Senator, as a 27-year VA social worker on a personal level, I say that is unacceptable and I will take this information back to the agency and get to the bottom of what happened; and, as you requested, come up with an answer and a response specifically to the Committee about the individual situation and what happened.

[The Senate Committee on Veterans' Affairs staff tracked this situation and are confident it was resolved. In addition, VA and DOD staff briefed Senator Burr on this issue on August 8, 2008.]

Senator BURR. You know, I hate to be as direct as I have been, but I really believe we have some tremendous health care professionals within the VA and within DOD. I question whether all the additions we are making are actually going to make it better or worse in the future, because in most cases, I see the additions that have been made over the years hampering our ability to actually deliver health care. Now, we do a pretty good job to people who access the health care system because, quite frankly, they are getting old.

Ms. DAY. Yes.

Senator BURR. Isn't it time we put the same amount of focus on the ones that are young and have a lifetime ahead of them, where we can alter what their quality-of-life is and hopefully we can meet some degree of what their expectations are relative to recovery and integration in the future.

So, I thank you for your willingness to be here. I thank our other witnesses. And Mr. Chairman, I look forward to the opportunity (in a non-adversarial way) for the VA to come in and walk us through these three cases demonstrating how what we have currently structured and do today would bring about a different outcome for three families in the future, and hopefully many more. I thank the Chair.

Chairman AKAKA. Thank you. Thank you, Senator Burr.

Dr. Sayers, you have done some excellent work in pointing out that reintegration is not an easy path for a servicemember or the servicemember's family, especially when PTSD is involved in the equation. The advocacy group Mental Health America has called for an aggressive outreach approach to ensure that no family in crisis should be unaware of services offered to them. My question to you is, is the VA's current approach aggressive enough in this area?

Mr. SAYERS. Thank you for your question. I wouldn't characterize all services. I am perhaps not the person to do that. I will say that our focus and my focus has certainly been developing innovative services to help family members, and I think it is really an important approach. I think we can do more of it. I think the process of research with these services are such that we have to try what is going to be effective and evaluate it and I think we are in the process of trying to do that.

Chairman AKAKA. What do you think of the idea that was mentioned by Ms. Day about creating a directory of resources?

Mr. SAYERS. I think that is a great idea. I think we need to look at that and many other kind of strategies to see what is most effective to reach families. I don't think that family members and the veteran are going to be all reached in the same way and I think it is going to take more than one effort to do that.

Chairman AKAKA. Thank you. Dr. Davis and Ms. Day, one of the common complaints that I hear is the confusion of dealing with the overwhelming size and complexity of the DOD and VA bureaucracies. Is this concern being addressed by providing families with a single point of contact to help them navigate through the system,

and absent a Federal Coordinator, who in the VA will that person be?

Ms. DAY. Yes, sir.

Chairman AKAKA. Ms. Day?

Ms. DAY. In May 2007, each and every VA medical center operationalized an OEF/OIF Case Management Program. There is a single point of contact at every VA health care system that will serve as the triage person for any OEF/OIF needs. And on that team, there are social workers and nurses to provide case management when necessary. So, if somebody doesn't meet the criteria of severity for Federal Recovery Coordinator and yet they need assistance accessing these systems, they have a clinical case manager assigned to them. In addition, we have a VBA partner on each team to assist with benefits and we also have a Transition Patient Advocate, who serves as a buddy, a peer counselor, if you will.

Many individuals will use the standard resources that VA has in primary care and in our specialty care, but this program stood up in May now has 6,800 OEF/OIF servicemembers enrolled in it who are receiving care who have indicated, yes, they need support, especially in this initial transition period as they are readjusting into community life and they need and require that extra hand during that transition. So, in less than a year, we have enrolled almost 7,000 OEF/OIF servicemembers in the program.

Chairman AKAKA. Yes. Dr. Davis?

Ms. DAVIS. Mr. Chairman, I would say that in the DOD, programs such as the Army Wounded Warrior that you heard about do provide a single point of contact, non-medical case manager. Our Soldier Family Management Specialists, in the case of AW2, are the point of contact, the familiar face, the one to call, the 911/411 individual that each of our service-injured programs provides to the servicemembers and the families; and that is not limited to those who have the most catastrophic injuries.

Chairman AKAKA. Thank you. Dr. Davis and Ms. Day, I am interested in the challenges veterans face when they return to their civilian lives. Naturally, this could be quite a distance from where the Recovery Coordinator is located. What strategies have you identified to maintain contact between the veteran and the Recovery Coordinator once he or she returns to civilian life?

Ms. DAY. Yes, sir. We have been working very closely with our IT partners, because what we have heard from the family members is that e-mail is very important to them as an easy venue for contact; and we are working through our security challenges to make sure that that is an option for them.

The initial cadre of Federal Recovery Coordinators were stationed at the MTFs, because the servicemembers and families had said, we need a single point of contact from the very beginning. So, we were attempting to address that need by creating a face-to-face relationship upon arrival at the MTF from Landstuhl. But the reality is, people will move and they will go across the country.

The MTF Federal Recovery Coordinator at Walter Reed will be engaged with a servicemember. They will remain the Federal Recovery Coordinator regardless of where that individual goes around the country or regardless of what set of circumstances or services that individual selects for themselves, even if it is not VA.

That is fine. We will continue to provide them with the Federal Recovery Coordinator.

Chairman AKAKA. Dr. Davis?

Ms. DAVIS. Sir, because of the mobility of our servicemembers and their families and the many locations where they receive care, especially when they are back in the community where they will be going to (oftentimes private sector providers or the VA centers or clinics), that the one place where we are trying to keep a horizontal integrated record is in this Federal Recovery Plan. That will be a place the servicemember and the family can all ultimately have access to view also. That is their plan for recovery and they will be able to have in that plan a list of all the services that they need for cognitive therapy: for education; employment; for the respite care, all the housing assistance programs that are available; not just through the Federal Government but in the community—something like Habitat for Humanity.

Everything will be in one place that the Recovery Coordinator and the family will be able to view. And as there is a change in the condition of somebody like Justin or Daniel, we will be able to change the plan and that will be where both the Recovery Coordinator and other case managers in the community will be able to view and modify it with the family.

Chairman AKAKA. Let me ask Ms. Dulin, as I understand it, the Army's Wounded Warrior Program only provides outreach to those who are medically separated with a 30 percent or higher disability rating. What services does Wounded Warrior provide to soldiers who do not meet this criteria? For example, what about those who later receive much higher ratings for issues like PTSD?

Ms. DULIN. Thank you. Just to clarify, the Wounded Warrior Program begins from the initial hospitalization and so our SFMSs, or Soldier Family Management Specialists, are working with both active duty as well as medically retired. We will provide services throughout the Wounded Warrior life cycle, if you will, from the initial hospitalization through treatment, rehabilitation, medical evaluation—meaning the MEB, the Medical Evaluation Board, Physical Evaluation Board—and then on to transitioning either back into the military community or back into the civilian community.

If someone does not meet our criteria, that is if they don't reach that 30 percent, we do not turn them away necessarily, but we will refer them. We do work closely with the OIF and the OEF coordinators at the VA medical centers to ensure that those soldiers receive the connection, I guess if you will, to the services that can continue to help them along.

Chairman AKAKA. Thank you.

Ms. DAVIS. Might I add, Mr. Chairman, that in addition to that program, the majority of the Army's injured individuals will return to duty and those are served under the Army Medical Action Plan, the Warrior Transition Brigades and Units, the 35 that are around the country located on military installations. So, those rated less than 20 percent are likely to also be served with their case management triad.

Chairman AKAKA. Thank you for that.

Dr. Davis and Ms. Day, this will be my final question. Your written testimony discussed demonstration projects that are being developed in States such as California for the seamless reintegration of veterans back into local communities. It would seem that all of our witnesses in panel one could have used some of that kind of help. Please explain how these projects will help new veterans like Justin Bunce, Daniel Verbeke and Michael McMichael.

Ms. DAVIS. Mr. Chairman, the reference to the demonstration projects, especially the one in California, is something that we are doing with the California Department of Veterans Affairs. As we mentioned, the national resource directory that we are trying to work with all our partners across the continuum of care and get the information that is needed there, we are taking California as a microcosm of how effectively we can ensure that we are reaching all of the assets in the California Department of Veterans Affairs—the California Department of Labor, their mental health department, all of the VISNs, all of the not-for-profit organizations in the State of California—so that as we build this directory we will ensure that we have everything that is necessary for the family member, the servicemembers returning to California. That is the same model we will do in every single State to ensure that the services needed in Pennsylvania or Virginia or North Carolina or in the great State of Hawaii are all inside that directory and available to the family and the Recovery Care Coordinator as they make that life map.

Chairman AKAKA. Do you want to comment, Ms. Day?

Ms. DAY. No, sir.

Chairman AKAKA. Thank you very much.

In closing, I want to say that we have further questions to ask and I will submit them for the record and open it for other members, as well.

I want to thank all of you for appearing today. I know that some of you had to travel a great distance to be with us. We truly appreciate you taking the time to give us all a better understanding of the challenges facing the families of our veterans and, of course, the efforts to meet those challenges.

I also want to thank the Wounded Warrior Project for working so hard with us on this hearing. My expectation is that VA needs to adapt to meet the needs of the families of the newest generation of veterans and prevent the stories that we have heard today from continuing to happen.

This hearing is now adjourned.

[Whereupon, at 12:15 p.m., the Committee was adjourned.]

A P P E N D I X

TESTIMONY SUBMITTED BY SUZANNE B. PHILLIPS PSY.D., ABPP, CGP ON BEHALF OF THE AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION

I am submitting this testimony on behalf of the American Group Psychotherapy Association (AGPA) to address the needs of veterans and their families. In the aftermath of 9/11, AGPA responded to the needs of a traumatized population with an extensive number of group programs including those for bereaved spouses, families, traumatized children, adolescents, schools, communities, survivors, service delivery workers and uniformed service personnel. Groups and trainings were conducted in-person, online and via the telephone. In all, AGPA conducted over 600 groups in group programs providing services to over 5,000 people and trained over 1,500 clinicians in group interventions. What I propose is that many of these programs have particular relevance to the needs of veterans, their families and those who work with them. As will be discussed, group intervention has been shown to be therapeutically effective, cost-effective and most importantly attends to the restoration of trust and connection needed in the recovery from trauma (Burlingame, Fuhriman, & Mosier, 2003).

I. RATIONALE FOR COLLABORATION OF THE AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION WITH THE VETERANS ADMINISTRATION IN MEETING MENTAL HEALTH NEEDS

With more than 3,000 soldiers killed and more than 25,000 wounded in Iraq and Afghanistan, the mental health needs of those who have served are considerable (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004; Hoge, Auchterlonie, & Milliken, 2006). The numbers of servicemen and women who will eventually seek help for Post Traumatic Stress Disorder and mental health symptoms, will far outstrip the Department of Veterans Affairs' professional resources and scope of services. The American Group Psychotherapy Association (AGPA) is particularly suited to support the DVA's efforts in terms of expertise with trauma, group expertise and 9/11 lessons learned as reflected in programs described and formally published in *Group Interventions for Treatment of Psychological Trauma* (Buchele & Spitz, 2004) and *Public Mental Health Service Delivery Protocols: Group Interventions For Disaster Preparedness And Response* (Klein & Phillips, 2008). Drawing upon such experience AGPA, a national organization for over 60 years with over 3,000 professional members, can serve as a resource for consultation, training and/or direct service to address the mental health needs of veterans, their families and the clinicians and DVA personnel who work with them.

Rationale for the Use of Groups with Veterans

The relevance of a group based military initiative that could incorporate various theoretical models, time phases, sub-groups, and readjustment issues and needs can be supported from many perspectives. Historically, each major military conflict has spurred the development and utilization of group methods to meet the sudden and greatly increased demand for psychiatric services coupled with the limited availability of qualified clinicians. The vast numbers of military casualties suffering from what were previously labeled "wartime neuroses" or "battle fatigue" syndromes were treated in groups following World War II, both in the U.S. and in Britain. The "Northfield Experiment" (Northfield Hospital) in England involved the application of group methods in a hospital setting. These efforts in turn spurred the development of "therapeutic communities" in the US for providing treatment. Small groups were used for group therapy and large groups were used to create a therapeutic milieu and to examine the role and value of capitalizing on and using group dynamics in the treatment process.

With the Viet Nam conflict, we saw the development of "rap groups." The use of a variety of groups for dealing with trauma began to grow. More recently, group

therapy has been labeled the treatment of choice for combat trauma since World War II: “The favored use of group as a modality is not a matter of economy, but of effectiveness” (Kingsley, 2007, p. 65).

Theoretically, several reasons underscore the effectiveness of groups in treating combat disorders. To begin with, traumatic events isolate and disconnect. They assault a sense of self, safety and the systems of attachment and meaning to others. Herman (1997) notes that “Traumatized people feel utterly abandoned, utterly alone, cast out of the human and divine systems of care and protection that sustain life” (Herman, 1997, p. 52). Central to the recovery of any trauma victim, and particularly to the returning veteran, is the need to recover a sense of trust and connection with self and others. Adding to this, groups for the military can utilize the “band of brothers” mentality that is central to the cohesion and resilience of military personnel. Underlying all group interventions is the development of trust and the communalization of trauma within a cohesive group. Based upon his extensive work with Viet Nam vets, Jonathan Shay (2002) underscores the importance of group work as a necessary component to all treatment. According to Shay, people recover in community and although a vet may need individual treatment, group is seen as a crucial step in the “reconnection” needed for recovery. A group offers substantive validation from an audience that knows and can bear witness—an audience that can help with the destruction of social trust that often prevails when someone has survived the chaos of war.

Economically and expeditiously, groups can successfully address the needs of many simultaneously. Group modalities have been effectively used with veterans to address specific symptoms as well as the needs of specific sub-groups within the military populations. PTSD, anger management, stress management, combat nightmares, etc. have all been successfully treated using groups (Bolton, Lambert, Wolf, Raja, Varra and Fisher, 2004; Chemtob, Novaco, Hamada, & Gross, 1997; Allen & Bloom, 1994; Brockway, 2005). In addition, group interventions have been used effectively with sub-groups of African American vets with PTSD and veterans suffering from war and childhood trauma (Goodman & Weiss, 1998; Jones, Brazel, Peskind, Morelli, & Raskind, 2000). Underscoring the viability of group intervention post-deployment, Makler, Sigal, Gelkopf, and Horeb (1990), reported in their work with Israeli soldiers that group therapy was particularly valuable in dealing with the rage, guilt, shame, dehumanization, abandonment and betrayal attendant to combat PTSD. Foy, Glynn, Schnurr, Jankowski, Wattenberg, Weiss, Marmar, & Gusman (2004), who reviewed group treatments with a variety of trauma populations (sexual assault victims, male combat veterans, multiple trauma survivors, etc.) with multiple symptom clusters found positive outcomes in 13 out of 14 published studies.

This body of evidence has led many health care providers and professional organizations to endorse the value of group interventions for the treatment of PTSD, including the International Society for Traumatic Stress Studies (ISTSS) (Foa, Keane, & Friedman, 2004). Similarly, the Iraq War Clinician Guide recommends group models as one of the viable interventions for addressing PTSD, grief and bereavement, anger management, and substance abuse, etc. (Schnurr & Cozza, 2004).

Given the number of military personnel and their families seeking health care, and the shortage and overload on military personnel (American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members, 2007), the use of evidence-based group models addresses the economics of mental health response and the importance of early and timely intervention. This modality allows for the provision of care for a large number of individuals while decreasing the demands on clinicians’ time. The opportunity to reach and respond to more servicemen and women and their families in a timely way with group models that facilitate screening for higher levels of care, normalization of symptoms, transition and family re-adjustment as well as treatment for grief, depression, PTSD or delayed PTSD is likely to reduce the severity and overall duration of suffering for those returning from war.

Operation Enduring Freedom and Operation Iraqi Freedom have seen the deployment of more women into active service with combat exposure than any prior war. The unique needs of this group may be well served by a modality that offers a venue for dealing with issues of isolation, distrust, and sexual trauma as well as for affirming resilience and supporting transition to civilian life. Also at risk are reservists and guardsmen who, unlike career military, do not have the military infrastructure to support post-deployment and home-coming issues. Months or even years after a war or mission, PTSD symptoms may present or be masked as anger, isolation, family problems, or substance abuse (Kates, 2001; Meyers, 2003; Schnurr & Cozza, 2004; Shay, 2002). While Readiness Programs have worked to serve these

families, the delay in combat PTSD underscores the value of different types of group programs to address personal, marriage and workplace post-deployment needs.

One of the most compelling rationales for using group modalities in meeting the mental health needs of military is that group experience by normalization and communalization of traumatic symptoms reduces the barriers to care. Even as symptoms appear, barriers persist to seeking help in the military. Stigma, fear of being judged, the view of the self as helpless and weak, and the risk to military careers, make attending to emotional needs difficult, if not impossible (Hoge, et al., 2004). The group modality capitalizes on reinstating the integrity of the “band of brothers.” Servicemen and women are not alone in their reactions or their grief. Whereas there is a natural trauma bonding that occurs even for civilians who have shared a life-threatening event, this is even more pronounced with uniformed service personnel who expect to rely on each other as they face dangerous situations.

Overall, group interventions have the potential to provide a structure, reduce shame and helplessness, foster symptom management, validate traumatic experience, permit ventilation and grief, rebuild safety and trust, decrease isolation, render meaning and support the reconnection to self, family, belief systems and society.

Rationale for Use of Programs for Marriages and Families of Veterans

The collateral damage from war is too often the destruction of the marriages and families of veterans—38 percent of the marriages of Vietnam veterans dissolved within 6 months of their return from Southeast Asia. We are already aware of the difficult homecomings of our veterans from OIF and OEF. Homecoming is a complicated process. It is difficult to reverse battlemind mentality. The hypervigilance, mission focus, non-negotiation, targeted aggression, necessary numbing and use of a weapon necessary for survival in war does not translate into mutuality and intimacy in marriages. Similarly the split off grief for loss of buddies or shame and self-blame for being injured translates into anxiety, depression and PTSD. Veterans serve bravely and then bring the war home in the physical wounds and post traumatic symptoms they bear. Over 29,000 of our veterans have been wounded and 25 percent of those seen at the DVA have mental health diagnoses. Their marriages and families are both at great risk and are the greatest resources they have—Research tells us that the lack of social support and subsequent life events are variables that put veterans at great risk for PTSD. Conversely, the strength of close social ties like marriages and families are the most potent antidotes to the despair and isolation of Combat stress.

II. PROGRAMS AND EXPERTISE OF THE AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION WITH ESTABLISHED EFFECTIVENESS AND SUITABILITY TO THE NEEDS OF VETERANS, FAMILIES AND STAFF SERVICING THEM.

The American Group Psychotherapy Association has expertise in group based mental health responses. AGPA provides evidence-based and supported interventions within pre-existing systems in order to deliver services efficiently, effectively and insure that the effort can be sustained into the future. We strive to build expertise and strengthen infrastructure simultaneous with direct service delivery.

The Association also uses a “train the trainers” format whereby national experts teach others to carry out the work. There are over 30 local and regional affiliates of AGPA positioned to work in their communities with assistance from a national network of experts. We have been delivering these programs nationally and internationally in response to a variety of traumatic events including the events of 9/11, hurricanes and tsunami, and school violence. Training and service programs have been delivered in-person, online and via the telephone. An overview of our programs and the populations serviced follows; these can be tailored to the specific needs of each community, including military personnel and their families.

For Service Providers/Caregivers: Helpers have an enormous need for consultation and support in the face of the demands of trauma work. Military and veteran administration settings are frequently understaffed with large client populations. The following are program elements that can be stand-alone or integrated based upon need.

- Didactic and experiential group intervention training in working with trauma, bereavement, the medically ill and more: basic group dynamics, the elements of responses to trauma, whether for chronic issues or responding to catastrophic events, as well as in-depth training in evidence-based group programs.
- Support groups and consultation for mental health professionals and clergy: a key element is the provision of a forum in which to process their experiences and connect with colleagues.

- Groups for other personnel providing trauma-related services (management, administrators, etc.): a more psycho-educational orientation for non-clinicians to support the cooperative goals of a setting requiring multiple areas to cooperate for over-all patient care.
- Educational programs focusing on self-care: Provides clinicians, clergy and other helpers with self-care tools to assist them in their work going forward, increasing their resiliency.

For Active Duty Members and their Families: The following programs have been developed specifically for this community, and can be modified even further to attend to the differences between service branches which are specialized populations with unique cultures and needs for themselves and for their families.

- On-site support services at service headquarters: provides an opportunity to receive care and support in a familiar and easily accessed setting, such as the military base, VA hospital or local agency.
- “Family Days” for armed service workers and their spouses and children: A program model successfully initiated with the Fire Department of New York Counseling Services Unit (FDNY-CSU), which provides support and connections for families of those in the service and for families of deceased service personnel.
- Couples programs to provide relationship support: The Couple Connection Program was initiated in partnership with The FDNY-CSU; this program is designed to provide support and increase familial resiliency by strengthening relationships. Couple Connection Program for Retirees addresses marriage and family issues in the aftermath of forced retirement due to injury.
- Telephone and online consultation with experts in working with trauma in groups: For those situations and locales when an in-person visit is not practical or timely (such as for homebound veterans or those in remote locations). An ongoing group with one’s peers can be an important support providing ongoing connections with peers and an experienced clinician.

For Children and Adolescents: Children and adolescents are best helped with programs designed to recognize their differing needs according to their age and developmental stage, which can be impacted by the chronic stressors of having a parent(s) on active duty and/or the loss of a parent.

- School-based groups for affected children (with possible co-leadership with school staff): Provides direct services to children and is designed to aid the healing and increase the resiliency of children using the school system (a familiar, naturally occurring setting with minimal disruption and stigmatization).
- School-based training and support for teachers and guidance counselors: Providing adult caretakers with the tools to provide the services insures continuation of the program and increases the community’s resiliency.
- Groups for affected families (including parents): An intervention model that provides the family structure with support and a forum in which to develop coping skills, augment personal resiliency and strengthen supportive resources. This program works in cooperation with military institutions, faith based service groups, public service agencies and schools in order to utilize existing and familiar community structures. The Going On After Loss (GOALS) program is an example of this and has potential to be adapted as Going On After War.
- Consultation and educational programs for caregivers (parents, teachers, daycare/after-school workers and others): Another avenue of providing adult caretakers with skills and tools to attend to the needs of children.

Program Format Options:

- Single Session Public Education Groups—This often involves a speaker offering information about a selected topic (e.g. trauma and its impact, the effects of trauma on children and adolescents, etc.) followed by small group discussion; this format is highly effective in coping with the stigma attached to mental health issues as it normalizes responses and feelings.
- Time-Limited Groups—A specified number of group sessions, usually from 10–15, during which membership may be closed, or open when a “drop in” format is used. The goals of these programs are usually to help work through a specific challenge, avoid relapse and/or bolster coping and resiliency skills.
- Extended Services Groups—Groups extending beyond 15 sessions for those who need more work to recover. Members usually stay until they have accomplished their goals and are ready to move on.
- System Consultation—This usually involves a needs assessment followed by an intervention tailored to the particular needs of the organization in question, in conjunction with recommendations on infrastructure changes to continue to support the program and the staff/community needs.

- Online and Telephone-Based Groups—Trainings and support groups for both caregivers and the general population are delivered online and via telephone. These are effective options for the homebound and those in remote and/or rural locales with minimal or no access to services.

Printed Materials Available:

Training Curricula

- Group Interventions for Treatment of Psychological Trauma—Ten (10) training modules for mental health professionals who work with different populations and phases of trauma work. The modules address: group interventions for adults, children and adolescents; evidence-based programs for adults, children and adolescents; the later stage (coping with the aftermath of traumatic events); countertransference, unique aspects of group work, masked trauma reactions, and bereavement. Powerpoints that can be used for training accompany each module.

- Public Mental Health Service Delivery Protocols: Group Interventions For Disaster Preparedness And Response—A set of population-specific best practice interventions for use in delivering mental health services following disasters including Uniformed Service Personnel (also applicable to the Armed Services), children and families, school communities, adolescents, survivors, witnesses and family members, helpers and service delivery workers, organizations and systems, local community outreach programs, and the role of the philanthropic community. These protocols, which are group-based and focus on lessons learned from actual service delivery practices, have been collaboratively developed with organizations and professionals who have responded to past disasters, nationally and internationally. Summaries of the Public Mental Health Service Delivery Protocols are as follows:

Children and Families Dealing with a Traumatic Event—Maureen Underwood M.S.W., CGP

Consistent with a strength-based or resilience paradigm, this protocol uses a family group intervention that acknowledges families' pain, fear and loss and then identifies and emphasizes strengths and effective coping. The protocol presented has applicability for use by faith-based agencies, school districts, disaster mental health agencies and communities. Drawing upon a pilot program utilized after 9/11 with families that have lost a father, it is a detailed guideline of a program that involves a series of community-based psycho-educational support groups. It includes parallel parent-child interventions carefully planned in terms of timing, structure, content and group activities to address trauma and the grief process while restoring and expanding family stability, communication, coping skills and hope. It includes suggestions for initial and continuing outreach, criteria for screening, referrals for additional services, leadership qualifications and guidelines, and evaluation and research.

Caring for a Traumatized School Community—Toby Chuah Feinson, Ph.D., CGP

This module draws upon a school protocol that served as a response to the traumatized school communities seeking help in the aftermath of 9/11. It delineates a multi-level template that can be adapted to the needs of diverse school communities. The school protocol presented is two pronged in that it addresses both the direct and secondary traumatization in school caregivers as well as the direct traumatization in children. Described with detail, it involves training, supporting and supervising school personnel to lead children's groups, and co-lead children's groups with a trained facilitator. It is designed to equip school staff with the tools, skills, guidance, strategies and on-going support to strengthen their own inner resiliency while expanding their group leadership skills for taking positive action in the face of children's needs. It offers guidelines for identification, parent appraisal and permission, screening for eligibility, selection and pre-group preparation, group contract and parameters, and developmentally appropriate tasks for strengthening resiliency, developing emotional insulation and using the peer group as an agent of change and healing.

Group Treatment with Traumatized Adolescents—Seth Aronson, Psy.D., CGP, FAGPA

Group treatment is a particularly appropriate modality for addressing the impact of trauma on adolescents given that both research and empirical experience reveal the adolescent peer group to play a crucial role in development of identity, self-esteem, social-interpersonal maturation and separation from family of origin. Drawing upon theory, and clinical material from adolescents groups, this protocol illuminates the impact of the trauma on the developmental tasks of adolescence, delineating and discussing the steps and issues in setting up an adolescent trauma group. Issues addressed include proximity of the traumatic event to the group, match of needs to

type of group, the screening interview, selection and balancing of group members, use of a group contract, roles and guidelines for leaders, and stages and phases of group development.

Responding to the Needs of Uniformed Service Personnel—Suzanne B. Phillips, Psy.D., ABPP, CGP and Nina Thomas, Ph.D., CGP

A comprehensive guide for working with uniformed personnel, it underscores the importance of understanding the culture, resilience, command structure, sense of mission, attitude toward injury, perception of mental health intervention etc. of firefighters, police, emergency medical services and military. This protocol highlights the pre-existing group mentality, the “Band of Brothers,” as a rationale for utilizing group response and intervention with uniformed personnel and emphasizes the goal of “added value” and restoring functioning without pathologizing. Drawing upon theory, research, consultation and experiences with members of each of the services after 9/11 and with respect to prior disasters and deployments, it offers responses, interventions, programs and resources to be utilized across the timeline of disaster and war.

Lessons Learned in Group Strategies for Survivors, Witnesses and Family Members—Richard Beck, M.S.W., CGP, FAGPA, Estelle Rauch M.S.W., CGP, Uri Bergmann, Ph.D., Alexander Broden, M.D., CGP, Bonnie Buchele, Ph.D., ABPP, CGP, DFAGPA, and Yael Danieli, Ph.D.

Vignettes of actual 9/11 group interventions are combined with theoretical expertise in this protocol, which is intended to expand the skills of previously trained mental health workers. The authors delineate high risk factors, the impact of trauma on neuro-chemistry and the impact of disaster when there has been previous trauma. The protocol both describes and exemplifies the characteristics of trauma groups for survivors, witnesses and family members as well as the types of trauma support groups that can be used across the spectrum of disaster recovery (short term grief groups, single session groups, corporate groups etc.). Guidelines for groups as well as the role of the leader are offered.

Support for Disaster Response Helpers and Service Delivery Workers—Michael Andronico, Ph.D., CGP, FAGPA, Trish Cleary, M.S. CCMHC, LCPC-MFT, CGP, FAGPA, Felicia Einhorn, LCSW, CGP, Madelyn Miller, LCSW, ACSW, CGP, Emanuel Shapiro, Ph.D., CGP, FAGPA, Henry Spitz, M.D., CGP, DFAGPA and Kathleen Ulman, Ph.D., CGP, FAGPA

This protocol underscores the attention and informed care deserved by service providers who are affected directly and indirectly and through shared experience with survivors. Group is recommended as an intervention that affords a context for sharing challenges, understanding experiences, sustaining identity, addressing self-care and supporting a sense of hope often compromised by all that providers must contain in the face of disaster. The protocol is a comprehensive guideline for providing group interventions for mental health service providers and other support workers. Reflecting theoretical understanding and clinical experience it addresses everything from suggested timeframes to the specifics of group content. It also includes an extensive set of appendices addressing vicarious traumatization measures, evaluation tools and group climate measures.

Crisis Intervention at the Organizational Level—Priscilla Kauff, Ph.D., CGP, DFAGPA and Jeffrey Kleinberg, Ph.D., CGP, FAGPA

This protocol provides a group-centered response to trauma with an organization as the client. It aims at returning an organization to its original pre-trauma structure and level of productivity. Recommending the use of “clinician consultants,” highly skilled group therapists with appropriate theoretical understanding of individuals, groups and systems, it stresses the needs of the organization as well as the individual must be addressed if the intervention is to be effective. Using experience and theoretical perspective, this protocol offers guidelines for the process of engagement with an organization, needs assessment, developing a working alliance, establishing a contract with management that accounts for issues of staff participation, and clarification of the advantages of a group format. The actual components of an intervention are detailed (e.g. design, composition, use of outreach leaders, content of material, decisions re mixing employees and supervisors) and address services to management, evaluation, long term relationship with the organization and helping the helpers.

Local Community Outreach Programs in Response to Disaster—Diane Feirman, CAE and Randi Cohen, M.S.W., M.A., CGP

This protocol delineates a community outreach model as an effective means of identifying, establishing and delivering group mental health interventions in the aftermath of disaster. The protocol is divided into two sections. The first section offers practical strategies for implementing an outreach model, i.e. identifying a Community Based Organization (CBO) as central to the effort, clarifying the role of the CBO, pairing with other agencies, identifying community needs and resources etc. The second section describes the actual clinical aspects of the model. It includes descriptions of the role of a clinical liaison in initiating and developing outreach possibilities, the consideration of community outreach across the timeframe of disaster and the possible group interventions used in an outreach model.

The Role of the Philanthropic Community in Disaster Response—Robert Klein, Ph.D., ABPP, CGP, DLFAGPA and Harold Bernard, Ph.D., ABPP, CGP, DFAGPA

This is an integrated set of recommendations for members of the philanthropic community, with recommendations drawn from the experience of major contributors to the relief and recovery work following 9/11. Resonating with the sentiments of Gotbaum, former CEO of the 9/11 fund that “the greatest challenge in helping the victims of 9/11 was not getting the resources-it was working together,” this protocol fills a valuable need by recommending specific pre- and post-disaster steps for philanthropic response, e.g. pre-disaster plans between government and philanthropic entities. It includes issues for philanthropies’ consideration, such as understanding donors’ intent, tailoring efforts to remain consistent to their mission, accessing communication networks between and among philanthropies and government agencies and providing clarity regarding the purpose and criteria for extending financial aid in the aftermath of disaster and transparency with regard to follow-up and evaluation.

Public Education Information:

- Group Works: What Everyone Should Know About Trauma—a short brochure geared to the general population which describes what groups are and how they work, and which contains an insert with information about responses to traumatic events. Electronic and hard copy are available, in both English and Spanish.

Clinician Research Tools:

- CORE Battery-Revised—An assessment toolkit for promoting optimal group selection, process and outcome.

III. PRIOR COLLABORATION BETWEEN AGPA AND SERVICE PROVIDERS

When you have the privilege of doing trauma work, when someone trusts you with their pain, by necessity you enter hazardous terrain. Aware of the impact on caregivers after 9/11, AGPA provided group training and curriculum guides to agencies and organizations to prevent and reduce secondary PTSD and Vicarious Traumatization in clinicians, spiritual caregivers, First Responders and other service providers. AGPA has continued to collaborate with agencies and institutions to provide Care to the Caregivers in initiatives set up in response to Hurricanes Katrina and Rita, and with First Responder Groups (police, fire and EMT) in the aftermath of critical incidents and disasters. For example, a program is planned in April 2008 for Military, First Responders and clinicians in the aftermath of the California Fires.

IV. PRESENT COLLABORATION BETWEEN AGPA AND THE DEPARTMENT OF VETERANS AFFAIRS

Program initiatives for clinicians and staff working with veterans are presently in process with Houston and San Antonio DVA Departments:

In Houston, Texas, plans are in place for a Basic Group Therapy Training Course for psychiatric nurses. This will be a 4-month, 24-hour course specifically designed to build the group therapy skills of DVA nursing staff assigned to programs in Mental Health Services at Michael E. DeBakey VA Medical Center, Houston, Texas. Special emphasis is placed on the unique issues that DVA group therapists face in serving Veterans and their families in this health care facility. The San Antonio DVA Department is working with a plan to do a needs assessment of Mental Health Personnel for workshops provided by AGPA. There is particular interest in trauma group training for ancillary staff (e.g. dental hygienists and occupational and physical therapists) with a recognition that in a system all aspects of sup-

port for veterans serve as resources to enhance their recovery. When staff are trained and understand PTSD, their risk of secondary PTSD is lowered and their potential to offer “added value” to veterans and families is enhanced.

V. PERSONAL FEEDBACK FROM RECIPIENTS OF PROGRAMS OF THE AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION

Staff Support Group Member:

The facilitators have done an excellent job in providing counseling to many if not all of the staff members in our division. Personally, I must admit that at first I was not too crazy about going to the Wellness Group. I was skeptical and didn't feel comfortable talking about my issues and frustrations at the work place. But S. and G. (the therapists) won me over, since I have been attending the meetings I have felt much more relaxed and I look forward to attending every Thursday meeting. These meetings have helped me both professionally and personally and I see the difference everyday.

Family Group Member:

My daughter, 7, and I often had the most meaningful conversations after group. They clearly stemmed from group topics. I know she is internalizing your messages, when I hear the following kind of response. I recently told her about 2 boys, ages 8 and 10, whose father died unexpectedly at the age of 37. I asked her what advice she would give them since she had been through the same situation. She very naturally replied that she would say, “Sometimes life is unfair, but you are strong and you can get through it. Some days will be bad but you can still have fun and be happy.

First Responders:

This weekend was wonderful. My husband and I had erected walls around us and this was a giant step toward knocking them down. It won't be easy but thank you for giving us tools that we can use.

Thank you for this opportunity! My husband and I definitely grew from our experiences here. Couples counseling is extremely important when dealing with the recent trauma we've experienced. We all need to support our family unit!

VI. SUMMARY

The last and most difficult stage in the recovery from PTSD is reconnection to self and others. I ask you to consider that the group programs and lessons learned by the American Group Psychotherapy Association in the aftermath of 9/11 hold potential as significant options for expanding the services to veterans and their families. By directly including spouses and children in programs, we not only reduce the impact of PTSD on them, we enhance the recovery of our servicemen and women. As their families and marriages are their greatest assets, we make possible the emotional connections that finally bring them home.

Respectfully Submitted,

SUZANNE B. PHILLIPS PSY.D., ABPP, CGP

References

- American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members (2007). *The Psychological Needs of U.S. Military Service Members and Their Families: A Preliminary Report*.
- Burlingame, G.M., Fuhriman, A.F. & Mosier, J. (2003). The differentiated effectiveness of group psychotherapy: A meta-analytic review. *Group Dynamics: Theory, Research and Practice*, 7(1), 3–12.
- Bolton, E., Lambert, J., Wolf, E., Raja, S., Varra, A., & Fisher, L. (2004). Evaluation of a cognitive-behavioral group treatment program for veterans with Post Traumatic Stress Disorder. *Psychological Services*, Vol., No. 2, 140–146.
- Brockway, S. (2005). Group treatment of combat nightmares in Post Traumatic Stress Disorder. *Journal of Contemporary Psychotherapy*, Vol. 17, No. 4, December 1987. 270–284.
- Buchele, B. & H. Spitz (Eds.) (2004). *Group Interventions for Treatment of Psychological Trauma*. New York: American Group Psychotherapy Association
- Chemtob, C.M., Novaco, R.W., Hamada, R.S., & Gross, D.M. (1997). Cognitive Behavioral treatment for severe anger in Post Traumatic Stress Disorder. *Journal of Consulting and Clinical Psychology*, 65, 184–189.
- Foy, D.W., Glynn, S., Schnurr, P., Jankowski, M., Wattenberg, M., Weiss, D., Marmar, C., & Gusman, F. (2000). *Group Therapy* in E.B. Foa, T.M. Keane,

- & M.J. Friedman (eds.), *Effective treatments for PTSD* (pp. 155–175). New York: Guilford Press.
- Goodman, M. & Weiss, D. (1998). Double trauma: A group therapy approach for Vietnam veterans suffering from war and childhood trauma. *International Journal of Group Psychotherapy*, 48, (1), 39–53.
- Galovski, T. & Lyond, J. (2004). Psychological sequelae of combat violence: A review of the impact of PTSD on the veterans' family and possible interventions. *Aggression and Violant Behavior*, 9, 477–501.
- Herman J. (1997). *Trauma and recovery*. New York: Basic Books.
- Hoge, C. MD, Auchterlonie, J., Milliken, C., Mental Health Problems, Use of Mental Health Services and Attrition from Military Service after returning from deployment to Iraq and Afghanistan, *JAMA*.—2006;295:1023–1032.
- Hoge, C., Auchterlonie, J., Milliken, C. (2006). Mental health problems, use of mental health services and attrition from military service after returning from deployment to Iraq and Afghanistan, *JAMA*.—2006;295:1023–1032.
- Hoge, C., Castro, C., Messer, S., McGurk, D., Cotting, D., & Koffman, R. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *The New England Journal of Medicine*, 351, 13–22.
- Jones, L., Brazel, D., Perkind, E., Morelli, T., & Raskind, M., (2000). Group therapy program for African-American veterans with Post Traumatic Stress Disorder. *Psychiatric Services*, 51(9), 1177–1179.
- Kates, A.R. (2001). *Copshock: Surviving Post Traumatic Stress Disorder (PTSD)*. Tuscan: Hillbrook Street Press.
- Kingsley, G. (2007). Contemporary Group Treatment of Combat-Related Post Traumatic Stress Disorder. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 35(1), 51–69.
- Klein, R. and Phillips, S.B. (Eds.), (2008). *Public Mental Health Service Delivery Protocols: Group Interventions for Disaster Preparedness and Response*. New York: American Group Psychotherapy Association
- Makler, S., Sigal, M., Gelkopf, M., Kochba, B., & Horeb, E., (1990). Combat-related, chronic Post Traumatic Stress Disorder: Implications for group-therapy intervention. *American Journal of Psychotherapy*, Vol. XLIV (3), 381–395.
- Meyers, S.L., (2003, June 21). Battlefield aid for soldiers battered psyches. *The New York Times*, pp. A1, A8.
- Schnurr, P., & Cozza, S. (Eds.). (2004). *Iraq war clinician guide*. (Second Edition). Washington, DC: Department of Veterans Affairs, National Center for PTSD.
- Shay, J. (2002). *Odysseus in America: Combat trauma and the trials of homecoming*. New York, New York: Scribner.

PREPARED STATEMENT OF PAT ROWE KERR, STATE VETERANS OMBUDSMAN,
DIRECTOR, OPERATION OUTREACH, MISSOURI VETERANS COMMISSION

The State advocacy agency, the Missouri Veterans Commission, has had the opportunity to work with thousands of servicemembers, their families and new Veterans throughout the United States in our various capacities serving Global War on Terror (GWOT) servicemembers, families and new Veterans. In 2004 we brought in to the State organization a program called Operation Outreach designed to specifically work with those deploying in support of the Global War on Terror. Outreach was originally begun in March of 2003 by this testifier.

This program is being mirrored by other States. Canada is sending their Canadian Veterans Ombudsman to Missouri to review the best practices; the CDC called having learned of the program through the National Institute of Health. We regularly work with OSD Family Programs and DOD America Supports You as well as Medical Hold at various bases on MED/PEB cases. We have provided support to the National Guard Association and to the JAG office of the US Navy as well as Marine For Life when it was initially set up and AW2.

Every State has a State advocacy agency (see attachment). Some are called the State Veterans Commissions; others are called the State VA. According to the Federal VA's own statistics, working with these State advocates rather than working directly with the Federal VA can bring an additional \$6,555 annually in to the home of a Veteran.

These State advocacy agencies are the only neutral point of contact for any servicemember of any branch or component or Veteran. The State advocacy agencies are not seeking recruitment for membership. They work as partners with the Veterans Service Organizations, branches and components.

As the State Veterans Ombudsman and Director of Operation Outreach, I coordinate the outreach program for GWOT in Missouri. I am also a Board member of

the Brain Injury Association and the caregiver of a professional suffering multiple injuries, including head trauma, as the result of a motor vehicle accident. Over these last 4 years I have been invited to speak nationally on various topics affecting our family members, deployed and injured Heroes.

As the mother of a female Reservist, a Captain who has had 2 tours to Iraq and currently serves as the Operations Officer for the Mobilization and Deployment Brigade at Ft. Riley, I am intimately familiar with the challenges facing our Warriors and their families. We also cared for her 13 month old while she and her husband were deployed until he was 5 years old.

Thank you for this hearing. It is with great faith that we hope you will truly make a difference for all of our servicemembers and injured regardless of acuity level.

Before I address continued and new gaps being faced real time, please let me reference a major gap we are headed for.

At least 7 States are currently undergoing mobilization for deployment to Kosovo under Global War on Terror orders. In Missouri this is our largest deployment of National Guard since WW II.

Because they are being deployed to Kosovo and not Iraq or Afghanistan, their ability to receive priority status for some benefits may be impacted even though they will be serving in a combat status under hazardous duty. Additionally, they are receiving combat pay, family separation pay, but not hazardous duty pay, when it appears that Kosovo in fact is hazardous.

As an example, currently some of the 501(c)(3) organizations do not provide financial support for these men and women because their original IRS applications used only the words "Iraq" and "Afghanistan."

Please pass an amendment stating that all previous legislation and future benefits are available to "those who have served in the military since October 1, 2001." This will follow the precedent set by the Social Security Administration which provides for an expedited Social Security disability benefit for our servicemembers "who have served in the military since October 1, 2001."

The second large obstacle is the outreach dollars that flow to the VA, DOD or National Guard. The State advocacy agencies do not have access to those dollars and we would request your consideration in providing grant dollars through VA or DOD to the States. Why? As you know, our Guard and Reserve are undergoing multiple deployments and they continue to come back to their States and communities seeking desperately needed resources.

State government cannot provide the dollars to support all the needs that are being created by Federal deployments.

We choose to speak here about those Warriors whose injuries may not locate them at facilities like Walter Reed Medical Center or Brooks Army Medical Center, but instead at Medical Transfer Facilities such as Ft. Leonard Wood or Ft. Riley, Ft. Sill.

Many of our injured fall in the VA rating category of 30 percent and above which means they will be provided resources otherwise not available to those who may still have an undiagnosed brain injury and will receive little support because of that lower acuity level.

Unfortunately, the general public, as well as the military system, have focused on open and major head trauma. Closed head trauma—with little outward sign to the observer—can have a negative life impact.

While recent presentations have been made that our returning troops are being tested for MTBI (minor Traumatic Brain Injury) and PTSD (Post Traumatic Stress Disorder), some of the stories attached occurred within the last 3 months.

The residuals—confusion, anger, intense and debilitating migraine headaches, to name a few—can also be confused with combat stress and/or post traumatic stress and has even been incorrectly diagnosed as mental illness. As a result, the Warrior, new Veteran and their families often receive the wrong diagnostic support and health care.

Several cases come to mind that span various timeframes prior to and since Walter Reed: the servicemember who hit his head on mechanical equipment and was found lost on a small base in Iraq. He lay in a hospital bed in Missouri at the Medical Holdover facility for several months, unable to remember his home phone number so his family could assist in his care.

His family only lived 30 miles away.

When questioned on why servicemembers were not receiving evaluations for minor traumatic head injury, the Medical Holdover case manager stated, "Unless they self identify a problem, they will not be evaluated for that medical problem."

If this servicemember could not remember his home telephone number which he had for some 25 years, how could he know he had a head injury and self report?

Ultimately, with the intervention of our State agency, the Missouri Veterans Commission.

Our Medical Treatment Facility has greatly improved since that timeframe.

However, there is the servicemember who currently is discharged with 93 pieces of shrapnel remaining throughout his body. He never went through a stateside major medical facility because he was evacuated from Iraq with his returning unit. He was within feet of a mortar blast, but received no comprehensive evaluation for Traumatic Brain Injury until the State agency's intervention. And not going through the major treatment facility has been a problem for him receiving TSGLI.

Or the servicemember who was in 3 vehicle incidents while deployed—(1) rear ended when a vehicle in front of his stopped quickly because it had run over a child, nearly decapitating the child and the servicemember's body was abruptly thrown forward and back; (2) thrown from a vehicle by a second abrupt stop, thus hitting his head on the ground; and (3) the quick vehicular stop wherein his head went back and struck an atropine needle which lodged in his skull (although not discharging).

Servicemember's VA records document a short-term memory retention of 1 percent, yet he had received no care for Traumatic Brain Injury.

With intervention by our State agency, we were able to get him into a private specialized facility where it was found that indeed he had suffered a Traumatic Brain Injury, among several other medical conditions.

A medication review revealed that of the 18 medication prescriptions from the VA, only one was appropriate for his care—his allergy medication.

We all agree that continuity of care must be a top priority for our returning Warriors.

It is important to note that all three of these Warriors are National Guard and Reserve soldiers and there continues to be gaps.

One has to question why any of these Warriors would be discharged through the Medical Board process from the Department of Defense at less than 100 percent.

Let's review several issues facing our returning Heroes today:

There is a gap between the Department of Defense discharge date and the adjudication of the Veterans Affairs claim—a gap that cannot be ignored with creditors calling at day 33 once a payment is missed.

None of these brave Heroes or their families has received the support of the TSGLI (Traumatic Service Members' Group Life Insurance) grant money. Yet they incurred significant financial expenses, one soldier losing his home and his Salutatorian son having to drop out of college to support his injured father.

There is the long-lasting tradition of the Department of Defense putting "adjustment disorder" or "personality disorder" on the DD-214's of a servicemember which will mean they will not be able to access VA benefits for post traumatic stress disability ratings or as importantly health care.

Please do not forget the routine lack of medical documentation that is happening in the combat zone—men and women on crutches with swollen knees who are not receiving line of duty documentation just to name one musculoskeletal issue that will follow them for the rest of their life.

For those injured who can remain in the military, annual physical evaluation forms need to be changed to allow the servicemember to receive health care for PTSD without disclosing that confidential information. It simply could say: Have you received care outside of the VA or outside a VA contracted facility?

We must contract with non DOD facilities and vendors already in place, including the mental health network providers located in communities. There is no time for VA to build more polytrauma units or train more staff. This will allow the new Veteran (Guard and Reserve) who remains part of the DOD to seek appropriate VA approved care in a timely manner closer to home.

Incidents of cancer in this short period of time are becoming increasingly significant. We must be proactive in our support of these "injured" as well.

Much of this testimony has been presented to the various Commissions and Committees established over the past 2 years.

We appreciate the attention the Senator has given to making systemic changes as these systemic challenges must be immediately addressed so that our Heroes will receive the benefits they deserve. Just like we have Troops in harm's way in Afghanistan and Iraq, we have Troops in harm's way that cannot access the care that they need.

Without immediate changes, recruitment and retention will be negatively affected.

Additional needs:
Education: Military Family Education Bill

Take out any minimum requirements for time in service. Some folks are being deployed who may have significant more years in than current legislation says and coming back injured to the point they need retraining/additional education.

Include dollars for the collage-aged children of NG and Reserve soldiers who deploy in support of The Global War on Terrorism whose families face a significant income decrease as a result of their deployment if that decrease materially affects their ability to attend college.

Include dollars for spouses of injured servicemembers (NG and Reserve soldiers) who deploy in support of The Global War on Terrorism whose injuries significantly impact their ability to return to their former professions after discharge.

Yes, there is Voc Rehab but the payments are not large enough to support the families' needs.

Mr. Chairman, please create dollars that flow to the States so we can continue the great advocacy and support we provide our citizen soldiers and our regular active duty injured.

[Two stories below are being submitted with this testimony:]

HERO STORIES

2008—SSG MATTHEW BAKER

My name is Staff Sgt Matthew Baker. My wife, daughter and I live in Archie, Missouri and I deployed to Iraq in support of Operation Iraqi Freedom in January of 2004.

I was originally a United States Army Reserve soldier and deployed with the 369 Transportation Unit.

I later trained our military as they prepared to deploy.

While in Iraq I encountered, between IED and mortars, some 200 explosions during the convoy missions we supported.

We traveled over 10,000 miles providing convoy security.

During this timeframe I lost my hearing as a result of the constant exposure to bomb blasts and gunfire and now am required to wear hearing aids in both ears.

As a result of an unexpected vehicle stop while traveling 40–50 miles per hour, I was thrown backwards out of our Humvee.

I injured my back so badly that it has required surgery and I now had 2 rods in my back and that area is fused from hip to hip.

As a result of my exposures in Iraq, I am being treated for severe post traumatic stress.

Currently I am assigned to the Medical Hold facility at Ft. Riley. I travel there for care from Archie, Missouri, and I travel to Fayetteville, Arkansas for care as well as to Columbia, Missouri.

The Army was going to discharge me with a 20 percent Department of Defense rating, which would not have allowed me to receive a full VA benefit until the amount of the severance check was paid back.

The medical personnel at Ft. Riley were basing that rating on 20 percent for my back and nothing for the PTSD. They later added 10 percent for anxiety.

That is despite the permanent injury to my back and the severe post traumatic stress which had been diagnosed.

The Army Reserves referred me to the Missouri State Veterans Ombudsman for assistance in review of my medical board rating.

She recognized that I had not been tested for a Traumatic Brain Injury and also requested additional testing for post traumatic stress.

Working with the Department of Defense, she was able to facilitate my admission to Rusk Rehabilitation, part of the University of Missouri Hospital System, in Columbia, Missouri where I spent 2 weeks and was tested for Traumatic Brain Injury and post traumatic stress as well as being set up on intensive physical therapy and occupational therapy, along with counseling.

She also coordinated the efforts for me to be evaluated by the Social Security Administration so that I may receive the “expedited military disability for wounded warriors.”

I currently have 3 days of intensive therapy at Rusk and have traveled from there to speak to you today.

As a result of that medical care, the medical providers at Ft. Riley have agreed with the new diagnosis of Traumatic Brain Injury and have agreed that I do have severe post traumatic stress and not simply anxiety.

My medical board rating has already been increased to 30 percent without the inclusion of these new diagnoses and we believe it will be increased to a higher rating.

This means that I will be able to receive a retirement disability from the Department of Defense that will not have a negative impact on my VA disability benefit.

I will also receive TRICARE for life for my wife, my daughter and myself as well as commissary benefits.

This would not have happened without the benefit of an advocate.

She works with me at all hours of the day and night and on the weekend.

I am here to let you know that there are hundreds of Missouri troops that need that type of assistance.

I ask that you find a way to provide additional resources so that there are more people like her at the Missouri Veterans Commission to work in Operation Outreach to help those of us who return with injuries.

It has been my honor to serve the United States of America in this time of war. Thank you for your time.

On January 15, 2007, at 6 a.m., my home phone rang. My husband and I had the day off from work due to the celebration of Martin Luther King Day. My husband answered the phone, and I knew from the sound of his voice and words, this was not a phone call I wanted. As a matter of fact, I had been in fear of this phone call for the better part of 4 years. Approximately 2 weeks prior to my son, Corporal Robert Weston (Wes) Schubert, finishing his 2nd 1-year tour in Iraq, he was shot by an Iraqi sniper. The phone call was Major Irwin with my son's unit calling to inform me of his injuries. I can still hear his voice, and some of his words . . . the words . . . "Is this Brenda Tyree . . . are you the mother of Robert Weston Schubert . . . I regret to inform you that your son has been shot in the neck and face by a sniper, and he is in very serious condition."

Those words still run chills down my spine. It is without a doubt one of the worst days of my life. Unless you have experienced a similar situation, you cannot imagine the actual pain you feel as someone is telling you something of this magnitude. I knew Major Irwin was telling me the truth, but I just could not believe it was real. My mind went blank . . . I could hear someone screaming . . . only to realize it was me that was screaming. Sometime . . . later in the day, or maybe the next day, while waiting for word that Wes had gotten out of Iraq safely . . . someone kept telling me to call Pat Kerr . . . it was my sister . . . and through a friend of a friend, she had been told that Pat Kerr was the lady to call . . . that Pat would be able to help. At first, the only person I wanted to speak with was someone that could tell me Wes was safe and he was going to be ok. When that wasn't happening . . . I decided to do as others had suggested . . . I called Pat Kerr. I am so glad I did. Her compassion and knowledge are EXACTLY what I needed. Pat was able to speak with me as a mother, and I felt as though she could actually feel some of what I was feeling. Pat was able to give me a lot of information, as well as who to contact for assistance with getting me and my husband, oldest son, and Wes's fiancée (wife now), to Walter Reed Army Medical Center in Washington, DC. Not knowing what to expect, my focus was completely on getting to Walter Reed Army Medical Center in Washington, DC, before Wes arrived from Germany. I wanted to see him and to touch him . . . I wanted him to know that his family was there, and that everything was going to be ok. I contacted the organization Pat told me about, and I was blown away. They paid for our airline tickets to Washington, DC, and told us who to get in contact with when we arrived at Walter Reed Army Medical Center. Amazingly enough, 4 days after I received the phone call from Major Irwin, my family and I was standing on the 3rd floor at Walter Reed Army Medical Center one-half hour before Wes arrived. We stood directly above Wes as they wheeled his stretcher into the hospital from the bus that had just brought him from the airport. Approximately 1 hour later, we were standing at his bedside when the doctors let him wake up from the drug-induced state he had been in since the injury. I will never forget the look on his face as he woke up and was able to see us for the first time in over a year . . . it was total disbelief. I cannot tell you how much it meant to us to be there when he arrived and when he woke up. Had it not been for Pat Kerr, none of this would have happened . . . we had no way of knowing which way to turn, who to contact, where to go . . . anything.

Operation Outreach is key in helping families when a crisis such as ours arises. I cannot stress how much we appreciate everyone involved with Operation Outreach, and everything that was done for us. I hope and pray that Operation Outreach continues for years to come. Pat and her staff are to be commended for their work, dedication, and compassion . . . they genuinely care. I sincerely hope that

additional funds will be present to keep this worthwhile program going for other families during their crisis.

Sincerely,

BRENDA TYREE,
*Mother of Corporal Robert Weston Schubert,
 U.S. Army, 1-37th AR, 1 BDE.*

PREPARED STATEMENT OF THE THE NATIONAL MILITARY FAMILY ASSOCIATION

Chairman Akaka and Distinguished Members of this Committee, the National Military Family Association (NMFA) would like to thank you for the opportunity to present testimony today on how the Department of Defense (DOD) and the Department of Veterans Affairs (VA) can work together to treat our wounded/ill/injured servicemembers and their families. We thank you for your focus on the many elements necessary to ensure access to quality health care for our servicemembers, veterans and their families within the DOD and the VA health care system.

NMFA will discuss several issues of importance to wounded/ill/injured servicemembers, veterans, and their families in the following subject areas:

- I. Wounded Service Members Have Wounded Families
- II. Who Are the Families of Wounded Service Members?
- III. Caregivers
- IV. Mental Health

WOUNDED SERVICEMEMBERS HAVE WOUNDED FAMILIES

Transitions can be especially problematic for wounded/ill/injured servicemembers, veterans, and their families. NMFA asserts that behind every wounded servicemember and veteran is a wounded family. Spouses, children, parents, and siblings of servicemembers injured defending our country experience many uncertainties. Fear of the unknown and what lies ahead in future weeks, months, and even years, weighs heavily on their minds. Other concerns include the wounded servicemember's return and reunion with their family, financial stresses, and navigating the transition process from active duty and the DOD health care system to veteran and the VA health care system.

The DOD and VA health care systems should alleviate, not heighten these concerns. They should provide for coordination of care, starting when the family is notified that the servicemember has been wounded and ending with the DOD and VA working together, creating a seamless transition as the wounded servicemember transfers between the two agencies' health care systems and eventually from active duty status to veteran status.

NMFA congratulates Congress on the National Defense Authorization Act for fiscal year 2008 (NDAA FY08), especially the Wounded Warrior provision, in which many issues affecting this population were addressed. We also appreciate the work DOD and the VA have done in establishing the Senior Oversight Committee (SOC) to address the many issues highlighted by the three Presidential Commissions. Many of the Line of Action items addressed by the SOC will help ease the transition for active duty servicemembers and their families to their life as veterans and civilians. However, more still needs to be done. Families are still being lost in the shuffle between the two agencies. Many are moms, dads, siblings who are unfamiliar with the military and its unique culture. We urge Congress to establish an oversight committee to monitor DOD and VA's partnership initiatives, especially with the upcoming Administration turnover and the disbandment of the SOC early this year.

WHO ARE THE FAMILIES OF WOUNDED SERVICEMEMBERS?

In the past, the VA and the DOD have generally focused their benefit packages for a servicemember's family on his/her spouse and children. Now, however, it is not unusual to see the parents and siblings of a single servicemember presented as part of the servicemember's family unit. In the active duty, National Guard, and Reserves almost 50 percent are single. Having a wounded servicemember is new territory for family units. Whether the servicemember is married or single, their families will be affected in some way by an injury. As more single servicemembers are wounded, more parents and siblings must take on the role of helping their son, daughter, sibling through the recovery process. Family members are an integral part of the health care team. Their presence has been shown to improve their loved one's quality-of-life and aid in a speedy recovery.

Spouses and parents of single servicemembers are included by their husband/wife or son/daughter's military command and their family support and readiness groups

during deployment for the Global War on Terror. Moms and dads have been involved with their children from the day they were born. Many helped bake cookies for fundraisers, shuffled them to soccer and club sports, and helped them with their homework. When that servicemember is wounded, their involvement in their loved one's life does not change. Spouses and parent(s) take time away from their jobs in order to travel to the receiving Military Treatment Facility (MTF) (Walter Reed Army Medical Center or the National Naval Medical Center at Bethesda) and to the follow-on VA Polytrauma Centers to be by their loved one. They learn how to care for their loved one's wounds and navigate an often unfamiliar and complicated health care system.

It is NMFA's belief the government, especially the DOD and VA, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded servicemember must also consider the needs of the spouse, children, parents of single servicemembers and their siblings, and the caregivers. The NDAA FY08 authorized an active-duty TRICARE benefit for severely wounded/ill/injured servicemembers once they are medically retired, but their family members were not mentioned in the bill's language. A method of payment to the VA, for services rendered without financially impacting the family, would be to include the medically retired servicemember's spouse and children. NMFA recommends an active duty benefit for 3 years for the family members of those who are medically retired. This will help with out-of-pocket medical expenses that can arise during this stressful transition time and provide continuity of care for spouses, especially for those families with special needs children who lose coverage under the Extended Care Health Option (ECHO) program once they are no longer considered active duty dependents.

NMFA recently held a focus group composed of wounded servicemembers and their families to learn more about issues affecting them. They said following the injury, families find themselves having to redefine their roles. They must relearn how to parent and become a spouse/lover with an injury. Each member needs to understand the unique aspects the injury brings to the family unit. Parenting from a wheelchair brings on a whole new challenge, especially when dealing with teenagers. Reintegration programs become a key ingredient in the family's success. NMFA believes we need to focus on treating the whole family with programs offering skill based training for coping, intervention, resiliency, and overcoming adversities. Parents need opportunities to get together with other parents who are in similar situations and share their experiences and successful coping methods. DOD and VA need to provide family and individual counseling to address these unique issues. Opportunities for the entire family and for the couple to reconnect and bond as a family again, must also be provided.

The impact of the wounded/ill/injured on children is often overlooked and underestimated. Military children experience a metaphorical death of the parent they once knew and must make many adjustments as their parent recovers. Many families relocate to be near the treating MTF or the VA Polytrauma Center in order to make the rehabilitation process more successful. As the spouse focuses on the rehabilitation and recovery, older children take on new roles. They may become the caregivers for other siblings, as well as for the wounded parent. Many spouses send their children to stay with neighbors or extended family members, as they tend to their wounded/ill/injured spouse. Children get shuffled from place to place until they can be reunited with their parents. Once reunited, they must adapt to the parent's new injury and living with the "new normal." Brooke Army Medical Center has recognized a need to support these families and has allowed for the system to expand in terms of guesthouses co-located within the hospital grounds. The on-base school system is also sensitive to issues surrounding these children. A warm, welcoming family support center located in Guest Housing serves as a sanctuary for family members. Unfortunately, not all families enjoy this type of support. The VA could benefit from looking at successful programs like Brooke Army Medical Center's which has found a way to embrace the family unit during this difficult time. NMFA is concerned about the impact the injury is having on our most vulnerable population, children of our military and veterans.

CAREGIVERS

Caregivers need to be recognized for the important role they play in the care of their loved one. Without them, the quality-of-life of the wounded servicemembers and veterans, such as physical, psycho-social, and mental health, would be significantly compromised. They are viewed as an invaluable resource to DOD and VA health care providers because they tend to the needs of the servicemembers and the veterans on a regular basis. And, their daily involvement saves VA health care dol-

lars in the long run. According to the VA, “informal” caregivers are people such as a spouse or significant other or partner, family member, neighbor or friend who generously give their time and energy to provide whatever assistance is needed to the veteran”. The VA has made a strong effort in supporting veterans’ caregivers. The DOD should follow suit and expand their definition.

So far, we have discussed the initial recovery and rehabilitation and the need for mental and health care services for family members. But, there is also the long-term care that must be addressed. Caregivers of the severely wounded, ill, and injured servicemembers who are now veterans, such as those with severe Traumatic Brain Injury (TBI), have a long road ahead of them. In order to perform their job well, they must be given the skills to be successful. This will require the VA to train them through a standardized, certified program, and appropriately compensate them for the care they provide. The time to implement these programs is while the servicemember is still on active duty status.

The VA currently has eight caregiver assistance pilot programs to expand and improve health care education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. These pilot programs are important, but there is a strong need for 24-hour in-home respite care, 24-hour supervision, emotional support for caregivers living in rural areas, and coping skills to manage both the veteran’s and caregiver’s stress. DOD should evaluate these pilot programs to determine whether to adopt them for themselves. Caregivers’ responsibilities start while the servicemember is still on active duty. These pilot programs, if found successful, should be implemented as soon as possible and fully funded by Congress. However, one program missing from the pilot program is the need for adequate child care. Veterans can be single parents or the caregiver may have non-school aged children of their own. Each needs the availability of child care in order to attend their medical appointments, especially mental health appointments. NMFA encourages the VA to create drop-in child care for medical appointments on their premises or partner with other organizations to provide this valuable service.

According to the Traumatic Brain Injury Task Force, family members are very involved with taking care of their loved one. As their expectations for a positive outcome ebbs and flows throughout the rehabilitation and recovery phases, many experience stress and frustration and become emotionally drained. The VA has also called for recognition of the impact on the veteran when the caregiver struggles because of their limitations. We appreciate the inclusion in the NDAA FY08 Wounded Warrior provision for health care services to be provided by the DOD and VA for family members as deemed appropriate by each agency’s Secretary. NMFA recommends DOD and VA include mental health services along with physical care when drafting the NDAA FY08’s regulations.

NMFA has heard from caregivers of the difficult decisions they have to make over their loved one’s bedside following the injury. Many don’t know how to proceed because they don’t know what their loved one’s wishes were. The time for this discussion needs to take place prior to deployment and potential injury, not after the injury had occurred. We support the recent released Traumatic Brain Injury Task Force recommendation for DOD to require each deploying servicemember to execute a Medical Power of Attorney and a Living Will. We encourage this Committee to talk to their Congressional Armed Service Committee counterparts in requesting DOD to address this issue because of the severely wounded, ill, and injured along with their caregivers will eventually be part of the VA system.

MENTAL HEALTH

As the war continues, families’ needs for a full spectrum of mental health services—from preventative care and stress reduction techniques, to individual or family counseling, to medical mental health services—continue to grow. The military offers a variety of mental health services, both preventative and treatment, across many helping agencies and programs. However, as servicemembers and families experience numerous lengthy and dangerous deployments, NMFA believes the need for confidential, preventative mental health services will continue to rise.

Recent findings by the Army’s Mental Health Advisory Team (MHAT) IV report stated current suicide prevention training was not designed for a combat/deployed environment. Other reports found a correlation between the increase in the number of suicides in the Army to tour lengths and relationship problems. The “Armed Forces Suicide Prevention Act of 2008” is a bicameral proposal calling for a review of existing suicide prevention efforts and a requirement for suicide prevention training for all members of the Armed Forces, including the civilian sector and family support professionals. NMFA is especially appreciative of the provisions addressing

the needs of spouses and parents of returning servicemembers provisions: providing readjustment information; education on identifying mental health, substance abuse, suicide, and Traumatic Brain Injury; and encouraging them to seek assistance when having financial, relationship, legal, and occupational difficulties. NMFA supports this proposed legislation.

It is important to note if DOD has not been effective in the prevention and treatment of mental health issues, the residual will spill over into the VA health care system. The need for mental health services will remain high for some time even after military operations scale down and servicemembers and their families' transition to veteran status. The VA must be ready. The VA must partner with the DOD in order to address mental health issues early on in the process and provide transitional mental health programs. Partnering between the two agencies will also capture the National Guard and Reserve population who often straddle both agencies' health care systems. The VA must maintain robust rehabilitation and reintegration programs for veterans and their families that will require VA's attention over the long-term.

The Army's Mental Health Advisory Team (MHAT) IV report links the need to address family issues as a means for reducing stress on deployed servicemembers. The team found the top non-combat stressors were deployment length and family separation. They noted that soldiers serving a repeat deployment reported higher acute stress than those on their first deployment and the level of combat was the key ingredient for their mental health status upon return. The previous MHAT report acknowledged deployment length was causing higher rates of marital problems. Given all the focus on mental health prevention, the study found current suicide prevention training was not designed for a combat/deployed environment. Recent reports on the increased number of suicides in the Army also focused on tour lengths and relationship problems. These reports demonstrate the amount of stress being placed on our troops and their families. Are the DOD and VA ready? Do they have adequate mental health providers, programs, outreach, and funding? Better yet, where will the veteran's spouse and children go for help? Many will be left alone to care for their loved one's invisible wounds left behind from frequent and long combat deployments. Who will care for them now that they are no longer part of the DOD health care system? Many will be left alone to care for their loved one's invisible wounds left behind from frequent and long combat deployments. We can no longer be content on focusing on each agency separately because this population moves too frequently between the two agencies, especially our wounded/ill/injured servicemembers and their families.

DOD's Task Force on Mental Health stated timely access to the proper mental health provider remains one of the greatest barriers to quality mental health services for servicemembers and their families. Access for mental health care, once servicemembers are wounded/ill/injured, further compounds the problem. Families want to be able to access care with a mental health provider who understands or is sympathetic to the issues they face. The VA has readily available services. The Vet Centers are an available resource for veterans' families providing adjustment, vocational, family and marriage counseling. Vet Centers are located throughout the United States and in geographically dispersed areas, which provide a wonderful resource for our most challenged veterans and their families, the National Guard and Reserves. These Centers are often felt to remove the stigma attributed by other institutions. However, they are not mandated to care for veteran or wounded/ill/injured military families. The VA health care facilities and the community-based outpatient clinics (CBOCs) have a ready supply of mental health providers, yet regulations restrict their ability to provide mental health care to veterans' caregivers unless they meet strict standards. NMFA supports the Independent Budget Veterans Service Organizations (IBVSOs) recommendations to expand family counseling in all VA major care facilities; increase distribution of outreach materials to family members; improve reintegration of combat veterans who are returning from a deployment; and provide information on identifying warning signs of suicidal thoughts so veterans and their families can seek help with readjustment issues. However, NMFA believes this is just a starting point for mental health services the VA should offer families of severely wounded servicemembers and veterans. NMFA recommends DOD partner with the VA to allow military families access to these services. We also believe Congress should require Vet Centers and the VA to develop a holistic approach to care by including families in providing mental health counseling and programs.

NMFA has heard the main reason for the VA not providing health care and mental health care services is because they cannot be reimbursed for care rendered to a family member. However, the VA is a qualified TRICARE provider. This allows the VA to bill for services rendered in their facilities to a TRICARE beneficiary.

There may be a way to bill other health insurance companies, as well. No one is advocating for care to be given for free when there is a method of collection. However, payment should not be the driving force on whether or not to provide health care or mental health services within the VA system. The VA just needs to look at the possibility for other payment options.

Thousands of servicemember parents have been away from their families and placed into harm's way for long periods of time. Military children, the treasure of many military families, have shouldered the burden of sacrifice with great pride and resiliency. We must not forget this vulnerable population as the servicemember transitions from active duty to veteran status. Many programs, both governmental and private, have been created with the goal of providing support and coping skills to our military children during this great time of need. Unfortunately, many support programs are based on vague and out of date information. You ask, why should the Veterans' Affairs Committee be interested in military children?

Given the concern with the war's impact on children, NMFA has partnered with the RAND Corporation to research the impact of war on military children. The report is due in April 2008. In addition, NMFA held its first ever Youth Initiatives Summit for Military Children, "Military Children in a Time of War" last October. All panelists agreed the current military environment is having an effect on military children. Multiple deployments are creating layers of stressors, which families are experiencing at different stages. Teens especially carry a burden of care they are reluctant to share with the non-deployed parent in order to not "rock the boat." They are often encumbered by the feeling of trying to keep the family going, along with anger over changes in their schedules, increased responsibility, and fear for their deployed parent. Children of the National Guard and Reserve face unique challenges since there are no military installations for them to utilize. They find themselves "suddenly military" without resources to support them. School systems are generally unaware of this change in focus within these family units and are ill prepared to look out for potential problems caused by these deployments or when an injury occurs. Also vulnerable, are children who have disabilities that are further complicated by deployment and subsequent injury. Their families find this added stress can be overwhelming, but are afraid of reaching out for assistance for fear of retribution on the servicemember. They often choose not to seek care for themselves or their families.

NMFA encourages the VA to partner with DOD and reach out to those private and non-governmental organizations who are experts in their field on children and adolescents to identify and incorporate best practices in the prevention and treatment of mental health issues affecting our military children. At some point, these children will become children of our Nation's veterans. We must remember to focus on preventative care upstream, while still in the active duty phase, in order to have a solid family unit as they head into the veteran phase of their lives.

National provider shortages in this field, especially in child and adolescent psychology, are exacerbated in many cases by low TRICARE reimbursement rates, TRICARE rules, or military-unique geographical challenges (large populations in rural or traditionally underserved areas). Many mental health providers are willing to see military beneficiaries in a voluntary status. However, these providers often tell us they will not participate in TRICARE because of what they believe are time-consuming requirements and low reimbursement rates. More must be done to persuade these providers to participate in TRICARE and become a resource for the entire system, even if that means DOD must raise reimbursement rates.

Many mental health experts state that some post-deployment problems may not surface for several months or years after the servicemember's return. We encourage Congress to request DOD to include families in its Psychological Health Support survey; perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for servicemembers as they deploy into theater); and sponsor a longitudinal study, similar to DOD's Millennium Cohort Study, in order to get a better understanding of the long-term effects of war on our military families.

NMFA is especially concerned at the lack of services available to the families of returning National Guard, Reserve soldiers, and servicemembers who leave the military following the end of their enlistment. They are eligible for TRICARE Reserve Select, but as we know Guard and Reserve are often located in rural areas where there may be no mental health providers available. We ask you to address the distance issues families face in linking with military mental health resources and obtaining appropriate care. Isolated Guard and Reserve families do not have the benefit of the safety net of services provided by MTFs and installation family support programs. Families want to be able to access care with a provider who understands or is sympathetic to the issues they face. NMFA recommends the use of alternative

treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographical practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture.

The VA must educate their health care and mental health professionals, along with veterans' families, of the effects of mild Traumatic Brain Injury (TBI) in order to help accurately diagnose and treat the servicemember's condition. They must be able to deal with polytrauma—Post Traumatic Stress Disorder (PTSD) in combination with multiple physical injuries. We need more education for civilian health care providers on how to identify signs and symptoms of mild TBI and PTSD. Military families also need education on TBI and PTSD during the entire cycle of deployment. NMFA appreciates Congress establishing a Center of Excellence for TBI and PTSD. For a long time, the Defense and Veterans Brain Injury Center (DVBIC) has been the lead agent on TBI. Now with the new Center, it is very important DVBIC become more integrated and partner with other Services, including the VA, in researching TBI.

Because the VA has as part of its charge "to care for the widow and the orphan," NMFA is concerned about reports that many Vet Centers may not have the qualified counseling services they needed to provide promised counseling to survivors, especially to children. DOD and the VA must work together to ensure surviving spouses and their children can receive the mental health services they need, through all of VA's venues. New legislative language governing the TRICARE behavioral health benefit may also be needed to allow TRICARE coverage of bereavement or grief counseling. While some widows and surviving children suffer from depression or some other medical condition for a time after their loss, many others simply need counseling to help in managing their grief and help them to focus on the future. Many have been frustrated when they have asked their TRICARE contractor or provider for "grief counseling" only to be told TRICARE does not cover "grief counseling." Available counselors at military hospitals can sometimes provide this service while certain providers have found a way within the reimbursement rules to provide needed care. However, many families who cannot access military hospitals are often left without care because they do not know what to ask for or their provider does not know how to help them obtain covered services. Targeted grief counseling when the survivor first identifies the need for help could prevent more serious issues from developing later. The goal is the right care at the right time for optimum treatment effect. The VA and DOD need to better coordinate their mental health services for survivors and their children.

NMFA strongly suggests research on military families, especially children of wounded/ill/injured OEF/OIF veterans; standardized training, certification, and compensation for caregivers; individual and family counseling and support programs; a reintegration program that provides an rich environment for families to reconnect; and an oversight committee to monitor DOD's and VA's continued progress toward seamless transition. NMFA recommends an active duty benefit for 3 years for the family members of those who are medically retired.

DOD must balance the demand for mental health personnel in theater and at home to help servicemembers and families deal with unique emotional challenges and stresses related to the nature and duration of continued deployments. We ask you to continue to put pressure on DOD to step up the recruitment and training of uniformed mental health providers and the hiring of civilian mental providers to assist servicemembers in combat theaters AND at home stations to care for the families of the deployed and servicemembers who have either returned from deployment or are preparing to deploy. Spouses and parents of returning servicemembers' need programs providing readjustment information, education on identifying mental health, substance abuse, suicide, and Traumatic Brain Injury.

DOD should increase reimbursement rates to attract more providers in areas where there is the greatest need. TRICARE contractors should be tasked with stepping up their efforts to attract mental health providers into the TRICARE networks and to identify and ease the barriers providers cite when asked to participate in TRICARE. Congress needs to address the long-term continued access to mental health services for this population.

NMFA would like to thank you again for the opportunity to present testimony today on the health care needs for the servicemembers, veterans, and their families. Military families support the Nation's military missions. The least their country can do is make sure servicemembers, veterans, and their families have consistent access to high quality mental health care in the DOD and VA health care systems. Wounded servicemembers and veterans have wounded families. DOD and VA must support the caregiver by providing standardized training, access to quality health care and

mental health services, and assistance in navigating the health care systems. The system should provide coordination of care and DOD and VA working together to create a seamless transition. We ask this Committee to assist in meeting that responsibility.

PREPARED STATEMENT OF ELISABETH BEARD, MOM OF ARMY SPECIALIST
BRADLEY SCOTT BEARD

I am submitting this testimony for the record for the Senate Committee on Veterans' Affairs, March 11, 2008 hearing on: DOD and VA Cooperation and Collaboration: Caring for the Families of Wounded Warriors. I would like to share my experiences with the VA and our recommendations on how VA can improve or strengthen support for the families/parents that have lost a son or daughter in OEF/OIF.

My name is Elisabeth Beard and I am the mother of Army Specialist Bradley S Beard, who was killed in Ramadi, Iraq, on October 14, 2004. Being the mother of a fallen hero is not a role that anyone would willingly choose, and I am no exception. I hate it that I have been forced by circumstances to be the mother of a fallen hero. Having said that, I would like to express my undying gratitude and unequivocal awe of that which the American military provides for me, each and every day of my remaining life: the freedom to live as an American citizen in the greatest nation on the face of the earth.

After more than 3 years, I still wish with every cell of my being that I had been the one to die, and not my son, Brad. Barring that possibility, I am naive enough to believe that I would far rather be bringing testimony to you today of his injuries, his difficulty in returning to civilian life, or anything at all that meant that he was still living and breathing, and that he was still on the roster of veterans who receive benefits from the VA. But we are not so fortunate as to have an injured soldier.

Our family's only connection to the VA after all the paperwork was completed for Brad's burial in Arlington National Cemetery, was the mandate that the VA, through its Readjustment Counseling Centers (Vet Centers) would provide bereavement counseling to us, Brad's immediate family, in honor of and in memory of his brave sacrifice.

I would like to thank all those who had the compassion and foresight to push for this benefit for surviving military families. To a surviving parent, bereavement counseling is the only continuing benefit supplied by any branch or department of the U.S. Government. Without the counseling I received at the Raleigh Vet Center in Raleigh, North Carolina, I question whether I would still be alive to bring you my testimony today.

By and large, Americans do not understand grief. We live in a fast food, drive-through window society. We want our comforts and we want them now. Unfortunately, regaining one's equilibrium after the death of a child is not fast, or convenient, or neat, or comfortable. The recovery is more difficult when your loved one dies suddenly, traumatically, homicidally, and publicly.

Because our society doesn't understand grief, and because those of us who lose a child to war may also suffer posttraumatic stress, I would like to share a little of our family's journey with you. This is our story.

Somewhere halfway around the world in Ar Ramadi, Iraq, an unknown terrorist wearing loose clothing, and scruffy sandals decided to push a button and detonate the IED that sent shrapnel into my son's brain on October 14, 2004. The force of the blast sent the projectiles right through his Kevlar helmet. SPC Bradley Scott Beard died of massive head trauma. And shortly thereafter when the Casualty Notification Officers had performed their solemn task, something within me died as well. The damage to our family was horrific, unrelenting, and incalculable. Brad's ultimate sacrifice swept us into an emotional chaos we could never have imagined or predicted.

The U.S. Army supplied a Casualty Assistance Officer to help us with the arrangements we needed to make and with all the paperwork we needed to file. We were grateful for his compassionate and competent help. But long after our soldier's body was placed in the ground, our family was still disoriented and hurting.

In the weeks following the death of our only son, we received a lot of paperwork from the Federal Government and its many agencies. I kept each item in a notebook, so I could refer back to it as needed, because we simply were not able to absorb much, if any, information at the time. I only wish the Department of Veterans Affairs had written to tell us of the bereavement counseling offered by the VA through one of its 208 Readjustment Counseling Centers. I already knew within weeks of Brad's death that I simply was not going to make it without help from somewhere. Our family was hurting too much to be of any comfort to each other,

our friends didn't know how to deal with our pain, and most Americans went on about their business without even noticing or acknowledging our loss.

Although one of the VA's Enabling Objectives (2) is to communicate with veterans and their families, we never received any communication from them . . . not even a letter of condolence. We found out about bereavement counseling quite by accident, and only because of the intervention of TAPS, the Tragedy Assistance Program for Survivors, a national non-profit organization committed to offering help and emotional support to families grieving the loss of a loved one in the military.

I had made several calls to TAPS, usually late at night when the crushing burden of despair weighed heavily upon me. They forwarded my contact information to the Readjustment Counseling Services of the VA, and I received a call from the Raleigh Vet Center. For our family, this was a godsend; although we may have been too brain dead to realize it at the time. I really don't know how well the three of us would have survived without the compassionate and understanding help of our Vet Center bereavement counselor. But I can tell you it would be hard to overstate the significance of his contribution to the ongoing viability of our family.

Because of this, I am asking you to consider instituting a policy of outreach for the surviving families of those killed in action in support of OEF and OIF. This policy would bring help to surviving families in a timely, personal, and compassionate way. I believe this would be in keeping with the Veterans Health Administration's goal of delivering "the right care at the right time in the right place" as well as the Vet Center's mission of "keeping the promise."

It is my understanding that in the case of a combat death, the Department of Defense releases the DD Form 1300, Report of Casualty, directly to the Department of Veteran Affairs. Item #7 lists the names and addresses of adult next of kin. It would be wonderful if the VA would send a letter of condolence along with information about bereavement counseling. Even more helpful, a counselor from the closest Vet Center could contact the family a few months after the soldier's death to explain the type of counseling and support that is available to them as a result of the ultimate sacrifice made by their family member. It was my personal experience that after 3 months the shock began to wear off, and the emotional pain became far more intense.

As horrible as it is to lose just one soldier in combat, the suffering of the surviving family makes the loss exponential. In my brief time of connecting with other surviving family members of fallen heroes, I have come into contact with parents or siblings who have: contemplated or attempted suicide, quit jobs, divorced, run away from home, become alcoholics, had mental breakdowns, gone to prison, engaged in risky life-threatening behavior, or are drug dependent to get through a day. And that only reflects what I know about the twelve families I met in the first year of my bereavement. Only one of those families had received any information about bereavement counseling through the Readjustment Counseling Service of the VA before I told them about it.

This does not seem consistent with information to be found online in which the VA states, "Objective E-2 recognizes the importance of increasing knowledge and awareness among veterans and their families about benefits and services."

My only recommendation to the Senate Committee on Veteran's Affairs today is to ask you to ensure that all surviving families receive information directly from the VA regarding Bereavement Counseling. In 2005, I wrote to then VA Secretary Nicholson asking the VA to do just that. In his response Secretary Nicholson explained, "We have refrained from contacting families directly . . . out of respect for them following their loss of a loved one in military service."

Although at the time I had no emotional stamina with which to address his misperception of what a surviving family would regard as "respect," I would like to address that now. I believe that respect for my son would include a letter of condolence. It would mean doing everything within your power to ease the awful burden of sorrow that I bear. It would mean honoring my soldier's love for his family by seeing that we were informed of any program that might help us to cope with his death. Respect does not equal distance, to someone who already feels isolated by grief. We would have welcomed any communication from the VA.

I am including with this testimony the letter I wrote to my bereavement counselor when I was ready to formally end our counseling relationship. I believe it will help you to see the depth of pain experienced by surviving military families as well as the help we can hope to find in bereavement counseling.

Thank you for the opportunity to submit this statement, and thank you for continuing to support the families within our borders who bear the brunt of the War on Terror.

Respectfully submitted,

ELISABETH A BEARD,
*Proud Army mom of SPC Bradley S Beard,
 who died in service to our country,
 in support of Operation Iraqi Freedom*

[The letter from Mrs. Beard to her bereavement counselor follows:]

LETTER TO VET CENTER COUNSELOR

February 6, 2007.

Dr. GREGORY INMAN,
*Raleigh Vet Center,
 Raleigh, North Carolina.*

DEAR GREG, Two years ago I couldn't bear to speak of my son. I couldn't think about him or dream about him or remember how he looked.

Two years ago I felt lifeless and shriveled and dead. I couldn't meet your eyes when I sat in your office shredding tissues while tears streamed silently down my face. I couldn't think, and quite honestly had no desire to do so.

Two years ago I dreaded falling asleep only to be ripped apart by nightmares. And I hated waking up to the dismal prospect of another day on this godforsaken planet. I cried myself to sleep most nights, and awakened each morning to fresh tears and a damp pillow.

I know for sure that I did not laugh at all for seven months, and after that I usually only did it because it was expected, not because anything filled me with mirth or delight or good cheer. At one point I remember deciding that I should attempt to smile at least once per day. I would literally stand in front of the bathroom mirror and force the corners of my mouth into an upward grimace. The "smile" never reached my eyes.

Two years ago I felt dreadfully sorry for you that you were the designated bereavement counselor at the Raleigh Vet Center. It meant that you would have to be acquainted with our grief, touch our pain, and quite possibly be caught in the near fatal undertow of our overwhelming despair. I remember thinking how depressing it would be for you never to see any improvement, any change, any signs of reviving, or reintegrating, or readjusting, or resuscitation, or resolving. I was pretty darn sure that we would be the clients who could never be fixed, the ones for whom nothing would ever change, the people who would chronically be engulfed in a miasma of horror and unending pain until one day, finally, you would say, "I don't think this is a very good fit," and then tell us "Your allotted time for grieving is up. Time to get on with your life."

But it didn't happen that way. You never said anything like that. You seemed to have faith in us when we had none. You seemed to think that at some point, somehow, I would be able to make the symbolic and metaphorical journey from stormy, rainy Portland, Oregon, to mostly-sunny-and-mild North Carolina. I, however, was under no such illusion. I didn't think it could possibly happen. I don't even know why I continued to make my feeble way to your office every week, long after I had quit my job, resigned all my volunteer positions, dropped out of every social commitment, and stopped cooking and cleaning and caring about much of anything. I think quite simply I had nowhere else to go.

Sure, along the way I found other broken bits of shattered humanity, military family survivors, but we all felt as insubstantial as a house of cards—only standing because we were leaning on each other and other people. A small gust of adversity could topple us instantly and leave us flat for weeks.

I remember the day when I had nearly convinced myself that my continued existence on earth was pointless in the extreme. I really scared myself that day, but I still had enough survival instinct to call your office. I have no idea what you told me, but it must have been profound. In fact, over the last two years you have probably told me many profound things. And I know I asked you to repeat them numerous times as they fell through the sieve of my grief-numbed brain. But you never seemed annoyed by the repetition.

I still cry myself to sleep sometimes, waken in the midst of unspeakable nightmares, and wish with every thought and every cell in my being that my son still inhabited this earthly plane. But the difference is I now know that I can endure the debilitating pain. I know that I can make it through the next day. And the next.

What else? I can talk about Brad's life as well as his death. I can think in short bursts about what he and I had together, even though it is gone. I can meet people's

eyes when I talk about Brad. I can breathe easier most of the time. On some days, I can almost imagine a lessening of the icy, relentless grip that for so long has squeezed my heart into a tiny, cold, hard knot. I can begin to care about other people again, although the energy to actually translate the care into action is still not there. I can laugh genuinely and only feel a small stab of guilt afterwards.

And why can I do these things? Because our family was fortunate enough to have found what we needed. In the words of Father Joe Mahoney:

NEEDED:

A strong, deep person wise enough to allow us to grieve in the depth of who we are,
and strong enough to hear our pain without turning away.

Someone who believes that the sun will rise again,
but who does not fear our darkness.

Someone who can point out the rocks in our way
without making us children by carrying us.

Someone who can stand in thunder and watch the lightning,
and believe in a rainbow.

Thank you, Greg, for being that person.
Most sincerely,

ELISABETH BEARD,
Mom of SPC Bradley Scott Beard.

PREPARED STATEMENT OF KRISTIN HENDERSON, MILITARY SPOUSE, JOURNALIST

I would like to thank Chairman Akaka and the distinguished Members of this Committee for the opportunity to provide testimony on how the Department of Defense and the Department of Veterans Affairs are caring for the families of wounded warriors as they transition from active duty. Because these families quietly serve our country in the background, they are often overlooked. You deserve special thanks for taking note of the service of families and focusing on their needs.

Based on my interactions with wounded warrior families and those who work with them, I will address the following issues:

- I. The role of the family in the wounded warrior's recovery
- II. The needs of family caregivers
- III. Challenges to meeting wounded family needs

I. THE ROLE OF THE FAMILY IN THE WOUNDED WARRIOR'S RECOVERY

An injured soldier recently told me that his wife is the reason he's still alive. For him and many other wounded warriors, that's no exaggeration. A patient's spouse, children, parents, and siblings have been shown to play a crucial role in the healing process.

After Marine SGT. Sam Nichols of Kilo Battery 3/12 was hit by an IED in Iraq, he was medevaced to Germany. His wife Erin flew to be by his side, just grateful he was still alive. But when she got there, the doctors asked her to sign a "Do Not Resuscitate" form. A neurologist told Erin that Sam's brain was so damaged that there wasn't much chance he'd recover.

That was in July 2007. Sam was in a coma for the first 2 months of his new life with Traumatic Brain Injury, or TBI. By Christmas, Sam was still hooked up to a feeding tube, a catheter, and a temporary colostomy bag. But he was awake and doing physical and occupational therapy 6 days a week. He couldn't speak, but when Erin asked him a question, he could understand and raise one finger for "yes" and two for "no." She worked with him on his alphabet board. She read "Harry Potter" and the Bible to him. When she'd ask him if she should keep reading, he'd let her know that he didn't want her to stop.

These are the successful milestones of Erin's new full-time job—caring for Sam. "I'm there every day, loving him and being his voice until he finds his," she wrote me in an e-mail.

According to her father, "Erin doesn't sit idly by and let the nurses and therapists care for Sam. I would say she is probably the biggest reason Sam has improved as much as he has." Until recently, Sam couldn't really communicate any problems he was having. "But," says Erin's father, "Erin is so in sync with him that she knows what questions to ask him. She determined that he is having bad dreams about the

IED attack in Iraq, and she determined that he was having migraine headaches and is working with the hospital staff to take care of that issue.”

Erin carries around a Bible with a little card in the front flap that says being a military spouse is the toughest job in the military. The day that IED hit Sam’s convoy, her job got tougher. In early December, Erin left the VA hospital in Palo Alto, California, and drove two and a half hours north to spend the day with her family. It was her 24th birthday. It was also her first day off from caring for Sam in 5 months.

Today, Erin continues to work with Sam fulltime. The staff at the VA recognize her as part of the treatment team. With help from the VA and the Marine Corps liaison, Erin has made a decision about which private facility to move Sam to for the next phase of his treatment. This will be her third move with Sam in less than year. She lives wherever he’s being treated—first in Bethesda, Maryland, when he was at the National Naval Medical Center, then in Palo Alto when he was at the VA’s Polytrauma Rehabilitation Center there, and now near the Kentfield Rehabilitation Hospital north of San Francisco.

Erin Nichols’ career has been set aside. Her future is on hold. Many marriages don’t survive this kind of challenge, but Erin writes, “He knows he is loved and has every reason to fight.” Late last month, a chest treatment made it possible for Sam to finally whisper to her, “I love you.”

The fact that the Nichols’ marriage has made it this far is a tribute to Erin and to the support she’s received from the VA. In fact, when Sam’s transfer to the private facility was delayed 2 weeks, Erin was actually happy that they would have a little more time with the VA nurses and therapists she now considers part of her family.

Erin isn’t the only one who has benefited. Her efforts have clearly improved Sam’s prognosis, which will save the VA money in the long run. So far, Erin and Sam Nichols are a DOD-VA transition success story. Adding to the good news is that the latest VA handbook on Federal benefits lay out many additional forms of support that are available to family members like Erin.

However, we still have a long way to go before every dependent feels as well cared for as Erin does.

II. THE NEEDS OF FAMILY CAREGIVERS

Even before Paula’s husband left for Iraq for the third time, she knew something was very wrong with him. She was right. Her soldier was suffering so severely from Post Traumatic Stress Disorder that when he was finally diagnosed 8 months into his 15-month deployment, he was sent straight back to Fort Bliss, Texas. (Because of his worries about stigma, as well as the inability to trust that is a symptom of PTSD, he asked that his name be withheld.)

“He was completely changed,” Paula says of him when he returned in the summer of 2007. He was depressed, suicidal, and self-medicating with alcohol. She remembers, “He was always very loving. He wasn’t aggressive at all before he went into the military.” But he was now so aggressive and verbally abusive toward Paula and their four children, ages 2 to 12, that he was temporarily removed from the family. The stress of his homecoming forced Paula, who is 30, to drop out of school, where she’d been studying human resource management.

He was assigned a case manager, who scheduled his therapy and anger management classes. Paula got some counseling. Although her husband had planned to make the Army a career, he could no longer function effectively as a soldier. And so the process began to transition him out of the Army.

According to Paula, the case manager was good but new, and didn’t know enough to help them navigate the system—evidence that the system is only as good as the people who administer it, or only as good as their training. “There was no information about what we do next,” says Paula. They didn’t even know whom to contact at the VA.

So Paula did her own research. Surfing the Internet, she chanced upon the Army Wounded Warrior program (AW2) and connected with an AW2 representative on Fort Hood, Texas. Paula also stumbled across Operation Homefront, a private charity that provides assistance to military families in crisis.

Meanwhile, the disability rating process took much longer than they were told to expect. In my conversations with disabled veterans, this comes up as an almost universal problem, as does accessing care in a timely manner. Another veteran suffering from PTSD tried to commit himself, but was told by the VA that he would have to wait 2 months. A private charity, *USWelcomeHome.org*, has stepped in to find a mental health practitioner near where that veteran lives to provide pro bono interim care so that he is at least receiving some counseling support while he waits.

In the case of Paula's husband, the delay and lack of information during the transition has led to a gap in treatment. Left to deal with his anxiety and other symptoms on his own, his solution has been to isolate himself. Paula is no longer receiving counseling either. Even the children have fallen through the cracks. They have essentially lost the father they used to know, what experts call a "metaphorical death." Yet they've had no therapy or expert guidance other than what Paula has been able to tell them herself. Paula, who's responsible for caring for her children and her disabled husband, has never been offered respite care.

Two weeks ago, the family left Fort Bliss and the Army for San Antonio. They moved there not because they're from Texas (they're from a distant State), but rather because they heard that in San Antonio they could find the long term services they are going to need from the VA and various private organizations. Operation Homefront is providing them with a free apartment in its new transitional housing complex near Brooke Army Medical Center. AW2 continues to advise them.

On top of having their lives turned upside down by their soldier's psychological injury, this family has taken a huge financial hit. He is not well and has no job, but his 30 percent disability rating means his income is now a fraction of what it was on active duty. As Paula settles the children into their new schools, she's attempting to get back into the work force after many years as a homemaker. The only employment readiness help that she has received came from the AW2 representative, who alerted her to an upcoming job fair.

If Paula had not been lucky enough to find AW2 and Operation Homefront on her own, it's an open question as to what would have become of her and her family. Without the help of those two organizations, Paula's husband would have transitioned from the DOD system to nowhere. This family, which has already sacrificed so much for our Nation, should not have to rely on luck to avoid being abandoned with most of their needs unmet.

Expert advocates for military families at the National Military Family Association (NMFA), the Military Officers Association of America (MOAA), and others, confirm that Paula's experience is not unique. They concur that despite recent legislation and good intentions, the military family piece of the transition process is not yet in place.

What do the families of wounded warriors need? Both Paula and Erin's stories reveal the specific types of support that are absolutely necessary for family caregivers. I want to emphasize that since many soldiers are single, caregivers include not just spouses, but also parents and siblings.

1) One-stop shop for information. Families need a transparent transition process during which information is easy to access and options are clearly laid out. During transition, veterans and/or their caregivers are sorting through complex issues and making major life decisions about care and benefits that will affect them for the rest of their lives. They need knowledgeable assistance to make the best decisions possible. At the very least, transitioning families need a one-stop shop for information referral modeled after *MilitaryOneSource.com*.

2) Caregiver training. VA currently has eight caregiver assistance pilot programs providing health care education, training, and resources. This needs to be rolled out nationwide and enhanced. What's needed is a standardized, certified training program that's accessible to caregivers across the country, wherever they may be located, including rural areas. Such training is needed whether the injury is physical or psychological, but it's especially crucial for TBI caregivers, who have a long road ahead of them. In addition, caregivers need stress management training and access to 24-hour supervision.

3) Compensation and job placement assistance. More must be done to compensate family members who sacrifice their careers and/or relocate to care for America's wounded warriors. This includes lost pay and costs associated with transportation and relocation. Family members who are still able to seek outside employment, but are starting over because their caregiver role has required them to relocate or re-enter the work force after a period of unemployment, should receive career counseling, employment readiness assistance, and help with job placement.

4) Childcare and child counseling. Children must be added to the list of priorities. An injury is traumatic for everyone—when a soldier is wounded, the whole family is wounded. Children of the wounded are especially vulnerable. They need professional counseling and extra caregiver attention, even as their primary caregiver's time and energy is being monopolized by the often overwhelming needs of the injured veteran. Sometimes it's not possible to simultaneously care for an injured veteran and parent a small child—for instance, while taking the veteran to appointments where the presence of children isn't appropriate. Those caregivers need free, safe, reliable childcare.

5) Respite care. The VA's four Project HERO (Health Care Effectiveness through Resource Optimization) demonstration sites are providing drop-off respite care. These must be expanded. Access to in-home respite care with 24-hour availability is urgently needed and should be added.

6) Counseling and peer support. Counseling for dependants is very accessible while they're still in the DOD system. The barriers arise during the transition to the VA system, including the physical move that usually accompanies the transition, during which existing providers are left behind. They're also leaving behind their formal and informal networks of support. Suddenly, they're isolated in a new location, and isolation increases the risk of depression and other problems that undermine the family member's ability to be an effective caregiver. To its credit, the VA has called for recognition of the impact a struggling caregiver can have on the recovering veteran. To that end, the Vet Centers' mandate must become more inclusive of military families. Peer support groups for family members must be expanded and actively promoted.

Experts at NMFA and MOAA, both previously mentioned, and other members of the Military Coalition, as well as Disabled American Veterans, and Paralyzed Veterans of America, have developed detailed proposals for meeting these needs. My purpose here is to affirm that, indeed, family needs are not yet being adequately met and that such prescriptions are still critically necessary for continued improvement.

III. CHALLENGES TO MEETING WOUNDED FAMILY NEEDS

The stories told by family members like Paula and Erin not only highlight their needs. They also hint at the challenges that are preventing those needs from being met as consistently as they should be.

To overcome those challenges, the nuts and bolts of what must continue to change have been well-documented elsewhere by groups such as those listed above, and deserve mention here:

- Improved timeliness of the disability claims process
- A permanent institutional structure for joint DOD/VA oversight
- A process for rolling out best practices throughout the VA system

When it comes to addressing the needs of military families, DOD has had a huge head start over the VA, ever since military wives first began demanding better support in the immediate aftermath of Vietnam. Not only is the VA now playing a game of catch up in caring for families, but it's doing so on an impossibly enormous playing field—the number of veterans, dependants, and survivors adds up to 70 million people.

Our entire Nation, not just the VA, has an obligation to care for veterans and veteran families. Leaving it all to the VA simply deepens the growing gulf that exists between those who enjoy the benefits of citizenship and those who protect them. The VA certainly should continue to do all that it is doing, and more, and the Congress should close the funding gap to make that possible. But it's neither realistic nor desirable to expect the VA to shoulder, all by itself, what should be the responsibility of every American.

Quite frankly, caring for veterans and their families is in every American's self-interest. I mentioned earlier that when a soldier is wounded, the whole family is wounded. But the ripple effect doesn't stop there—the community is wounded, too. Unaddressed physical and psychological wounds result in troubled children and disrupted classrooms, domestic violence and increased police calls, snowballing health problems and more frequent emergency room visits. All this costs the community.

Many civilian organizations and communities have begun to recognize this and are making an effort to educate themselves and reach out to veterans and families. On the mental health front, civilian groups as varied as *GiveAnHour.org*, *USWelcomeHome.org*, and the Deep Streams Zen Institute have begun organizing community support. Some of the services these groups provide aren't even possible for the VA to offer within its medical model, yet are wanted and needed by a significant number of veterans and families. That said, strengthening VA partnerships with civilian organizations must be done in a way that does not undermine the expert, comprehensive, trackable in-house care that veterans service organizations have fought so hard to ensure.

"The community is ready," to partner with the VA, according to Michael Wagner, co-founder of *USWelcomeHome.org*. "They just need to be tied into the system in some way. They need training in how to work with veterans." Communities even need education about the VA itself. They may contact the benefit or medical elements and think they've talked to the Vet Center, not realizing that these are three discrete organizations within the VA.

Communities that try to partner with VA should not get the response that a group in the Dallas-Fort Worth area received. When Mental Health America of Greater Dallas and the Mental Health Association of Tarrant County were awarded half-million-dollar grants to work with veterans, they organized a community education conference and invited the VA to come talk to them. The VA didn't show up.

The VA's own National Center for PTSD (NCPTSD) provides an excellent model for community education and partnering. I have participated in two 1-day educational conferences that were organized by Vermont communities with help from NCPTSD. They were attended by civilian teachers, clergy, police officers, medical and mental health practitioners—anyone in the community who was likely to cross paths with veterans and their families.

Remember, it was civilian community organizations that saved Paula and her military family when they fell through the enormous gaps that remain in the DOD-VA safety net. You, the Members of this Committee, could use your bully pulpit to encourage more communities to help close those gaps, even as you continue your laudable efforts to push for a seamless process for wounded warriors and their families as they transition from DOD to VA.

Thank you for giving me this opportunity to give voice to the wounded families who are living through that transition.

