MENTAL HEALTH TREATMENT FOR FAMILIES: SUPPORTING THOSE WHO SUPPORT OUR VETERANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

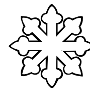
ONE HUNDRED TENTH CONGRESS

SECOND SESSION

FEBRUARY 28, 2008

Serial No. 110–73

Printed for the use of the Committee on Veterans' Affairs



U.S. GOVERNMENT PRINTING OFFICE

41–373 WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
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MENTAL HEALTH TREATMENT FOR FAMILIES: SUPPORTING THOSE WHO SUPPORT OUR VETERANS

THURSDAY, FEBRUARY 28, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Berkley, Hare, Miller, and Moran.

Also Present: Representative Kennedy

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to call this hearing to order. I want to thank everyone for coming. We will have some votes this morning. We are supposed to get done at noon. So to try to speed the process up, I will be extremely brief and ask unanimous consent that if any Members have opening statements, that they be submitted for the record.

We are here today to talk about mental health treatment for families of veterans. This is a very important issue. One that this Committee looks to address. These are issues that we hear a lot about when we go back home to our districts and talk to Guard and Reserves and active military. I think it is very important that whatever this Congress and this Committee does we not only look at veterans, but we also look at the family and the community. I want to thank all the witnesses here today for coming. I really appreciate that. And look forward to your testimony.

As I mentioned earlier, I request my full remarks be submitted for the record.

[The prepared statement of Chairman Michaud appears on p. 46.]

Mr. MICHAUD. Mr. Hare, do you have an opening statement?

Mr. HARE. No.

Mr. MICHAUD. Okay. Without any further ado, on our first panel we have Linda Schwartz, who is Commissioner of Veterans Affairs for the State of Connecticut; Stacy Bannerman, who is from Fife, Washington; and Peter Leousis, who is Deputy Director and Principal Investigator for Citizen Soldier Support Program National Demonstration.

And without objection, we will make sure that your full testimony is submitted for the record. I would ask Ms. Schwartz to begin her testimony.

STATEMENTS LINDA SPOONSTER SCHWARTZ, RN, DR.P.H., FAAN, COMMISSIONER OF VETERANS AFFAIRS, STATE OF CONNECTICUT; STACY BANNERMAN, M.S., FIFE, WA, AUTHOR, *WHEN THE WAR CAME HOME: THE INSIDE STORY OF RESERVISTS AND THE FAMILIES THEY LEAVE BEHIND;* AND PETER LEOUSIS, PRINCIPAL INVESTIGATOR, CITIZEN SOLDIER SUPPORT PROGRAM NATIONAL DEMONSTRATION, AND DEPUTY DIRECTOR, H.W. ODUM INSTITUTE FOR RESEARCH IN SOCIAL SCIENCE, UNIVERSITY OF NORTH CAROLINA (UNC) AT CHAPEL HILL

STATEMENT OF LINDA SPOONSTER SCHWARTZ, RN, DRPH, FAAN

Ms. SCHWARTZ. Good morning, Mr. Chairman, and thank you very much for letting me speak. It is a very important subject as you know. I am retired from the Air Force. I was medically retired because of injuries I received as a reservist. And that was probably my first trip to this place, this room, looking for justice.

And I think we are all coming today here for justice. It is no secret that the military has changed from the time I joined in 1968. There are more women. There are more married families and a heavy reliance on our Guard and Reserve has brought the needs of our returning veterans to every town and city of this United States.

I am really not going to go into the specific problems. But I am going to tell you that in Connecticut we realized when we saw a lot of the disruptions of the family life, when we saw some of our returning veterans who were having a very difficult time readjusting, and we realized that there was an increase in domestic violence, Driving Under the Influence (DUIs), and breach of peace, and a lot of dangerous behaviors by returning Connecticut veterans.

Governor Rell charged me to do whatever it takes to ensure that the families and the returnees received all of the help that we could possibly give.

I am lucky because in Connecticut the General Assembly in 2004 set aside $1.4 million for a program, which we now call the Military Support Program. This was to be opened for all families of the Reserve components, pre-, during, and post-deployment. And we actually have learned over time that the more important thing is that we not only included the spouses and the children, we included significant others, the parents, and the siblings, immediate family members.

We have a 24/7 toll-free number that is manned by a real person. When anyone is in need of help and we have done a lot to actually advertise the program. The way it works is if someone calls the toll-free number, we have taken this model building on some of the experience Connecticut had after 9/11, we have trained mental health professionals throughout the community.

We called it “Military 101.” And it was 16 hours of training. All of the clinicians had to go through this training. And they are actu-

ally certified through the Department of Mental Health and Addiction Services of the State of Connecticut.

So if someone is in need and they call this toll-free number, if it is not a mental health issue, they are referred to the appropriate agency. But morning, noon, and night, if they should call this number, they are given the name of three clinicians within their immediate geographical area who have agreed to take these calls and have agreed to engage in treatment with these families.

And if everything else, all other funding sources are not available, we pay for that care for those individuals from the fund that was set aside by our General Assembly.

The best thing about this is that we call back after receiving a call within 7 to 10 days to see how things are going. If they haven't actually engaged in treatment, we certainly encourage them to do that.

Additionally, what we have done is the idea that continuity of care. I did cite in my written statement to you a study that was done in your own home State of Maine, which illustrated that returning veterans are more likely to engage in mental healthcare with their families, because the stigma that we all hear about kind of subsides because the military member is doing it for their family, not necessarily for themselves. However, they are engaged in treatment.

We have had—March 1, 2008, in the 10 months that we have been in business, we have had over 360 calls and made 180 referrals of families who are now in treatment.

I think that in addition to that we have had done a lot of other activities for example, we are doing a survey of our returning veterans. And now one of the other things is that the outreach for these veterans is a very, very important thing that my Governor has tasked me to do.

But along with that, maybe because she was the member of a military family, she certainly realizes the importance that the family provides, the support that they provide, to our troops in the field.

And that concludes my testimony.

[The prepared statement of Ms. Schwartz appears on p. 47.]

Mr. MICHAUD. Thank you.

STATEMENT OF PETER LEOUSIS

Mr. LEOUSIS. Mr. Chairman and Members of Subcommittee, thank you for the opportunity to speak this morning. I am the Principal Investigator of the Citizen Soldier Support Program National Demonstration.

This program was funded by Congress to develop model approaches for mobilizing and engaging communities to support citizen soldiers and their families.

Before I begin, I want to thank the North Carolina Congressional delegation and the UNC Board of Governors for their support of this work. I also want to emphasize that while we have been laying the groundwork for this initiative for many months, the elements are just getting underway. We will have a much better picture of our impact in 6 months.

Our focus is on the National Guard and Reserves. In North Carolina, most citizen soldiers don't live near a military installation. And their families don't often think of themselves as military families.

To date, more than 10,000 citizen soldiers in North Carolina have served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). And most of them came home to communities and towns that might not even be aware of their service and sacrifice.

We know that most families are resilient. But repeated deployments and reintegration can be as challenging for families as it is for veterans.

And there is evidence that exposure to combat has an even greater affect on the Reserve component than it does on the active component. Clearly, the mental health needs of returning veterans affect the entire family. The issue is not whether many families will face mental health challenges, but how we can make sure they get the services they need where and when they need them. Mental Health treatment should be made available to the entire family when it is clinically appropriate.

The initiative I am overseeing focuses on rural communities and communities without ready access to U.S. Department of Veterans Affairs (VA) medical facilities and Vet Centers. And I have some maps that I want to show you very quickly this morning.

The first map shows that every county in the State has either Guard or Reserve members. The green indicates the highest concentration. The red is the lowest concentration.

The second map shows the Vet Centers and VA medical facilities in North Carolina. Those circles are 20-mile radiuses. In other words, about a 30-minute driving distance to each one of those facilities or Vet Centers.

Our initiative is focused on those little dots that you see out there in the counties. Those are licensed clinical social workers, of course, the greatest concentrations are in the urban areas where the Vet Centers and the medical facilities are.

But virtually every county in the State has licensed clinical social workers and other mental health providers who can also work with these families and provide services outside of VA medical facilities.

In fact, our approach is targeting those folks who live outside of those circles. It is guided by three principles. The first is that we have to complement the work that others are doing. And that includes the VA. One of our very close collaborators has been Dr. Harold Kudler at the Mental Illness Research, Education and Clinical Center. That is located in Durham at the VA medical center there.

Another principle is that we need to take a systems approach. Our efforts are focused on leveraging existing mental health training and delivery systems to enhance the delivery of services throughout the State.

The third principle is that there is no silver bullet. We need to take a variety of different approaches and move forward on many different fronts at the same time.

We have five components. The first is to provide evidence-based, best practice behavioral health training for healthcare professionals

who are in counties outside of those circles. That includes primary care physicians and mental health providers, because often times the physicians are the gateways to mental health services.

Second, we are working on a demonstration to provide specialized mental health services to returning vets and families using an integrated care model that combines healthcare and mental healthcare in family health clinics in rural underserved counties.

The goal is to be self-sustaining within 3 years through TRICARE, third party payers, and Medicaid.

The third component is to expand TRICARE participation throughout the State to physicians and mental health providers. We are also working very hard to recruit those folks into the system and to recruit the hospitals, the major hospitals, in the State.

Fourth, we want to address the critical shortage of clinicians in medically underserved rural counties through a tuition loan forgiveness program for psychiatric nurse practitioners to get that care out there in the communities.

And then finally, we have online information for consumers, for the families, and military servicemembers through our NC Health Info website, and information for providers through the AHEC Digital Library. AHEC is the Area Health Education Centers.

Our goal is to implement these strategies in North Carolina and to help other States replicate those that are successful.

That concludes my remarks, Mr. Chairman. Thank you very much.

[The prepared statement and referenced maps of Mr. Leousis appear on p. 57.]

Mr. MICHAUD. Great, thank you. And I am very glad that you are the first one to use this new technology we have——

Mr. LEOUSIS. I understand.

Mr. MICHAUD [continuing]. And glad that it works.

Mr. LEOUSIS. It works very well.

Mr. MICHAUD. Ms. Bannerman.

STATEMENT OF STACY BANNERMAN, M.S.

Ms. BANNERMAN. During the few hours it takes for this hearing to conclude, another veteran will commit suicide. Most likely a veteran of the Guard or Reserves who make up more than a half of veterans who committed suicide after returning home from Iraq and Afghanistan.

There will be at least seven family members left behind to deal with the adjustment, loss, anger, and grief. And they will do so alone. Forced to live with the pain of their preventable loss for the rest of their lives.

I am currently separated from my husband, a National Guard soldier who served 1 year in Iraq. And just as we are finding our way back together, we are starting the countdown for a second deployment. Two of my cousins by marriage have also served in Iraq, one with the Minnesota Guard, a 22-month deployment, the longest of any ground combat unit. And my other cousin, active duty, was killed in action.

When the home front costs and burdens fall repeatedly on the same shoulders, the anticipatory grief and trauma, secondary, intergenerational and betrayal, is exponential and increasingly

acute. Guard families experience the same stressors as active-duty families during all phases of combat deployment. But we have nowhere near the same level of support, nor do our loved ones when they come home.

The nearly three million immediate family members directly impacted by Guard and Reserve deployments struggle with issues active-duty families do not.

The Guard has never before been deployed in such numbers for so long. Most never expected to go to war. During Vietnam, some people actually joined the Guard in order to dodge the draft and avoid combat. Today's Guard and Reservists are serving with honor and bravery each and every time they are called.

But when the Governor of Puerto Rico called for a U.S. withdrawal from Iraq at the annual National Guard conference, more than 4,000 Guardsmen gave him a standing ovation.

These factors are crucial to understanding the mental health impacts of the war in Iraq on the families of Guard and Reserve veterans and tailoring programs and services to support them.

At least 20 percent of us have experienced a significant drop in household income during our loved one's combat deployment. And that is an added stressor. Some veterans lost their jobs as a direct result of deployment. Some of us relocate. We go to food shelves. Where we once shared parenting responsibilities, we are the sole caregiver. And we have no on-base childcare center.

During deployment, we may attempt to cope by drinking more, eating less, taking Xanax or Prozac to make it through. We cautiously circle the block when we come home, our personal perimeter check to make sure there are no Casualty Notification Officers.

Our kids may act out or withdraw, get into fights, detach or deteriorate, socially, emotionally, and academically. And there are no organic mental health services for the children of Guard and Reservists, even though they are more likely to be married than active-duty troops.

When our soldiers come home, they are given a perfunctory set of questions. And then they are given back to us. Fifty percent of Guard and Reserves who have served in Iraq suffer post-combat mental health issues. And the government has known for decades, decades, decades. The VA has done nothing about it. And I question—I question commissioning reports and conducting studies if we are not going to apply what we have learned.

Perhaps rather than forking out another $5 or $10 million for a study, that money could be used to fund a community-based center that would provide our families and veterans 3 years of the free services they are desperately begging for but that aren't available.

We should commission the people who have their doctorates in deployment. The military families and veterans, they know what is needed, what helps, and what the emerging issues are.

I knew the suicide rates of citizen soldiers who served in Iraq were going to be off the charts when I started hearing from their family members more than 2 years ago.

And although it stands to reason that the branch of service with the highest rates of post traumatic stress disorder (PTSD) would be the same one with the highest rates of suicide, the Department of Veterans Affairs had to do a formal analysis to determine that cit-

izen soldiers are more likely to kill themselves as war veterans. A Military Citizens Advisory Panel could likely have saved lives, dollars, and years of pain.

After a loved ones return from deployments that have all the precursors for post-combat mental health issues, we are given a pamphlet and told to "give it time." And while we are reading and waiting, we are losing our veterans, our marriages, our health, and our families.

For one military family living with a combat veteran who wrote, "Back in May, Kyle suffered a PTSD disassociative state of mind and held me at knife point. He had me and my family sitting on the floor and was speaking to us in Arabic for an hour and a half."

The veteran's unresolved traumatic re-enactment resulting in domestic violence is the nucleus of intergenerational trauma, which the children and grandchildren of these veterans are going to be living with forever.

The VA's mental health professionals preach to the wives about resilience. But they aren't the ones being woken up at three in the morning because their husband has shot the dog, or is holding a gun to your head, or a knife at your throat.

Expecting the wife and family member to treat the veteran violates the professional standard prohibiting family members from treating their own. It places the burden of care on the family. It creates a highly unfair and unethical expectation that we are trained mental health providers. It excuses the VA from fulfilling its responsibilities to our veterans. And it discounts our reality, while placing an immoral burden on our veterans, our family members, who are likely already suffering undue mental health and financial consequences.

Another issue before I make the recommendations that the Committee requested that I provide at this hearing. Another critical, critical issue is the one of betrayal trauma. When the Veterans Administration repeatedly proves to us that we can't trust them to take care of our loved ones, we feel betrayed. When our loved ones 5 years into this war still don't have the equipment, they need, we feel betrayed.

And there is no dictionary large enough to describe what you feel when you learn that your loved one has fought, died, been wounded, is on the ground or on alert to return to fight in a war that was launched on 935 lives.

Mental health experts refer to what is going on with military families, particularly in the Guard and Reserve, as betrayal trauma. That is what occurs when the people or institutions we depend on for survival, the VA, and the Pentagon, the U.S. Department of Defense (DoD), when they violate us in some way.

And I assure you when it is life and death and your loved one on the line, and when they are fighting for country and Constitution, military service is no mere contract. It is a covenant. And it has been betrayed.

Now in order to genuinely care for our Guard and Reserve veterans, we must attend to the need of families who are left behind and serve as the first line of support.

However, right now within the Veterans Administration, treatment is tied to the veteran. Military spouses can't access services

at the VA until their soldier has acknowledged his or her trauma, registered with the appropriate agency, provided paperwork or given permission for the spouse to receive assistance or attend a support group, which may or may not be available at the time.

The majority of affected loved ones, the siblings, the parents, the significant others, are beyond the scope of services. Guard and Reserve families often don't have private insurance. We can't afford the copays. We are unable to find adequate mental health providers who have the experience, training, and awareness to address the particular needs of our community during a time of war. And those inadequacies put the health, well-being, and future of all military family members and their veterans at risk.

A few brief recommendations——

Mr. MICHAUD. Yes, because——

Ms. BANNERMAN. Yes, sir.

Mr. MICHAUD [continuing]. I was ready to—this is twice the amount of time.

Ms. BANNERMAN. Thank you. I appreciate that immensely.

Mr. MICHAUD. So if you could go through as quickly as possible.

Ms. BANNERMAN. Very brief.

Military Citizens Advisory Panel, the real support for citizen soldier veterans and loves ones can't be achieved without the perspectives of those who are directly affected by combat.

I would recommend that the experiences, and the perspective, and the realities of the people who have—the people who have the doctorates in deployment are brought into the policy program and oversight processes of the Veterans' Affairs Committee.

I would recommend peer-to-peer support groups. I would recommend that you look at implementing an adopt a family program that would involve community members in taking a Guard or Reserve family member under its wings for all phases of combat deployment.

I would recommend, particularly in the rural areas, 40 percent of our veterans live in rural areas, that you conduct home visits.

I would recommend that the VA fund community-based weekend retreats. Our citizen soldiers work full time when they come home. We need weekend retreats, or we need experiential programs. We need non-clinical services. We need night services.

And please, please develop and implement a family systems theory programming and services. Please, thank you.

[The prepared statement of Ms. Bannerman appears on p. 51.]

Mr. MICHAUD. Well, thank you very much. And thank you also for writing the book entitled "When the War Came Home: The Inside Story of Reservists and the Families They Leave Behind."

I haven't had a chance to read the book. But I definitely will. So I want to thank you for your interest, in this area as well. It is very helpful.

Mr. HARE. I have a couple of quick questions. Commissioner Schwartz, you had mentioned about the Connecticut Military Support Program. Knowing what States are going through with budgetary shortfalls and the way the economy is, how does Connecticut plan to continue to fund this program, or do you plan on continuing to fund the program?

And my second question is, is there any way the VA can help support what Connecticut's doing for this particular program?

Ms. SCHWARTZ. Let me say, sir, that I give that credit to the foresight of the General Assembly. We sold the site, which had been a psychiatric hospital. And a portion of the money that was realized from that was set aside well in advance. Yes, they do intend to continue to support it, because we have found that our families—I hope you can hear me.

We have found that—you know this as well as I do, families in distress on the home front, can now electrically transmit immediately through emails and cell phones the distress that they are in. This actually does affect mission readiness.

The most important thing about it is that we are proactive, in addition to this, I have commissioned a study of recently returned veterans, a survey that is being conducted by Central Connecticut State University out of funding they have received. And it is going to just recently returned veterans, because I would like to make a point. Many people would not like to hear this point, but the truth of the matter is that our veterans who are returning today are not—are not joining the veteran service organizations. They are into the peer-to-peer support groups.

Student groups throughout Connecticut, I have actually been working with university presidents to have at least an office for the veterans to drop in, because we have many veterans in our college campuses who are finding that they just don't fit.

And as a veteran of the Vietnam War, I know that feeling well. So I want to do whatever I can to assure that doesn't happen again. That is my charge. And that is my daily goal.

Getting back to what can VA do, I want to just say your State, my State, all the States of the union, put together—$4 billion is what our States invest in the care of veterans throughout America. That is second only to a very small second, but second only to the Federal VA.

I am sure you have heard this before, but let me say it again. We need to know when these folks are coming home. There is no—there is no vehicle for us to be informed when they are coming home. But they are Reservists who are not attached to a unit. National Guard has a great safety net, because at least we know who they are.

But as you may know, my Congressman, Joe Courtney, has sponsored legislation to require that VA and DoD inform the States when people are coming home.

Let me also say that there are some things the VA cannot do. You just heard a litany. VA cannot possibly respond in the time that they need to do that. And that is why working with the States, because I am accountable not only to my Governor, but to the citizens of my State. And all of my counterparts across the country care, they are vitally interested in this.

And I think that VA needs to see us as a natural partner. When you put the resources of Connecticut together with the resources of the VA in Connecticut, we have—we have developed a continuum.

Right now we are working on the issue of so many of our veterans returning facing jail time. And we are working on an alternative to incarceration, which includes VA.

Mr. MICHAUD. Thank you very much.

Mr. Leousis, can you speak to the unique mental health challenges that members of the Guard and Reserves and their families have, particularly those who live in rural areas?

Mr. LEOUSIS. Yes, sir. Well there is a lot of research that indicates, as I said, that first of all, Guard and Reservists are affected at roughly twice as much. There was an article published in the "Journal of the American Medical Association" last year that said returning Reservists and Guardsmen have roughly 42 percent mental health issues.

It definitely affects their families. And what we are finding is that they live too far from VA centers, or the vets medical facilities, or the Vet Centers to get the kind of treatment or services they need once they become eligible for those services.

So our goal is to train providers in those rural areas who then will go into a directory that will be available not just through NC Health Info, which is information for consumers for the families themselves, but also go into a directory working with the local medical—the North Carolina Medical Society so that primary care physicians would also have information about who they can refer those families to when they show up at their offices.

Mr. MICHAUD. Okay. And the program—Citizen Soldier Support Program—engages community support for members of the National Guard and Reserves. Are there any plans to expand this program to other States?

Mr. LEOUSIS. Yes, there are. What we would like to do is stand up a national center at the university that I work at. But the goal would be to take the successful demonstrations and practices that we are developing in North Carolina. And then working with other States and people like Colonel Schwartz in Connecticut, develop a strategy that is tailored to Connecticut, not to North Carolina, but that takes a lot of the principles.

Over 40 States have AHEC systems. AHEC stands for Area Health Education Centers. And those are training systems that exist in States to reach mental health and healthcare providers.

Mr. MICHAUD. Thank you. Congressman Hare.

Mr. HARE. Thank you, Mr. Chairman.

Ms. Bannerman, thank you so much for coming. And I thank all the panelists. I had an opportunity in my office to meet with the parents of Tim Bowman who committed suicide when he got back. And his mother was telling me something that I think about almost every day. She said when he—before he came home or when he was coming home, they were given less than 5 minutes of things to look out for, things that they may encounter.

And, you know, here sits the parents of this wonderful young man and taking the blame for something. "We should have seen it. But we didn't see it. Didn't know what to look for." I wonder if—you know, if maybe you could just from your perspective, you know, because you mentioned a word I think that is incredibly important. It is also the families of these people, because if you come home suffering post traumatic stress disorder. I have had people come up to me. And the little kids will say, "Why is my dad hitting my mom?" or "Why is he doing the things that he is doing?"

So I wonder maybe if you could talk a little bit about maybe some things you would suggest we could do to help the families of people, because it is not just the servicemember that needs the help, it is the families who are greatly affected by whether, you know, it is post traumatic stress or whether the person takes their life. And, you know, to keep a family or to help—try to help them get through this terrible time or things to look out for.

Again, this mother told me—she said, "Congressman, I should have seen this. I should have done something about it." And I said, "Well, if you don't know what to look for, how can you—you know."

I am just wondering maybe to get some thoughts from you on that.

Ms. BANNERMAN. Thank you for asking me Congressman. Virtually every family member I have spoken with who has lost their veteran due to suicide or divorce has said, "I thought that if I loved him enough I could fix him."

When we are just given a pamphlet, and then sent home, and there is no kind of follow up, chances are good that pamphlet goes in a drawer somewhere. If the person reads through it once, then it goes into a drawer. And that is about the end of that.

What would have been hugely beneficial, one, I think that the VA should be—start making efforts to reach out to families or begin tracking our soldiers at the midpoint of their deployments. I don't understand this business of waiting until they have been home forever. It just seems like forever to us. That is all.

And I think also one of the things that would be huge is if our families—again, especially Guard and Reserve, you know, when you are active family, you have somebody living next door to you on base who is going through the same thing or who has been through it.

If we had just heard from a combat veteran, if we had just heard from military families who have lived through deployments. If they had come to us, rather than this public relations outreach specialist from the VA, with the pamphlet, if we heard from a combat vet and military family members, that would have been huge.

If there had been follow up done, you know, at regular periodic intervals. We know that post-combat trauma manifests in different ways and kind of at different stages. And there should be check ins.

In my husband's case, when he got home, there wasn't a comprehensive mental health screening done until he had been home for more than 8 months. There had been no follow up for him whatsoever. The regular active-duty people, they have weekly kind of mental health check in stuff. It is mandatory. The Guard has got nothing.

And then they didn't call him with the results of his mental health screening until almost 10 months after they did it. So that is oh gee, a year and a half that went by from the time he got home until the time they called him and said, "Yeah, we got your test results, and you have some symptoms of PTSD. And we suggest you get counseling." That was it.

Mr. HARE. Not to interrupt you, but in my home State of Illinois, it is my understanding that all Guardsmen are tested, or screened for PTSD. But yet, many places across the country they are not.

And for that person to actually step forward and say, you know, I think I have this problem. They may need—first of all, they may not even know they have a problem. It may not manifest itself for months or years.

There has to be a much better way. We have to do a much better job it would seem to me of screening every person when they come. And that and then following that up with talking to their families too, because this is not just for the veteran. This is for their entire family that is affected by this.

Ms. BANNERMAN. Minimize the delays as much as possible. And also, I think one of the things too is a whole lot more needs to be done to shift the language. I mean, we are talking about this like it is kind of—it is a mental problem. And it is a heart problem. It is a soul problem——

Mr. HARE. Mm-hmm.

Ms. BANNERMAN [continuing]. A lot of it, you know? And we have so pathologized combat-related mental health issues, that of course there is this stigma when, in fact, the reality is that a healthy person after being in combat—combat situations, unlike any other for longer than ever, a sign of health is that they come back and they have difficulty reintegrating.

And so it is also about the framing of it. And it is about the language. And it is about having much more. Don't just put these guys from combat to cul-de-sac in 48 hours.

Mr. HARE. Right. Well, listen I thank you so much. I look forward to reading your book.

Ms. SCHWARTZ. I would just like to say something.

Mr. HARE. Sure.

Ms. SCHWARTZ. The U.S. State of Illinois, you have a wonderful Director of Veterans Affairs. And she——

Mr. HARE. Tammy Duckworth. Yeah, she does a great job.

Ms. SCHWARTZ. Yes. And she has instituted a traumatic brain injury (TBI) screening that is something that we all—for all returning Guardsmen. And it is true that they do.

I personally have been to the demobilizations (DMOBs) myself. But, you know, the euphoria of the troops coming home, they are in the best shape they have been in in months.

And so when you do a screening like VA, or when you look at the TBI screening that they are doing now with some concerns that there is no validity to this test, that screening—the most important thing you could take away from it is the screening at the—immediate DMOB is not working.

But what we find is 30 days after they come home, that is when reality sets in.

Mr. HARE. Mm-hmm.

Ms. SCHWARTZ. And the DoD has said, oh, come back in 90 days. But it is really 30 days. I know some States, Minnesota is one of them, has been successful negotiating with DoD to be able to do this at 30 days.

But I think when you have to negotiate with DoD, that is a tall order. And that somebody needs to really think about bringing them back at 30 days, not the 90 days.

Mr. HARE. Great. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you. Mr. Moran.

Mr. MORAN. Thank you, Mr. Chairman. Just one question as a follow up to either one of our witnesses that I have heard testify.

Is there some justification for this 90 days? What is the explanation for why it is not being done at the most appropriate time?

Ms. SCHWARTZ. I think that in the beginning they felt that they were doing—that 90 days was just actually implemented a couple of years ago. They felt like it——

Mr. MORAN. It used to be longer?

Ms. SCHWARTZ. Yes. And the issue was that, you know, they have been at war. Give them some downtime.

But I think experience has shown, and it is across the board, that 30 days is the mark. And we need to be looking at them at 30 days. That is when, as I said, reality sets in. And readjustment issues start to surface. That is when you can pick up on some of these mental health issues before they become a crisis.

Mr. MORAN. Thank you very much. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you. Ms. Berkley.

Ms. BERKLEY. Thank you, Mr. Chairman. I have a statement that I would like to submit for the record.

[The prepared statement of Congresswoman Berkley appears on p. 47.]

Mr. MICHAUD. Your statement will be made part of the record.

Ms. BERKLEY. I also want to thank our witnesses for being here and helping to educate us further. So thank you for your time and attention to what is a very serious and increasingly more prevalent issue.

Mr. MICHAUD. Thank you. Once again I would like to thank our first group of panelists very much for your testimony. It has been very enlightening. I look forward to working with you as we move forward on this issue. I now would like to invite the second group to please come forward.

Our second panel includes Charles Figley, who is a Ph.D. from the American Association for Marriage and Family Therapy (AAMFT); Ralph Ibson, who is Vice President of Government Affairs for Mental Health of America; and Suzanne Phillips, who is here on behalf of the American Group Psychotherapy Association (AGPA).

I want to thank all three of you for coming today as well. We do have your written testimony, and it will be submitted for the record. We ask that you stay within the 5 minutes.

We still have a couple panels to come. So if we can try to stay within that 5-minute time frame, it would be appreciated.

So without further ado, Mr. Figley.

STATEMENTS OF CHARLES FIGLEY, PH.D., LMFT, FULBRIGHT FELLOW AND PROFESSOR, COLLEGE OF SOCIAL WORK, AND DIRECTOR, TRAUMATOLOGY INSTITUTE AND PSYCHO-SOCIAL STRESS RESEARCH AND DEVELOPMENT PROGRAM, FLORIDA STATE UNIVERSITY, TALLAHASSEE, FL, ON BEHALF OF AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY; RALPH IBSON, VICE PRESIDENT FOR GOVERNMENT AFFAIRS, MENTAL HEALTH AMERICA; AND SUZANNE B. PHILLIPS, PSY.D., ABPP, CGP, PSYCHOLOGIST–PSYCHOANALYST, GROUP THERAPIST, NORTHPORT, NY, ADJUNCT PROFESSOR OF CLINICAL PSYCHOLOGY, C.W. POST CAMPUS, BROOKVILLE, NY, POST–DOCTORAL FACULTY, DERNER INSTITUTE, POSTDOCTORAL PROGRAM IN GROUP PSYCHOTHERAPY AND PSYCHOANALYSIS, ADELPHI UNIVERSITY, GARDEN CITY, NY, ON BEHALF OF AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, INC.

STATEMENT OF CHARLES FIGLEY, PH.D., LMFT

Mr. FIGLEY. Dear Mr. Chairman and other Members of the Subcommittee, on behalf of the American Association for Marriage and Family Therapy, I would like to thank you for shedding light on the need for the Department of Veterans Affairs to expand VA mental health services to include family members of veterans in addition to veterans themselves.

We are honored to participate in this important dialog. And by holding today's hearing, which is Mental Health Treatment for Families: Support Those Who Support Our Veterans, access to family oriented mental health services will finally be formally addressed, so we can begin to help heal the clandestine wounds increasingly affecting those closest to returning servicemembers.

As background, the AAMFT is a national non-profit professional association representing the interests of over 52,000 marriage and family therapists across the United States. And it was started in 1942.

Family therapists are the only mental health profession required to receive training in family therapy and family systems. Not only are marriage and family therapists (MFTs) licensed in 48 States and this District of Columbia, but each licensed or certified MFT must meet strict professional requirements including a minimum of a master's degree, even though 30 percent have a Ph.D., in marriage and family therapy or equivalent degrees with substantial course work in MFT. In addition, MFTs must complete at least 2 years of a post-graduate clinical supervision internship.

At the end of 2006, the President signed into law a sweeping veterans' bill that finally added marriage and family therapists as eligible providers of mental health services under the VA. It is Public Law 109–461.

As one of the 5 core mental health professions, designated by the Heath Resources and Services Administration, family therapists are trained to treat disorders commonly faced by veterans, including clinical depression, post traumatic stress disorder, among others. Despite our ongoing collaboration with the leadership of the VHA and the law having been in effect well over a year, our 52,000 U.S. family therapists are still awaiting implementation into the

VA system as we can begin to aid our Nation's veterans, as we have served active-duty military for over 30 years.

Family therapists have been eligible to provide medically necessary mental health services to active military personnel and their families under the CHAMPUS and TRICARE program for decades, as well as recognized by the Department of Defense.

Additionally, family therapist interns serve veterans in VA facilities, but presently cannot continue this care as licensed MFTs since our VA implementation is incomplete.

So why are we so anxious to get to work at the VA? The impact of mental illness on our veterans and their families is striking. Recognition of the need to expand VA mental health services to include families is growing as an impact of mental health disorders among veterans of OIF and OEF manifest, following their mustering out of the military.

A 2004 study, that I am sure you are aware of, demonstrated the significant mental health consequences of the wars in Afghanistan and Iraq. This publication in the "New England Journal of Medicine," cites the estimated risk for PTSD from service in Iraq Wars as 18 percent, while the risk of PTSD from Afghanistan is 11 percent.

According to a less well known study in the "Journal of Marital and Family Therapy" in October of 2006, "domestic violence rates among veterans with post traumatic stress dirorder are higher than those in the general public. Individuals who have been diagnosed with PTSD who seek couple therapy with their partners constitute an underrepresented and understudied population."

Additionally, servicemembers deployment length is intrinsically related to higher rates of mental health problems and marital problems.

Data within the U.S. military report, the "Mental Health Advisory Team (MHAT) IV," my journal had a special issue just last month on this, shows that there are at—has been at least 72 confirmed soldier suicides in Iraq since the beginning of OIF as late as 2006.

As with previous MHAT reports, this also finds suicide rates at 28 percent higher compared to the average Army rates for those not deployed. For servicemembers, deployment length and family separation were the top non-combat deployment issues.

Marital concerns were higher than in previous surveys among these OIF troops. And like other concerns, they were related to deployment length. Those in Iraq were more than—who are more than 6 months, which includes the Army and Marine Corps for example, were at least 1½ times more likely to be assessed as having mental health problems. In addition, those troops were more likely to have—I understand—the marital concerns, reporting problems of infidelity, and were almost twice as likely in planning—in planning for a marital separation and divorce.

And the data goes on and on. So let me just come to a conclusion. What about the Reservists and National Guard that was noticed—noted on the last panel?

The obvious problems of hampering veterans access to mental health services is a shortage of qualified mental health providers

in rural communities. This is where marriage and family therapists come in.

Once you have a way of addressing the staffing problems is through the increased access to mental health services provided by practitioners who are widely present in rural communities. These are, again, family therapists.

Our own data show that 31 percent of all rural counties have at least one family therapist, demonstrating our strong MFT representation in rural America. Improving access is critical, particularly since the National Rural Health Association reports on the average distance between a VA care facility and the veteran is 63 miles.

This is unacceptable travel time for those who have already traveled the world on behalf of—in pursuit of U.S. safety and security. Our servicemembers deserve more and to help and make a seamless transition out of active duty and into veteran status.

[The prepared statement of Mr. Figley appears on p. 62.]

Mr. MICHAUD. Thank you very much. Mr. Ibson.

STATEMENT OF RALPH IBSON

Mr. IBSON. Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for holding this truly important hearing.

Military deployment, particularly for a Guardsman and Reservist, can be enormously stressful as many witnesses have already testified this morning. The strain that war places on families and marriages does not necessarily end with a homecoming.

The post-deployment period can also be a time of difficult readjustment. As one writer put it, "In many instances, a traumatized soldier is greeting a traumatized family, and neither is recognizing the other."

Clinicians have described adjustment reactions among OIF/OEF veterans that include feeling anxious, having difficulty connecting to others, experiencing sleep problems, strains in intimate relationships, as well as problems with impulse control and aggressive behavior.

These understandable reactions impair the process of reintegrating an individual back into family life. Clearly, the family has a profoundly important role in a veterans readjustment and recovery. But family members who have been scarred by the trauma of the deployment experience and who sometimes suffer anxiety and depression themselves, may not have the capacity to provide that needed support.

It is critically important certainly that veterans get the counseling and treatment they need. And that they receive that help early to avoid problems becoming chronic or worsening.

But if the veteran is to be truly helped, we cannot ignore the mental health needs of those family members whose support is so critical.

Let me emphasize that current law already reflects the importance of providing mental health services to family members of veterans.

Section 1782(a) of Title 38 specifically directs using the word "shall." It directs VA to provide counseling and mental health serv-

ices to immediate family members when those services are necessary to support the treatment of a service-connected condition.

Given that service-connected status is a key element in that provision, it is important to acknowledge that Congress has already established what amounts to presumptive service-connected status for all OIF/OEF veterans for healthcare eligibility. And it just recently extended that presumption—that effective presumption—from 2 to 5 years.

So what is the practice in VA today? The VA is a national healthcare system. But when it comes to meeting the needs of veterans with mental health problems, which for many does include addressing the family's mental health, getting needed support depends entirely on where the veteran lives. If one can get to a Vet Center, family counseling is probably available.

But what about the veteran living a considerable distance from the closest Vet Center? A few, I emphasize a few, VA medical centers provide an excellent program of family support services that includes consultation, education, and psycho-education.

But it is our experience that most medical centers and clinics do not offer such programs. It is difficult to square that patchwork with language in Title 38 that, as I noted, says the Secretary "shall provide consultation, professional counseling, training in mental health services as are necessary in connection with treatment of a service-connected condition."

Only a handful of facilities appear to be providing any of those services. And notwithstanding that clear language, we are not aware of any VA medical centers or clinics that provide mental health treatment as required by law to family members of veterans for treatment of a service-connected condition.

If VA is treating an OIF/OEF veteran for PTSD that has not been adjudicated as service connected, current law limits provision of family services to instances where the veteran has been hospitalized. That limitation appears to us to make no sense, particularly given VA's transformation a decade ago from a hospital-based system to one that is heavily reliant on ambulatory treatment. Continuation of hospitalization as the test seems anachronistic and contrary to good medical practice.

We see no sound rationale for providing family services in Vet Centers on the one hand and restricting them in the medical centers. And we urge the Committee to amend section 1782.

Finally, it appears to us tragic that with the prevalence of PTSD among returning veterans, the Department has not heeded the advice of its own experts.

And I think it goes very much to Congressman Hare's earlier question. The VA Special Committee on PTSD some 2 years ago stated, "VA needs to create a progressive system of engagement and care that meets veterans and families where they live." And as Ms. Bannerman spoke earlier, the emphasis should be on wellness, rather than pathology, on training rather than treatment.

Finally, the PTSD Committee went on to say, "Because virtually all returning veterans and their families face readjustment problems, it makes sense to provide universal interventions that include education and support for veterans and their families, cou-

pled with screening and triage for the minority of veterans and families who will need further intervention."

That concludes my summary.

[The prepared statement of Mr. Ibson appears on p. 64.]

Mr. MICHAUD. Great, thank you very much. Ms. Phillips.

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

Ms. PHILLIPS. On behalf of the American Group Psychotherapy Association——

Mr. MICHAUD. Could you turn your microphone on, please?

Ms. PHILLIPS. On behalf of the American Group Psychotherapy Association, I thank you for the opportunity to testify for the needs of veterans and their families.

In the aftermath of 9/11, the American Group Psychotherapy Association faced the needs of a traumatized population by running an extensive number of groups for bereaved spouses, children, families, schools, communities, churches, corporations, and first responders.

In all, AGPA ran 600 groups, meeting the needs of over 5,000 people. The curriculum we used, the protocols we developed have been published. And they have already been translated to the needs of other populations such as the victims of Hurricanes Katrina and Rita, and more recently the California fires.

I am here to propose that many of those group programs are particularly relevant to the needs of veterans and their families.

Trauma, assault, connections and social ties. We have found that group interventions are particularly viable, not only because they are cost effective, but because they reduce barriers of care.

Groups normalize, destigmatize, they validate. They offer the opportunity to bear witness, to support resiliency, as well as to restore connections.

Too often the collateral damage from war is the destruction of the marriages and families of our veterans. Thirty-eight percent of the marriages of Vietnam veterans were dissolved within 6 months of their return from Southeast Asia.

We have heard today already of the difficult homecomings of our veterans from Iraq and Afghanistan. Homecoming is a complicated process. It is difficult to reverse battle mind mentality. It is difficult to move on when others have been lost.

In fact, many of our veterans bring home the war in terms of physical wounds and psychological scars. Their marriages and their families are at risk. But they are also their greatest resources. Research tells us that it is the close social ties, the marriages and the families that are the most potent anecdote to the despair and isolation that unfold from combat trauma.

One of the programs that was particularly effective after 9/11 that is relevant to vets was the Couples Connection Program that we ran in partnership with the Counseling Office of the Fire Department of New York. After 9/11, the Fire Department of New York had lost 343 of their men. Firefighters are much like military. In fact, many of them are Reservists and Guardsmen. They have the same code. You go in together, you come out together, and you leave no man behind.

As a result, for months they stayed on the pile looking for traces of lost brothers. By the time the pile was closed on June 2002, many of their marriages and families were devastated. It was in response to this that we ran the Couples Connection Program over 15 times for the next 2 years relative to the delayed response of PTSD.

These programs involved 25 couples at a time in group experiences that normalized PTSD, addressed survivor guilt, masked depression, and the isolation and helplessness of those who wait on the home front, as well as the necessary steps back to marriage and intimacy.

Another very relevant program was the family program called Going on After Loss. This program did a great deal to restore stability in families, as well as to address trauma and the need for new role definitions. This could very easily be translated into families going on after war, particularly with wounded parents.

The program ran parallel family, children, and parents groups. It emphasized communication, coping skills, and new beginnings.

AGPA was very aware of the impact on caregivers after 9/11 and provided many group programs and training to deal with the secondary post traumatic stress dirorder and vicarious traumatization that affects spiritual caregivers and clinicians dealing with families and those who have been traumatized.

This is very relevant to our VA clinicians as well as non-clinical staff who are dealing with so many returning vets. Initiatives are already in place with the DVAs in San Antonio and Houston to provide training for psychiatric nurses and ancillary staff dealing with our veterans.

Much like dealing with family members, when you support and train the system that surrounds veterans, you enhance the possibility of their recovery.

In terms of trying to connect across a distance, AGPA provided a great deal of training by means of telephone contact and online panels. At one point as we were running our online panels for trauma training, we had over 2,500 participants worldwide checking in.

This has potential——

Mr. MICHAUD. If you could please sum up.

Ms. PHILLIPS. In terms of the programs that we could present, we know that the families and the spouses of our veterans are their best resources. By including them directly in programs, we make possible the reconnections that really bring them home.

That concludes my testimony.

[The prepared statement of Ms. Phillips appears on p. 68.]

Mr. MICHAUD. Great. Once again, I want to thank all three panelists very much for your enlightening testimony. And I will be submitting some questions for the record, if you could respond.

[No questions were submitted.]

Mr. MICHAUD. Mr. Miller.

Mr. MILLER. Thank you very much, Mr. Chairman. I apologize for being late. I was in an Armed Services hearing on the Army budget.

Mr. Ibson, I came in during your testimony I believe. One of the comments you made was that Congress should have no hesitation of amending current law to allow family members of Operation

Iraqi Freedom and Operation Enduring Freedom veterans to get counseling services that would enable them to better support the veteran in his or her treatment.

For clarification, do you support, advocate opening treatment just so they can deal with the veteran and their issue, or are you advocating furthering the process to allow family members to receive mental healthcare as well?

Mr. IBSON. Well, current law certainly links the provision to services to family members to a nexus for the treatment of veterans.

I think one could certainly look at the extraordinary trauma of the deployment and post-deployment period on that family member and liken it to service connection. That that trauma is as much linked to war as is the veteran's experience in service.

I could understand lines the Committee might feel it appropriate to draw. But certainly at a minimum, we would see nexus to the veteran's treatment as a critical point. And the failure to make that bridge for veterans who have not yet been adjudicated service connected seems troublesome.

Mr. MILLER. But you do acknowledge that it could be very problematic to expand care to family members that may have preexisting issues and see how that could mushroom into a tremendous cost for the VA system, and in some ways even hamper the ability to provide healthcare to the veteran?

Mr. IBSON. But, again, with the analogy to establishing service connection, whether or not there is a preexisting issue when the experience of military service aggravates an underlining disorder, we make no distinction with respect to the veteran.

And I think in the spirit of furthering the veteran's well-being, it behooves us, at least from our perspective, to ensure that the family member can get needed services and be supported.

Mr. MILLER. So you recommend that if a family member has childhood issues that they are being treated for then the VA should be responsible for treating those issues because they are in fact a family member of a returning veteran.

Mr. IBSON. That is not the point I was trying to make, sir.

Mr. MILLER. Well that is the point I am trying to make.

Mr. IBSON. I understand.

Mr. MILLER. That is what I am saying. You see how the nexus could be drawn. You are now providing—I understand aggravating or mitigating circumstances. I think we would all agree, but I am just saying can you see how broad it then becomes? It becomes a system whereby we are treating individuals who clearly could be, clearly who have no nexus, no connection to the veteran's mental health.

Mr. IBSON. The art of line drawing is always challenging, sir. And in the final analysis, my judgment would be, or my recommendation would be that the Committee look to what can serve the reintegration, recovery, readjustment of that veteran.

Mr. MILLER. Do you subscribe that is not what this Committee does already?

Mr. IBSON. No. I don't mean to suggest that at all, sir.

Mr. MILLER. Thank you. Another question, you stressed that VA needs to create a progressive system of engagement and care that meets the needs of the veterans and their families where they live.

Can you give me some ideas of how that is accomplished in our rural areas, as most all of us, maybe except Ms. Berkley. Do you have any rural areas in your district? Obviously, veterans do not always live where the care is most readily available.

Mr. IBSON. Yes, sir. And I think this Committee has already taken a historic stand on that point in marking up, and moving to the floor, and passing in the House the Chairman's Bill H.R. 2874, provisions of which would direct the VA to mount a national program to train returning servicemembers to function as peers, to do outreach, and engagement, and support.

And I think, again, it speaks to the issue that Mr. Hare and that you are raising. That it allows for an opportunity to work with community providers who under H.R. 2874 would be encouraged to employ such trained peers to reach the many, many veterans, particularly the National Guardsmen and Reservists, who are remote from the VA.

Mr. MICHAUD. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. Mr. Figley, if I could get an opinion from you here. Do you think the VA fully understands the importance of involving the families, and spouses, children, and parents in mental health treatment for the veteran?

Mr. FIGLEY. No.

Mr. HARE. Okay. Okay then.

Mr. FIGLEY. You wanted me to be brief. I am trying to be brief.

Mr. HARE. Pardon me. Well there went my 5 minutes in a hurry. No. Well, what do they need to do? You know, I understand that. So what would you suggest that they do to change that no into a yes at some point?

Mr. FIGLEY. Well it really starts with what I was trying to emphasize—one of the major messages that Congress passed a law that allowed and authorized the VA to have marriage and family therapists to address the mental health issues of these returning veterans.

And this group, our group, is the most qualified in the world really to deal with these kinds of issues. And for various reasons, I mean, I am not sure why, that has not happened. So my sense is that there is a lack of commitment there.

But if that happens, if there are lots of marriage and family therapists running around, they will constantly say why aren't you talking—why aren't you focusing on a family system, particularly with this group of veterans who are concerned about—you know, we have basically false positives and false negatives in terms of assessing for PTSD and other things.

And so if you focus on the impact on the family, then it is a very different kind of situation. If you tell your commanding general I am going for marriage counseling, that is very different than going for counseling as an individual.

Mr. HARE. Well we have heard this point. And I hear this a lot too. You know, the veteran—the servicemember on a Monday is in Iraq, and on Thursday is at their kid's soccer game.

Mr. FIGLEY. Right.

Mr. HARE. It is here 1 day. And you are back this next day. And it would seem to me that, you know, the Chairman's talked about an idea, and I just kind of want to run it by the panel, of before this person is released back in that they have what you call almost a debriefing boot camp, or for lack of a better title where there is some time spent for the veteran, to understand the programs that are available, to understand, to be screened, and the things to look out for.

But also on the family side, to somehow pull that family in, because they clearly don't understand. And as I said before, this mother of the young man who committed suicide, she had no idea what to look for. And he obviously had some serious problems that weren't—you know, that he didn't get the help for.

So I am trying to figure out, what do you think of that idea or that concept? How do we ultimately pull the families in to be a part of this? This is a family thing. This is just not solely related to that person who has served.

And especially I think as someone said earlier, sometimes these are people who are on their second, third deployment when they are coming back. For heaven's sake we—you know, if there is not a problem, if they don't think there is a problem there, there is. And we just have to be able to identify it, and find it, and be able to help them.

Mr. FIGLEY. Yes. I am sure the other panelists will add to this. It should start long before they are deployed. There should be an orientation for families, as well as the troops that are being deployed about the common and expected kinds of reactions and what to do about it and resources established.

The National Guard and Reserves are the ones that I worry about most, because your analogy of coming back, they are in a community that understand this.

Mr. HARE. Yes.

Mr. FIGLEY. But those that go back to their own rural community, sometimes don't even know if they have gone. So, yes, there should be a comprehensive orientation prior to deployment, during, and following deployment to educate and to constantly monitor and provide assistance.

Ms. PHILLIPS. One of the first steps in recovery from trauma is establishing safety. We found that psycho-educational groups for families that, in fact, as you say Mr. Hare, informs them of what to expect so that it demystifies some of the symptoms, it reduces the anxiety in the children. These are—the psycho-educational piece also offers a way to screen for higher levels of care.

So in terms of groups, even apart from services to family, training groups and psycho-educational input seems to be not only preventive but really reinforce further recovery.

Mr. HARE. Thank you very much. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you. Ms. Berkley.

Ms. BERKLEY. I don't really have any questions of the panel. I think my question is and when I had an opportunity to review the information for today's hearing, and looking at all of the services that the VA provides, is it—you know, Congress people are very keen on passing more laws. And, you know, we hear from a panel

and we go my gosh, we have to introduce a piece of legislation allow—having family counselors do this or that.

But I am wondering if it is not a matter of passing the laws? Do the laws exist? Is the flexibility there? Is it a function of the VA not having the resources to carry out Congress' wishes?

And that—I mean, when I look at this, we are providing education, counseling, community referrals, caregiver training and support, respite care, homemaker/home health program, adult day care, home-based primary care, palliative, hospice care, Fisher Houses of course.

I am wondering what it is that I can do as a Member of Congress in recognizing that the needs are extraordinary. And recognizing that I have no rural areas in my district. And I don't have the problem of being in such an isolated area that you can't get any care. I have a problem of being in a very populated area and not getting any care.

But I don't—as I sit up here feeling so helpless and concerned that yet another law isn't going to solve any problem and isn't going to save a single veteran from a mental health issue or ease the hardship of a family that is going to have a family member who served and is suicidal or has committed suicide. And we have—you know, I have had a few servicemen in Nevada that have committed suicide after their service to this country. It is a heartbreaking thing. What can we do up here?

Mr. FIGLEY. What you are doing right now. This is a historic—in my opinion, this is a historic session, because what you are suggesting, not just to the VA but to all Federal programs, and we have State representatives as well, of changing the paradigm, focusing on the family. Recognizing the family members are veterans too. That they have served their country through these multiple deployments. And there is so much evidence to show how our military is being worn out by the deployments. The families are being worn out as well. And we have an obligation to take care of them.

Ms. BERKLEY. I couldn't agree with you more. Some of my Nevada National Guard Army people are on their fourth deployment since 9/11, not necessarily in Iraq, but a year away from home. Fourth, which just I think indicates how stretched our services are.

I have family members that—and these are National Guard. They are not kids usually. They are adults. Families while there—while mostly husbands, not always, but mostly husbands are serving, you have women that are losing their homes, they are moving their children into their parents' home. This is something—they haven't lived at home since they were 18. And now they are moving back with adult children of their own. They are having a hard time making ends meet. And this is what our National Guard people are coming home to, a family in crisis that needs counseling of its own separate and apart from dealing with somebody that has just gotten back from Iraq.

And that is a concern of mine, providing the necessary services, mental health and otherwise, to people that—you are right. They are on the frontline. They may not be in Iraq, but I will tell you something, they are sacrificing plenty on behalf of this country.

And it is—and I am talking to, you know, women in their 30s and their 40s that are having a very, very tough financial time.

And the kids are, you know, messed up obviously. And there is not a father figure in the house. And they have—we are going to be stuck with the problems of this war for many, many decades to come. And I think it is time that we recognized that and start planning for a future that might be quite a bit different for thousands—hundreds of thousands of Americans than they anticipated.

Mr. IBSON. Just to add to Mr. Figley's remarks, I think he is quite right that the leadership this Committee will play is a tremendously important part in moving forward.

At the same time, there are gaps in VA's authority with respect to provision of family services. I would be happy to work with you or the staff to develop a piece of legislation if you would like.

I think it is very clear that there are anachronistic statutory limitations that unless a veteran is service connected for PTSD or a mental health condition, the entry point for family members into the system is very limited. And I think that amending the law is certainly a step the Committee could take to help those veterans and their families.

Mr. MICHAUD. Once again, I would like to thank this panel for your testimony today. It has been very helpful. I look forward to working with you as we move forward on this very important issue. So thank you very much.

We have just been called for votes. So we will not have time to take the third panel. We will recess. But I would like to introduce the third panel. It will be Scott Sundsvold who is representing the American Legion; Joy Ilem, the Disabled American Veterans (DAV); Fred Cowell, from the Paralyzed Veterans of America (PVA); Dr. Thomas Berger from the Vietnam Veterans of America (VVA); and Todd Bowers from the Iraq and Afghanistan Veterans of America (IAVA).

So I would invite the third panel to come forward when we begin. And once again, thank you very much. We will be in recess until further notice. It shouldn't take too long, we have three votes. So thank you.

[Recess.]

Mr. MICHAUD. Once again, I apologize for the interruption. Let's begin. We will start with Mr. Cowell. We have your testimony. It will be entered into the record. So if you can begin.

STATEMENTS OF FRED COWELL, SENIOR HEALTH ANALYST, PARALYZED VETERANS OF AMERICA; THOMAS J. BERGER, PH.D., CHAIRMAN, NATIONAL PTSD AND SUBSTANCE ABUSE COMMITTEE, VIETNAM VETERANS OF AMERICA; TODD BOWERS, DIRECTOR OF GOVERNMENT AFFAIRS, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND SCOTT N. SUNDSVOLD, ASSISTANT DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION

STATEMENT OF FRED COWELL

Mr. COWELL. Mr. Chairman and Members of the Subcommittee, the Paralyzed Veterans of America appreciates this opportunity to present its views and recommendations concerning how the VA can

best assist veterans with mental illness by providing counseling and educational services to their families.

The prevalence of mental illness is high among soldiers currently serving and veterans who have returned from service in Iraq and Afghanistan.

Combat exposure, coupled with extended and frequent deployments, are associated with an increased risk for post traumatic stress dirorder and other forms of mental illness. VA reports that Operation Iraqi Freedom and Operation Enduring Freedom veterans have sought care for a wide array of possible co-morbid medical and psychological conditions, including adjustment disorder, anxiety, depression, post traumatic stress dirorder, and the effects of substance abuse.

VA has also reported that of the 299,000 separated OIF/OEF veterans who have sought VA healthcare since fiscal year 2002, a total of 120,000 unique patients had received a diagnosis of a possible mental health disorder. Almost 60,000 enrolled OIF/OEF veterans had a possible diagnosis of PTSD. Almost 40,000 OIF/OEF veterans have been diagnosed with depression. And more that 48,000 reported non-dependent abuse of drugs.

However, soldiers and veterans are not the only individuals being affected. For every unique OIF/OEF veteran who is fighting mental illness, there is also a veteran's spouse or a family member who is also directly affected.

Veterans' spouses and other family members provide the majority of care and support for veterans who have chronic mental illness.

Caregiving is a job that cannot be neglected, and in many cases it cannot be delegated. Family caregiving is physically and emotionally draining and has a financial impact as well. The National Family Caregivers Association (NFCA) notes that caregivers often feel isolated, and report that their lives are not normal, and no one can possibly understand what they are going through.

In a NFCA survey, 61 percent of caregivers report depression and 51 percent sleeplessness. Additionally, spouses and family members must make sacrifices at work to attend to duties at home.

It is PVA's belief that VA's treatment of veterans with mental illness will produce more positive outcomes if veterans' spouses, appropriate family members, and other caregivers receive detailed counseling and education services from VA professionals.

Spouses, family members, and other caregivers need access to a comprehensive VA counseling and education services program that offers a systemwide, uniform curriculum of information. But also one that is flexible enough to be condition specific.

Spouses and family members need to know about mental illness and need information about the specific condition affecting their loves ones.

These caregivers also need to understand how to recognize the warning signs of potential crisis situations. The importance of medication management assistance and the need for regular attendance during ongoing professional treatment and counseling sessions.

They need access to a peer support program where they can share and discuss common problems and find solutions from experi-

enced caregivers. They also need VA's physician and counselor contact information when they feel the need to seek professional advice. Perhaps a family hotline can help bridge the gap when weekend assistance is needed and for those times when a VA medical health expert is not on duty.

They need to have a fundamental understanding of how VA services work. This aspect of the curriculum should include information on the scope of VA medical and financial benefits that are available to the veteran.

Additionally, Mr. Chairman, any VA program must find ways of assisting with the caregiver's personal problems as well. Counseling and education only goes so far. If the veteran's family unit is to remain stable, then avenues of assistance such as referrals for treatment for spouses and family members must also be available.

At the very least, VA must provide a mechanism where the problems of caregivers can be heard and advice given.

Mr. Chairman, PVA knows firsthand the benefit of counseling and educational services for spouses and family members of veterans with spinal cord injury.

Caregivers of veterans with spinal cord injury play a primary role in the successful rehabilitation, activities of daily living, and of his or her reintegration into civilian life. Perhaps the PVA's spinal cord injury system of care program for family counseling and education could be a model, if modified, to serve families of veterans with mental illness.

PVA believes Congress should formally authorize and VA should provide counseling and educational and support services to family members of severely injured and mentally ill veterans.

These services should include education on mental illness, relationship and marriage counseling, VA benefit counseling, and related assistance for the family coping with the stress associated with caring for a severely injured or ill veteran.

Finally, Mr. Chairman and Members of the Subcommittee, we thank you for holding this important hearing and recognizing the pressing needs of veterans' families as they struggle to assist and support veterans with mental illness.

The VA has great expertise in treating veterans with mental illness. And PVA believes that this cadre of VA mental health professionals could easily assemble a comprehensive counseling education program that can be there for veterans' families.

This concludes my remarks, Mr. Chairman.

[The prepared statement of Mr. Cowell appears on p. 82.]

Mr. MICHAUD. Thank you very much, Mr. Cowell. Mr. Berger who is from the Vietnam Veterans of America.

STATEMENT OF THOMAS J. BERGER, PH.D.

Mr. BERGER. Mr. Chairman and other distinguished Members of this Subcommittee, Vietnam Veterans of America or VVA appreciates the opportunity to present our views on the need for the Department of Veterans Affairs to provide mental health assistance and treatment within VA medical centers for family members of veterans.

And, again, we would like to thank you for your leadership in taking point on the mental healthcare of our veterans' families and

in seeking the views of veterans' service organizations on this very important and timely issue.

As you are well aware, one of the recommendations of the Dole-Shalala Commission was to "significantly strengthen support for families." This will not be an easy task. But VVA believes this hearing can serve as the opening dialog on this very serious concern.

As more and more troops return home damaged emotionally and mentally as well as physically, their families must contend not only with the shock of seeing the physical desolation of their loved ones, but come to grips with the new reality of their lives, which have changed dramatically, and not for the better in many cases.

Take for example a 35-year-old soldier or Marine with two children who returns home with what is diagnosed as Traumatic Brain Injury or TBI. His or her impairment affects the future of the entire family. His or her spouse and children have to deal with his or her inability to concentrate, the mood swings, depression, anxiety, even the possible loss of employment.

As you can imagine, the economic and emotional instability of a family can be as terrifying and as real as any difficulty focusing or simply waking up in the middle of the night and crying.

In cases of severely brain-damaged casualties, spouses, parents, and siblings may be forced to give up careers, forsake wages, and reconstruct homes to care for their wounded relatives rather than consign them to the anonymous care at a nursing home or assisted living facility.

VVA believes that the mental health stresses of war may be even greater for the families of those serving in the National Guard or Reserves. In that deployment of these individuals often results in dramatic losses of income along with numerous legal and family complications affecting the children, including domestic violence or substance abuse.

In addition, unlike family members of active-duty military who often have an established support system available to them on the base as we have heard earlier, family members of Guard and Reserve troops must often struggle to create their own systems of support.

You will hear cries that the VA medical facilities, with the notable exception of the VA Vet Centers operated by the Readjustment Counseling Services, are not authorized to provide mental healthcare treatment for the families of veterans.

You will also hear that neither the military DoD or the VA has the organizational capacity or the personnel resources to provide such.

There are other issues about the intensity and drains of vitally needed services and family support that will be hard to sustain, as well as significant issues regarding the complexity of other medical and specialized needs.

However, in calendar year 2007, thanks largely to the leadership of this Committee, along with others in our Congress, along with the Speaker of the House, more than $11 billion was infused into the VA system, mostly for healthcare.

Unfortunately, this is only a start, albeit a very good start, toward restoring and building the organizational capacity needed to

properly take care of veterans and every generation who have earned the right to healthcare by virtue of their service to the country in uniform.

VVA believes that many of the logistical and organizational challenges that I have mentioned or alluded to can be overcome through legislation that authorizes partnerships between the VA and professional mental health organizations such as the National Council for Community Behavioral Healthcare, which represents over 1,400 community-based mental health programs, as is already suggested in H.R. 2874, the "Veterans' Healthcare Improvement Act of 2007," and its companion bill in the Senate, S. 38, the "Veterans' Mental Health Outreach and Access Act of 2007."

A model of such a collaborative partnership involving the VA, the Maine National Guard, sir, and the Community Counseling Center, a local behavioral healthcare provider, has been in operation since 2006 in Portland, Maine, and has achieved positive, very positive, results.

The example of what is happening in Connecticut, as we heard from Commissioner Schwartz this morning, is yet another model of the type of creative partnerships and very effective and useful work that can be done when VA does not insist on having total bureaucratic control over all of the activities in healthcare delivery in which they play some role.

This distinguished panel can make a difference by promoting the process of healing of veteran and family members in a way that has never been done before, as Mr. Figley has strongly suggested, if there is cooperation across the jurisdictions of Congress.

I thank you. That is the end of my testimony.

[The prepared statement of Mr. Berger appears on p. 84.]

Mr. MICHAUD. Thank you very much, Mr. Berger. Mr. Bowers who is with the Iraq and Afghanistan Veterans of America. Thanks for coming today. Thanks for your service.

STATEMENT OF TODD BOWERS

Mr. BOWERS. Thank you, Mr. Chairman. Mr. Chairman, Ranking Member, and distinguished Members of the Committee, on behalf of the Iraq and Afghanistan Veterans of America, and our thousands of members nationwide, I thank you for the opportunity to testify today regarding mental health needs of military families.

I would like to point out that my testimony today does not reflect the views of the United States Marine Corps in which I still currently serve as a Reservist. I am here testifying today in my civilian capacity as the Director of Government Affairs for the Iraq and Afghanistan Veterans of America.

In my 10-year career as a Marine Reservist, I have had the honor of serving in Iraq twice. When I returned home from my tours, I realized that combat deployments are hard on members of the Armed Services, but they are even more difficult for military families.

My family was no different. During my second tour in Iraq, I was wounded when a sniper's bullet impacted the scope on top of my rifle. Fragments of that bullet are still lodged in my face today as a constant reminder of how lucky I was that October day in Fallujah.

The circumstances surrounding my injury were so fantastic that I knew my parents would eventually hear about the incident. My command and myself, felt it was important that I contact my family via satellite phone to inform them of what had happened. While this was the correct decision, I knew that the impact on my loved ones would be tremendous. Over the phone I told my mother, "You can hear my voice. I am alright."

But the incident that physically wounded me, wounded my mother much worse. She had a difficult understanding—difficult time understanding what had happened. In her own words, she never knew why someone would want to shoot her Todd, although she may take that back the way I acted in high school sometimes.

While I was completing my tour in Iraq, my mother needed help at home. My family lives far from the reserve center that I deployed from and was not involved in any formal family counseling groups. Her only contact with fellow military families was via email or phone.

As she struggled to cope with the knowledge of my injury, my mother was more than alone, she was lost. She sought assistance through the only means she was aware of, the mental health counseling covered by her own health coverage.

For 1.6 million veterans of Iraq and Afghanistan, the stresses of deployment really hit home. As the Committee knows, rates of psychological injuries among new veterans are high and rising. According to the VA Special Committee on post traumatic stress dirorder, at least 30 to 40 percent of Iraq veterans, or about half a million people, will face a serious psychological injury, including depression, anxiety, or PTSD.

Data from the military's own Mental Health Advisory Team shows that multiple tours and inadequate time at home between deployments increases rate of combat stress by 50 percent. These deployments, the Mental Health Advisory Team has concluded, also puts families at a tremendous strain. Twenty-seven percent of soldiers and Marines in Iraq are reporting marital problems.

It is not only marriages that are being tested. More than 155,000 children have parents currently deployed in support of the wars in Iraq and Afghanistan, and 700,000 children have had a parent deployed at some point during the conflicts, according the American Psychological Association. According to the Pentagon, almost 19,000 children have had a parent wounded, and 2,200 children have lost a parent in Afghanistan or Iraq.

Much of the difficulties that these families will face will be knowing where to reach out to receive help. This is often connected to the stigma that we have seen with mental health issues. This doesn't just resonate within the military. It also resonates among military families. That is why I am very proud to announce that IAVA has partnered with the Ad Council, the non-profit organization responsible for some of America's most effective and memorable public service campaigns, including "A Mind is a Terrible Thing to Waste," "Only You Can Prevent Forest Fires," and "Friends Don't Let Friends Drive Drunk."

This summer, the Ad Council and IAVA will launch a multi-year campaign to destigmatize mental healthcare for servicemembers and more importantly their families. The broadcast, print, web, and

outdoor ads will encourage those who need it to seek mental healthcare and inform all Americans that seeking help is a sign of strength rather than weakness. We are very excited to partner with the Ad Council to help get troops, veterans, and their families the care that they need and that they deserve.

Mental health and support for veterans' families are also key components of our 2008 legislative agenda. One of our six legislative priorities this year is new funding to combat the shortage of mental health professionals.

The VA must be authorized to bolster its mental health workforce with adequate psychiatrists, psychologists, and social workers to meet the demands of the returning Iraq and Afghanistan veterans and their families, including funding for Vet Centers to alleviate staffing shortfalls.

While IAVA applauds the VA initiative to hire new Iraq and Afghanistan veterans as outreach Coordinators, as of April 2007, VA numbers show that more than half of the 200-plus Vet Centers need at least one or more psychologists or therapists.

IAVA also supports the creation of a new VA program to provide family and marital counseling for veterans receiving VA mental health treatment. For the many military and veteran families, unlike my family—for the many military and veteran families who, unlike my family, are among the 47 million uninsured Americans, this may be their only access to mental healthcare that they need to cope with the effect of the wars—that the wars have had on their families.

I thank you for providing me the opportunity to testify before you this afternoon. All of the data and IAVA recommendations I have cited today are—can be located in our mental health report and our legislative agenda, which I have brought copies for you all today. Thank you.

[The prepared statement of Mr. Bowers appears on p. 86. The IAVA report entitled, "Mental Health Injuries, the Invisible Wounds of War," January 2008, will be retained in the Committee files. The report can be downloaded from the IAVA Web site at: http://www.iava.org/documents/Mental_Health.pdf.]

Mr. MICHAUD. Thank you very much, Mr. Bowers. Ms. Ilem, from the Disabled American Veterans.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you Mr. Chairman and Members of the Subcommittee.

The Disabled American Veterans being invited to testify today regarding the mental health needs of family members of veterans.

Service-related polytraumatic injuries and post-deployment mental health issues exact a severe toll, not only on the veteran, but on military and veteran family members as well.

Many severely wounded and disabled veterans require continuous and intensive family caregiver support for many years and for some, a lifetime. In most cases, a spouse, parent, or other family member assumes the role of primary caregiver, often leaving behind jobs, college, or other personal and professional goals and responsibilities.

With the wars in Iraq and Afghanistan, the demographics, family dynamics, and expectations of disabled veterans and their families have changed. And so too should VA benefits and services.

The changed conditions in these families, including the impact of post-deployment readjustment problems, and the physical and emotional demands of long-term caregiving, warrant a new program to care for and comfort these families and provide relevant and specialized support and counseling services when they need them.

While we are pleased that VA has initiated a variety of caregiver assistant pilot programs, VA currently lacks a comprehensive program of caregiver assistance, counseling, and related services to ensure these families receive adequate support.

Therefore, we recommend that VA expeditiously develop a systematic policy based on the best-practices garnered from these pilot initiatives.

Family support is critical to a disabled veteran's successful rehabilitation. Therefore, we should provide the training and services necessary so they do not become overwhelmed by the impact of readjustment issues on the family and responsibilities in caring for these extraordinary veterans.

It is important that these family members are properly educated and trained to deal with the symptoms of and how to live with someone who has experienced a devastating injury or illness, while at the same maintaining their own good mental and physical well being.

Like previous generations of veterans, our newest war veterans are returning with not only serious physical injuries such as amputations and Traumatic Brain Injury, but also post traumatic stress dirorder, depression, anxiety, and substance abuse disorders, and other post-deployment mental health problems.

If left untreated, these conditions can destroy marriages and ultimately separate families and even result in homelessness. The absence of a personal caregiver or attendant for seriously disabled veterans would mean even higher costs to the government to assume total responsibility for their care. And more importantly, would lower the quality of life for the very veterans for whom VA was established.

Likewise during this transitional period, caregivers themselves are at risk for stress-related mental health disorders and adverse physical effects. For this reason, we support and recommend that Congress authorize a full range of psychological and social support services as an earned benefit to family caregivers of severely injured and ill veterans.

At a minimum, this benefit should include relationship and marriage counseling, family counseling, technical training, and related assistance for the families coping with post-deployment mental health issues or with the stress and emotional consequences of caring for a severely injured or permanently disabled veteran.

For many younger, unmarried disabled veterans, their parents must once again assume the role of caregiver. They too face the same dilemmas of spouses of severely injured veterans. And we believe Congress should also address the needs of these parents who are now primary caregivers for their severely ill or injured chil-

dren, as well as other designated family members who assume this full-time role.

We also believe VA should establish a national program to make a variety of respite services available to all severely injured veterans who need it. Alternative VA respite care programs should be established with age appropriate settings and strong rehabilitation goals suited to the needs of a younger veteran population.

We note that one of the new caregiver pilot programs offers 24 hour in-home respite care to temporarily relieve caregivers for up to 14 days a year. This kind of in-home service may be an optimal setting for many severely disabled veterans and their families.

Mr. Chairman, we believe that VA must continue to adapt its services to the particular needs of this new generation of disabled veterans. Likewise, these programs should be improved and available for the previous generations of veterans with similar disabilities.

Finally, we are hopeful with Congress' support that VA will make a change from a system that focuses primarily on the needs of a veteran patient to one that also fully embraces the challenges of family caregiving.

That concludes my statement. Thank you.

[The prepared statement of Ms. Ilem appears on p. 78.]

Mr. MICHAUD. Thank you, Ms. Ilem. Mr. Sundsvold.

STATEMENT OF SCOTT N. SUNDSVOLD

Mr. SUNDSVOLD. Mr. Chairman, the American Legion appreciates this opportunity to share its views on mental health treatment for families of veterans.

Mr. Chairman, in order to ensure this Nation's veterans receive a complete continuum of care, families of those injured must receive the most appropriate treatment to understand, accommodate, and transition with the veteran.

When military personnel are deployed, the families are the most tangible source of trust and disclosure. They are affected by the letters, emails, and phone calls from those deployed. Although they are not the actual personnel deployed, their love and care for those who are in the way of danger may indeed cause permanent stress related issues. When their loved one returns from deployment, there is yet another possible stressor, the transition from military duty to civilian life.

The National Defense Authorization Act of Fiscal Year 2006, directed the Secretary of Defense to establish a task force to examine issues related to mental health and the Armed Forces and create a report containing an assessment of and recommendations for improving the effectiveness of mental health services provided to members of the Armed Forces.

The report introductions spoke on this Nation's involvement in the Global War on Terrorism and the unforeseen demand on military members and their families. It was also stressed that DoD must expand its capabilities to support the psychological health of its servicemembers and their families.

In June 2007, the Defense Health Board Task Force on Mental Health released the report titled "An Attainable Vision." This report derived from the Task Force's visits throughout military com-

munity at 38 installations worldwide. According to the Task Force, the military health system lacked the fiscal resources and personnel to fulfill its mission to support psychological health.

Mr. Chairman, these findings also imply that if the treatment was insufficient during the military member's term of service, the veteran's issues do not vanish upon entry into the civilian community. And they often affect the family as well.

The findings and recommendations reported by the Task Force suggest an elevation of family involvement in mental health treatment. When transitioning from military to civilian life, veterans and their families full continuum of care should not be stifled.

Currently, the VA does not have the authority to include veterans' family members in treatment for mental health concerns. The American Legion is in agreement with the statement of the Secretary of Defense, Robert M. Gates, who stated, "Care for our wounded must be our highest priority." This statement includes those affected both mentally and physically.

According to the Task Force report, the cost of mental illness extends beyond discharge from military service. There was also a recognized need for extensive family involvement in the long-term process of rehabilitation and community integration, which include close involvement of families in the recovery process, as well as a greater responsiveness in the treatment of family members' needs.

In 2007, the American Legion conducted site visits of various Vet Centers throughout this Nation to include Puerto Rico. During these visits, it was reported that successful services provided ranged from marriage counseling to reunion debriefings.

However, no mental health services for family members were provided. Also offered were family therapists for veterans suffering from mental illnesses, ensuring that the veteran's immediate support network is prepared to care for and cope with the veteran's mental health issues, but no mental health support for the veteran's immediate family members.

The success of services provided within VA and their satellite facilities as they relate to veterans and their families should be extended to include mental health treatment for family members to fully ensure a complete and successful transition into the community.

Mr. Chairman, to ignore the need for mental health support of family members invalidates the meaning of full continuum of care. The American Legion urges Congress to appropriate sufficient funds for the VA to ensure comprehensive mental health services are available to the veteran and their family members.

Mr. Chairman, the American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you to improve the lives of America's veterans and their families. Thank you.

[The prepared statement of Mr. Sundsvold appears on p. 76.]

Mr. HARE. Thank you. Thank you all very much for coming by this afternoon. Obviously, the first priority is care for veterans. But it is clearly evident that the care for veterans also means ensuring that the veteran's support system, their family, is prepared to take care of them. And particularly given the prevalence of mental health issues, post traumatic stress dirorder, and TBI coming out

of OEF and OIF, the need for providing counseling treatment and education for families and caregivers is clear.

I would like to know, from all of you, if you wouldn't mind, in your opinion, what is the best way that this Committee can adequately address meeting the needs of veterans but also integrating mental health services for their families? Is it, you know, clarifying existing language that we have or don't have? Is it creating programs? If so, how far should these programs go?

In essence, what I would like to know from all of you is what do we need to do here to better address this problem so we can move toward helping veterans and their families?

Mr. BERGER. Mr. Hare, I will jump right in. It may be time to do a joint hearing with the authorizing and/or Appropriations Committees that oversee the funding for all these different kinds of things, because as you have heard, sir, when we speak about the issues involving the veteran and his or her family, they are very complex. There are many of them.

Funding for these kinds of things is handled under a variety of Committees. And that I would suggest that this Committee could initiate some joint hearings with the Appropriations Committees that oversee the Federal dollars that go to these community mental health programs for example and that sort of thing. To see if there can be incentive funds made available to better serve the families of the returnees, as well as the families of those families while the servicemember is deployed.

Mr. HARE. Ms. Ilem.

Ms. ILEM. I would think that there is a couple of things that the Committee could do. I mean, first VA has indicated they recently established eight caregiver pilot programs throughout the country that had some very interesting, very, you know, alternative ideas and options for—especially for caregiver support.

I would ask VA, you know, how are those programs going. I would think they just got—you know, they are probably just getting stood up and getting hired in terms of, you know, that the staffs for those programs.

But definitely there would have—you know, there would be a lot to be gained to see the oversight of those programs and what comes out of them, how successful they are, what is the patient satisfaction, what is, you know, the success of those programs? So that they could develop something that is consistent throughout the system and available to all veterans who need it.

On the mental health, for post-deployment issues, I see that on there—on the panel would be Dr. Batresand obviously the Vet Centers have been very critical in terms of family involvement.

But I would also ask that you ask VA what are really the numbers and the data in terms of the mental health that is provided in connection with services for our veterans rehabilitation for post-deployment issues in the medical centers and within their more traditional mental health programs as well to get an idea where the real gap in services are.

Mr. HARE. Mr. Sundsvold.

Mr. SUNDSVOLD. Mr. Chairman, in 2006, the American Legion passed a resolution asking that the VA provide more oversight on

the strategic spending of the mental healthcare money that is given. And we can provide a copy of that resolution to that effect.

Mr. HARE. Mr. Bowers, did you have something?

Mr. BERGER. Yes. Mr. Chairman, I think a number of things that the Committee could do. I think we need to review the extension of authority that is available for families of veterans. Obviously, we believe that the treatment and care of the veteran must come first as you pointed out. But, obviously, we live in unique times. And the consequences of what is happening to veterans of OIF/OEF are devastating for families.

The Vet Centers are certainly the frontline of treatment for our veterans and what limited services are available to families. We think, you know, a uniform, systemwide criteria or curriculum should be developed that provides a comprehensive set of services to families.

The VA needs to be clear about what they can provide. And, obviously, an expansion of counselors, and psychologists, and social workers need to be developed and expanded to serve the Vet Centers.

We also think that VA should look into developing mobile support clinics that can reach out into rural areas and bring mental health services to veterans in those areas and their families.

Mr. HARE. Thank you. Mr. Bowers.

Mr. BOWERS. I would just agree with the rest of my panelists that the Vet Centers have been incredible for OIF and OEF veterans. The only fault being that they are relatively short staffed right now and having a hard time keeping up with the demand.

Over the past few weeks, we have been doing focus groups around the country to meet with veterans and most importantly veterans' families. These have been interesting, 2-hour sessions that we spend with them to find out what difficulties they faced when they came home. The one thing that is apparent from all the families is that lack of communication of what resources were available was the number one issue.

They found out way too late about services and programs that were available at the VA after the fun was smoking. So it made things very difficult for these families. So that is a line of communication of what is out there is going to be extremely helpful in the future.

Mr. HARE. Thank you, Mr. Bowers. I couldn't agree with you more. As I said earlier, I met with the parents of a young man who committed suicide. And they had no idea what to look out for. I think they said they had maybe 5 minutes—a 5-minute briefing—your son is coming back.

They feel that somehow they failed their son, except they didn't know what they were looking for. So I couldn't agree with you more on the need to give the families the opportunity to know so they can help that person when they do get home.

Let me thank you all. At this time I would like to recognize my colleague, Congressman Kennedy, who has taken time out to come and be with us this afternoon. I would be happy to yield to the gentleman.

Mr. KENNEDY. Thank you very much. I appreciate it very much. And I thank all the witnesses for coming and testifying on this crit-

ical issue. There is nothing more important than making sure we don't turn our backs on those that were there for us and the families that were there for them.

And they are secondarily there just as much as the veteran themselves, because they are making the same sacrifices as our veteran. And I fail to see the difference in the sacrifice our families are making. I think we should be looking at the veteran and their family as a whole unit. So far as the services we should provide, we should be providing them to the whole family. I am glad to see this hearing focusing just that.

I would like to see us make sure we track the impact on the secondary effect of post traumatic illness on the children, because I am really concerned in the years ahead, especially for the Guard and Reservists, what impact these second, third, fourth deployments are going to have on these children.

And, you know, we have anecdotal evidence from Vietnam and so forth the effects on these children. We know from other studies and child studies that children who grew up in households where there is detachment, disturbances, emotional problems and the like, that they are at much higher risk for various other problems. And clearly, you would imagine any child is growing up under the stresses and strains that these children are forced to grow up in are going to be faced with enormous challenges.

And we, as a country, ought to be preparing ourselves to make sure that they don't face those challenges. And the best way to do it is to head them off rather than wait for them to arrive.

Just to talk about making people more aware of everything, I got a great briefing the other day from a group that made a film. They did some documentaries about suicide and prison. But they have made documentaries now on—docudramas I should say, on returning veterans. And what it does is to highlight the process that veterans have gone through in a very powerful way. So as to bring more understanding on the part of people who aren't cognizant of the challenges they are facing.

And what these videos are meant to do are to educate judges, because a lot of these judges don't have any idea. Healthcare workers, educators, teachers, for example, in my State. You know, teachers and kids who come from the base, they don't have to worry, because the teachers know what is going on. But kids who come from schools outside the base, they don't know the Guard kids from regular kids. And they need to know what is going on with these kids.

And so having some understanding of what is going on, and having these scenarios of what it is like, having these scenarios painted out in these docudramas, is probably very helpful. And having these stories told, I think, are really important for the understanding and appreciation of all those.

In addition to, as was just pointed out by Chairman Hare, the parents of these families need materials on PTSD outlining the symptoms and the signs. So we need to do a much better job at getting these materials out to the families, getting them out to the providers, getting them out to anyone who is going to be touching these veterans.

I would like to ask all of you to comment, because one of the things that in many of my tours around the VA hospitals and Vet

Centers I have been constantly impressed with is that veterans want to get their care with other veterans principally. And the Vet-to-Vet Program has been the most welcoming to most vets that I have found, because they like nothing better than a peer to talk to.

But it has been—we haven't brought it to scale. In other words, we have seen it effective in one place in the country and another place in the country. But we haven't really brought it to scale, because we have such a huge problem out there in terms of the demand for services for mental health. But we haven't had the capacity to meet that demand within the VA.

And what I am thinking is why not take all those vets that are out there homeless and jobless, get them in there doing some work counseling other vets by training them up, giving them some skills, and getting them to help their fellow vets, because there is nothing more empowering than one veteran sharing and supporting and helping another vet. It is mutually beneficial. It is beneficial to the vet who is helping. And it is beneficial to the vet that is being helped. It is that miraculous miracle that comes from peer support.

I wonder if you could think of whether we should put together some curricula in our community colleges or what kind of professional development you think we should be doing to train up and give our vets some kind of certificate to get them into this kind of quasi-consulting role for their fellow vets?

Mr. BERGER. Certainly, sir, peer counseling, peer support programs are very important. They serve a very important social function as well as the trust issues involved with that sort of thing.

But at the same time, on the clinical side of things, as a mental health professional, they cannot be used to substitute for evidence-based clinical programs. And so I would be careful. Okay.

Mr. KENNEDY. Well, there is no question about that. What I am just—there is nothing out there now. I have been absolutely—I am absolutely disheartened by the lack of outreach by the VA. I know they are doing everything that they think that they are doing. But the statistics speak for themselves. The facts speak for themselves.

The sheer numbers of vets returning, and you take a fifth—whatever number you want, a third, however many. Forty percent of those who are Guard and Reservists who say they are going to—have some kind of flash back or some kind of problem.

The fact is, we ought to be reaching out to every single vet who is returning. It ought to be mandatory for every single one returning, so that we don't stigmatize a single vet returning to say, oh, well you are the one who has the mental health problem. You mean, you have a problem? That is how we stigmatize them. We ought to have a total 100-percent mandatory screening for all vets. And if the VA ain't doing it, there is something wrong with them. Okay?

So we don't have crap going on right now as far as I am concerned. They aren't doing their job. And I am absolutely outraged and frustrated by the absolute lack of attention toward our veterans right now.

So I don't want to hear about how we don't have enough professional development. We have to get them all professional—sure, as hell we do. But if we don't have that, we better get them some-

thing. And the best thing I can think is we better get them something we can get done quickly.

And as far as I can see, we can do this quickly. And that is get the vets that we got already out there. And get them trained up quickly. And get them out there talking to one another, because there is nothing—a miracle about self help groups. They are pretty effective. And they can be started up pretty quickly. And until we get that going and get some outreach going where vets can go and talk to one another, and then we can start supplementing it with professional development.

And while the VA is dragging their heals coming up with the approval process for who can provide clinical support, because they want to do everything in-house. Oh, sure, they have a vision here or there. But they are not prepared to take a national policy saying, okay, here are the criteria. Go at a community mental health center. Any community mental health center, any substance abuse center, private, non-profit, hospital, anywhere in this country. You can provide these services. At this pay scale, you are hired by the VA. Go out there. Take care of our veterans. And you find them. And sign them up. We are going to get paid.

Mr. HARE. Congressman——

Mr. KENNEDY. That is the way we ought to have it. And anything short of that, I think, is them not doing their job. And right now they are waiting for—they are waiting for our veterans to come in and sign up. That ain't the way for us to be waiting for them—for us to be dealing with our vets. I am sorry.

Mr. HARE. No, no.

Mr. KENNEDY. I am just outraged.

Mr. HARE. Listen, let me say, Congressman, I couldn't agree with you more. And, you know, we will get there. It is going to—you know, but we need to get there sooner rather than later.

I want to thank you for coming today, and for expressing your opinions on this. You are a leader on this in the House, and I appreciate your being here. We are all better because of people like you serving in this House. I appreciate your passion for this.

Let me thank the panel so much for taking time out to come this morning. I am sorry we were delayed with the votes coming back, but I appreciate you taking the time to come. So, thank you all very much.

Our last panel is composed of Kristin Day, who is the Chief Consultant in Management and Social Work Services, Office of Patient Care Services for the Veterans Health Administration, U.S. Department of Veterans Affairs.

Ms. Day, thank you so much for being with us this afternoon. If you would care to introduce the people you brought with you. And welcome to the Subcommittee.

STATEMENT OF KRISTIN DAY, LCSW, CHIEF CONSULTANT, CARE MANAGEMENT AND SOCIAL WORK SERVICE, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY IRA KATZ, M.D., DEPUTY CHIEF, PATIENT CARE SERVICES OFFICER FOR MENTAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND CHARLES FLORA, EXECUTIVE ASSISTANT TO THE CHIEF READJUSTMENT COUNSELING OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. DAY. Thank you so——

Mr. HARE. Could you turn your microphone on please. I am sorry.

Ms. DAY. To my right is Dr. Ira Katz, Mental Health Service. And to my left is Charlie Flora from the Vet Center Program.

Mr. HARE. Welcome.

Ms. DAY. Sir, before I read my testimony, I would like to say that on behalf of myself and my colleagues, we have heard many compelling stories and issues this morning. And we stand ready to serve any and all who we might be able to help to resolve some of the immediate problems that they are having.

VA supports caregivers of the wounded, ill, and injured veterans by providing assessment, counseling, training related to the caregiver's ability to provide adequate care. Specifically, this includes education about the veteran's illness and disability, be it mental or physical, and referral to community agencies for services that VA is unable to offer.

We conduct visits to assess the adequacy of the home environment and the need for home equipment or home modification.

VA provides limited services to family members, which include members of the immediate family, the legal guardian of the veteran, or the individual in whose household the veteran certifies an intent 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 that veteran's treatment. We diligently extend these services under those circumstances. Likewise, if a veteran is receiving hospital care for a non-service connected disability, VA is authorized to provide these services, as are necessary in connection with that treatment, if the services are 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 our hospital system, VA's Vet Centers also provide family counseling to family members to promote post-combat veteran's successful readjustment to civilian life.

The Civilian Health and Medical Program of the Department of Veterans Affairs is a comprehensive healthcare program in which VA shares the cost of covered healthcare services and supplies with eligible beneficiaries. CHAMPVA provides coverage, provided the dependents are not otherwise eligible for DoD TRICARE benefits to the spouse or widow or to the children of a veteran who is rated permanently and totally disabled due to a service-connected dis-

ability, or was rated permanently—excuse me. Was rated permanently and totally disabled due to a service-connected disability at the time of death, or died of a service-connected disability on active—or on active duty. CHAMPVA provides broad health coverage and includes a $50 annual deductible and 25 percent co-pay for services.

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 TBI and polytrauma case manager assigned to each veteran and active-duty servicemember receives care in VA's Polytrauma System of Care, coordinates support-efforts to match the needs of each family.

In October of 2007, VA partnered with the Department of Defense to establish the Joint VA/DoD Federal Recovery Coordinator (FRC) Program. VA has hired a Federal Recovery Coordinator Director, a Federal Recovery Coordinator Supervisor, and eight Federal Recovery Coordinators as of December of 2007.

The FRCs are currently located at Water Reed and Brooke 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 in San Antonio and Balboa Naval Medical Center in San Diego. Vet Centers provide family counseling for military-related problems that negatively affect the veteran's readjustment to civilian life. Family members are usually the first to realize the effects of possible war-related problems, especially among National Guard and Reserve members. 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 healthcare benefits. Vet Centers have full latitude to include family members in the treatment process, as long as this is aimed at post-war adjustment 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.

VHA works diligently to support veterans, their families, and their caregivers. Often without the support of these dedicated family and friends, many veterans would not be able to maintain their independence or their preferred community-based lifestyle.

Thank you again for the opportunity to appear here today. My colleagues and I would be happy to answer any questions you may have.

[The prepared statement of Ms. Day appears on p. 88.]

Mr. HARE. Thank you, Ms. Day. From my perspective there is a severe shortage of mental health professionals within the VA system, and no cohesiveness in providing mental health services for veterans and their families. So States like North Carolina and my home State of Illinois are left to fill those gaps that we have by establishing their own programs.

What are the VA's plans to increase the number of mental health professionals in the system? That is one question. You mentioned

the Vet Centers, three of which are in my district. What does the VA have specifically planned to be able to help those rural people in rural communities who have just as much need for mental health and their families but don't have access to those facilities?

Ms. DAY. Dr. Katz, would you like to answer the first question?

Dr. KATZ. Sure. VA currently has approximately 17,000 mental staff members in our system. A number that has been increased by over 3,800 over the last 2½ years. It is really a substantial number and a very substantial enhancement in mental health services. The budget sent to the Hill from VA estimated approximately a $320 million increase in mental health funding between this year and next. That would be both for staff and for contracting or fee basing of services. All are related. And all are designed to help us both meet the need of returning veterans and to enhance care for all veterans. The funding increase, if it is totally devoted to increasing staff at approximately 100,000 per staff member, would be a projection of 3,200 new staff members. Really a substantial further increase.

Ms. DAY. Mr. Flora.

Mr. FLORA. With reference to rural veterans, the Vet Center Program also has a contract for fee program where they—private-sector providers under contract with VA are reimbursed for providing readjustment counseling service. And most of these are located in areas distant from other VA facilities to serve rural veterans.

Also, outreaching to veterans is a mandated part of the Vet Center mission. We do travel to veterans that are not able to come into our facilities and see them in their homes or in their workplaces.

Additionally, the Vet Centers—all Vet Centers, upon request from a veteran, will have after hours appointments or weekend appointments to facilitate veterans that may need—that are working or that may need to drive in a considerable distance from their hometowns. Thank you.

Ms. DAY. Sir, if I may, I would like to tell you about three programs.

Mr. HARE. Could you turn your microphone on. I am sorry. Thank you.

Ms. DAY. Is it on?

Mr. HARE. Yes.

Ms. DAY. Is that better?

Mr. HARE. Thank you.

Ms. DAY. I would like to tell you about three programs. I have the honor of being the Chief Consultant in a new office called Care Management and Social Work Service in Patient Care Services.

And in June of this year, of 2007, we stood up the OEF/OIF case management team at every VA. And they—we now have 7,000 OEF/OIF servicemembers enrolled in that program. There are clinicians, Veterans Benefits Administration representatives, and transition patient advocates. They are on that team. The transition patient advocates have been tasked with going out into the community, doing home visits, making remote visit sites, particularly to the severely injured, so that they will lessen that sense of isolation.

The social workers on the team, we have almost 6,000 social workers across VHA now. They are—one of their missions is to en-

gage the community services at the local level to provide people who are isolated in rural areas support.

In addition, the new joint program between the Department of Defense and VA, the Federal Recovery Coordinator Program, is also in the new office. And the FRCs are VA employees. But they will be working and providing oversight on care to all severely injured, regardless of where they get their care.

So if a veteran lives in a rural area and doesn't have access to VA care, maybe using their TRICARE benefits or some other benefit, VA will still provide a Federal Recovery Coordinator for them to help the oversight of their care.

Mr. HARE. Thank you. I would like to ask unanimous consent that Mr. Kennedy be invited to sit at the dais. You can tell I am new at this. I failed to do that previously. And I want to welcome, again, my friend Congressman Kennedy, and recognize him for any statement or questions that he might have.

Mr. KENNEDY. Thank you very much. If you kind of respond earlier to some of the concerns I had about, you know, 500,000 vets that have come back that haven't touched the VA. Forty percent of whom, you know, will roughly need mental health services. And how we are reaching out to them. I mean, frankly you can't just hire all these people inside the VA and think we are going to solve the problem. We got to do a better job of doing the kind of partnering within the existing—you know, we have to leverage other mental health infrastructure. VA can't just think that we are going to deal with this.

Most of the mental health—a lot of mental health is going to be delivered through the workplace and peoples' employer health plans. A lot of it is going to be dealt with in community health centers. A lot of it is going to be dealt with in other venues.

I mean, so I want to know what you are doing to make sure those connections are going to be made? They are going to be made properly. Those providers are going to be trained up in PTSD, so that they are going to be properly equipped to have some of that. Because a lot of these veterans aren't going to want to have their records "found out" by some government entity, because they are terrified—they are all terrified about the stigma of having mental health issues. And they are not going to go near a government agency to get mental health treatment.

So, you know, what are we doing to get dollars out where they are not going to be traced to you, the VA? I mean, the Vet Centers is one of the places where I want to see a lot of dollars—more dollars go.

But, you know, I heard about the contracting, Mr. Flora. But that is not happening frankly. That is not happening. From my look around the Veteran Integrated Services Networks (VISNs) in this country, the VA is tightfisted. They don't like to contract out. Why should they? Every VISN Director is in charge of their own pot of money. They don't want to contract out. And furthermore, everyone says, oh, that is a slippery slope to privatization.

You know, so I want to know what you all are doing to use existing resources? Why are you waiting so long? You have turned back money in the past to hire people. Get the workers that you already have out there. And get them to help support these veterans. There

are veterans suffering today, because there is not enough—the capacity is out there. But you are waiting to hire your own people instead of using existing people that are already out there.

What is the wait? What are you waiting for? Why aren't you contracting out with people right now to provide these services? What is the hold up? Why are you waiting to hire people? Why not hire existing people that are in the community health centers right now? Why not?

Dr. Katz, why aren't you hiring people in the community health centers right now across America to provide these services?

Dr. KATZ. I will first respond to what you said about the——

Mr. KENNEDY. Well answer that for me first.

Dr. KATZ. What we are planning to do beginning at the end of this fiscal year is to define what services should be available for every veteran. And then to——

Mr. KENNEDY. What are you talking about? What are you talking about what services? You are trying to figure it out now? Every service should be available to every veteran. Okay? If someone needs help, get them the help. You know, what is the—we are at a point of urgency, urgency, urgency. People are dying. People are falling apart. Families are falling apart. You have to get the contracts out there. Got to get the help out there.

We have NASBHC in town, the National Association of Behavioral Health Clinics. They are dying to reach out. They have vets coming in every day. They are coming up to me all the time. I know all this stuff, because I am ushering the whole charge on mental health parity. I am all over the country on mental health. I know all this stuff.

All mental health providers around the country are screaming and yelling at me that they have veterans pouring in. And you guys are sitting there trying to figure out what plan you are going to have.

What are you going to do for veterans? Why not start hooking up with these people and helping pay them so they can help provide—help you provide the job that you are supposed to do and help take care of our veterans? Why haven't you done that?

Dr. KATZ. Sir——

Mr. KENNEDY. You think it is all up to you to do it? Do you think it is just—VA is supposed to do it all. Is that what it is?

Dr. KATZ. Sir, what I was going to say was that our goal is to define specifically what services must be available to all veterans.

Also to define what services must be provided at medical centers, large mid-sized and small Community Based Outpatient Clinics (CBOCs). We recognize that there may be gaps between the services that must be available to the veteran and the services that must be provided especially at the smaller CBOCs.

And we will require that where we are not providing the services near to the veteran, we provide them in some other way, either by travel to residential care facilities for severe conditions or by partnerships with community-based providers.

This is where we are moving with mental health enhancements. We will be focusing on patient-centered care that must be available to all veterans. We recognize that there are going to be gaps be-

tween what we can provide and what must be available and we will fill them.

Mr. KENNEDY. But I will just stop you for a second. There are two issues here. You have mental health that needs to come through the VA. And that is where people will go to the VA for severe mental health issues that they are going to need real clinical support with.

And then you have mental health. I have post traumatic illness——

Dr. KATZ. Yes.

Mr. KENNEDY [continuing]. From the war. And you have every vet coming back is going to face some of that. All right, as a matter of course. And they don't want this—you know, for their part necessarily to have to go through the cumbersome process of going through the whole VA, because of the stigma. Frankly speaking because of the stigma.

And the less cumbersome you make the dollars and bureaucratic, you make the whole mental health part of your task. So it is not all about this has got to be a serious mental illness type thing, PTSD clinic. Okay?

But you make it more, this is hey folks, here are—there is healthcare out there for you to take care of your post traumatic illness. And it is available here. And it is available here in the Vet Centers. And complement services here and here through here. And your Guard is going to have these available services.

And you are going to have a plethora of areas, so that you are not feeling as if you have to come down that narrow hall and go up to floor seven and knock on that door, 7B, in order to get your PTSD treatment. That is what I am talking about. There are two kinds of levels.

Now if you need that seventh floor, you are going to have that seventh floor. But I am talking about the 500,000 that are going to need counseling and support out there but a far spectrum. There is going to be a big spectrum. And we need to push the dollars out there for 85–90 percent who are going to need some mental health. But that doesn't mean they are all going to need to come to the VA for your 3,000 new psychiatrists.

Mr. HARE. I am sorry to interrupt. Let me just——

Dr. KATZ. We fervently believe that what you are describing, a universally available education and counseling, is public health and prevention. And if that were available, fewer people would need the seventh floor, get a diagnosis and need my services.

It could be a good investment.

Mr. KENNEDY. So what are you doing to provide it? Where is that? What are those programs?

Dr. KATZ. We will have to take that and get back to you.

Mr. HARE. Let me just say this. I want to thank you Congressman for spending some time with us and for your questions. I share your concern about this too. I want to thank this panel.

I'll close by saying this I think all of us on this Subcommittee and all of us across this Nation want to do the best we can for the men and women who have served this Nation when they come back, as well as their families.

Ms. Day, you talked about it in your opening statement when you said you heard some stories today. At the end of the day, for Tim's family when they were in my office feeling that somehow what had happened to him was their fault. They didn't know what to look out for. They didn't know the warning signs.

As Congressman Kennedy said, so many veterans come back not wanting to say I think I have a problem. We need to screen everybody, and families need to know what this is. We need to look at them longer. We need to go down the road farther than we are doing this, because this isn't something that necessarily manifests itself immediately, as you all well know.

At the end of the day it seems to me that our mission is to do everything we can, because not all wounds are physical. And I see them at the Vet Centers. I have a Vet Center two blocks from my district office in Moline, Illinois. I see the vets that come in.

And, you know, for their families and for all of us, this is a moral obligation that we have as a Nation. And I would really hope that the VA will do everything that they can if it is—as I said, if it is money, if it is changing whatever the programs are, adding new programs, we stand ready to do that, because it is our obligation.

If we don't do this, it is really shame on us, not just as the Congress, but as a nation.

Thank you very much for coming today and spending time.

Mr. KENNEDY. Mr. Chairman, if I could just, there is a—these videos, there is a set of a whole documentary of docudramas called "Together with Valor." And they are an educational series of videos for families, professionals, and judges that are going to be coming out within the next 2 weeks. And it is called "Together with Valor." And it also has a complimentary DVD set. And it is going to be going online.

I just want to make people aware of it. That it will have resourced all of these things, "Together with Valor." My office will have more on it. Dan Murphy from my office, and he will give you the contact person if you are interested.

Mr. HARE. Thank you, Congressman. Thank you all very much. We will have additional questions submitted for you. With that, this hearing is adjourned. Thank you all very much.

[No questions were submitted.]

[Whereupon, the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

I would like to thank everyone for coming today. We are here today to talk about mental health treatment for families of veterans. This is a very important issue and one that this Committee is looking to address.

Mental health issues are at the forefront of our agenda, and for good reason.

Of the approximately 300,000 veterans from Operations Enduring and Iraqi Freedom who have accessed VA healthcare, over 40% have presented with mental health concerns, including PTSD, substance abuse and mood disorders. Veterans' mental health conditions not only affect the returning veterans, but also have a significant impact on their families. Living with and caring for veterans with mental health concerns is stressful and can change the way that families relate to one another.

While the VA is working hard to care for veterans with mental health needs, too often families of these veterans are neglected. Spouses, children and parents of veterans have been affected by this conflict, yet oftentimes they do not have access to treatment which may help them. In turn, veterans may have a more difficult time recovering from their mental health concerns because of family problems.

As we will hear, the VA is currently limited in the authority Congress has given them to provide treatment to families. I know that the VA does everything they can to care for the whole veteran, including the family unit, when possible. But the question is, how can we do more?

The purpose of this hearing is to hear a variety of perspectives about how Congress might expand VA's current authority to provide mental health treatment to families of veterans. We will hear from leaders of regional and state programs who are currently providing services to families of veterans. We will also hear about the importance of the family's mental health to the mental health and well-being of the veteran. Finally we will hear from the VA about what services they are currently authorized to provide to families.

The Committee realizes that this is a complex issue. But we also recognize that it is an important one that deserves serious thought and consideration.

Prepared Statement of Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman.

Good morning and welcome to our witnesses and other interested audience members.

I am pleased that we are having this hearing today on what I consider to be one of the most significant and timely subjects this Subcommittee has to explore—mental health services for our Nation's wounded warriors and their families.

A report released in November 2007 by the Institute of Medicine found that there is a correlation between deployment to a war zone and several mental health conditions including PTSD, depression, and marriage and family conflict. Unfortunately, this is not news to those of us familiar with the myriad of issues facing veterans.

Although valuable mental health services are provided by VA and DoD, family members still are the first and most important network of support for veterans and their role in the mental healthcare process should not be underestimated. Family presence and participation is essential as veterans readjust to civilian life following a deployment.

Families of soldiers make tremendous sacrifices so that the men and women they love can defend the country we all love and I want to take this moment to thank them for their role in supporting America.

Currently VA does provide certain mental health services open to assist family members. This includes Readjustment and Bereavement Counseling Services at VA Vet Centers, the VA's Family Mental Health Learning Program and care for Civilian Health and Medical Program of Department of Veterans Affairs (CHAMPVA) beneficiaries.

I look forward to hearing from our witnesses and their views on what else could be done to support the mental health needs of family members. Meeting the healthcare needs of veterans in the best way possible will always be our first and greatest priority.

In closing, I would also like to commend the VA on their recent efforts to improve access to mental healthcare for veterans and to ensure that such care is safe, timely, and effective.

I look forward to working in a bipartisan manner with Chairman Michaud and the other members of this Committee to ensure that our veterans and their families are given the best possible care.

Again, I thank you all for being here and I yield back the balance of my time.

Prepared Statement of Hon. Shelley Berkeley, a Representative in Congress from the State of Nevada

Mr. Chairman, Thank you for holding this hearing today on such a pressing issue. As servicemembers return from combat, it becomes increasingly important to provide them with the mental health services they need to readjust to society. While we take care of our veterans, we must not forget about their families. Along with our servicemen and women, families are the backbone of the U.S. military. They sacrifice for this country when a loved one is called to active duty. Too often marriages and families are under great strain when a servicemember is on deployment. That risk continues even when he or she returns from active duty. It is important that spouses and families are educated on how to help their veteran cope with a mental illness such as PTSD. We must not overlook the needs and concerns families are facing.

I look forward to working with the Committee and VSOs, the VA, and others to determine how to best meet the needs of veterans and family members.

Prepared Statement of Linda Spoonster Schwartz, RN, Dr.P.H., FAAN, Commissioner of Veterans Affairs, State of Connecticut

Good morning Mr. Chairman and Members of the Committee, my name is Linda Schwartz and I have the honor to be Commissioner of Veterans Affairs for the State of Connecticut. I am medically retired from the United States Air Force Nurse Corps and hold a Doctorate in Public Health from the Yale School of Medicine. I also serve as North East Vice-President and Chairman of Healthcare for the National Association of State Directors of Veteran Affairs. I want to thank you for holding this hearing and for your concern about the mental health needs of families and those supporting our deployed troops and returned veterans.

I served 16 years in the United States Air Force both on Active Duty and as a Reservist during the Vietnam War, since that time, a great deal has changed in the composition and needs of America's military and the Nation's expectations for the quality of life and support for the men and women of our Armed Forces. For example, now women comprise approximately 15% of the military force, a stark contrast to the fact that before the advent of the all volunteer force, women were limited by law to only 2% of the Active Duty force. Another striking feature of our military force today is the heavily reliance on the "citizen soldiers" of our Reserve and National Guard and the increasing number of military men and women on Active Duty who are married with children. The Department of Defense reports that 93% of career military are married and the number of married military personnel not considered career is 58%. As a recent report by the Rand Corporation observed, "Today's military is a military of families". I would add that the families of many Active Duty, Guard and Reserve units are no longer housed on military installations and are lacking the support systems enjoyed by previous generations of military members.

As America has continued to task Reserve and National Guard units with greater responsibilities in combat areas the realities of multiple deployments, loosely configured support systems and traditional military chain of command mentalities are not solving problems, they are creating them. Transitioning in and out of family life is

not only difficult for the military member, the family, spouse, children, mother, father, sister, brothers and/or significant other are also traumatized as well. This is not happening on a remote site or military base, this time we read about our neighbor next door, the young woman who teaches kindergarten, our friend from school or church. In essence the war has come to every town and city in America only it is invisible until a crisis or tragedy surfaces to remind us that the cost of war is also borne by those who wait and watch for the return of our troops.

As Connecticut's Commissioner of Veteran Affairs, I have a unique position and responsibility to be sure that we do not repeat the mistakes of the past. As a veteran of the Vietnam War and a nurse who has dedicated over 20 years to advocacy for veterans, I am acutely aware of the fact that the veterans returning home now are very different than the veterans of my generation or my fathers World War II generation. While they are not encumbered with validating the legitimacy of post traumatic stress dirorder, they have brought the issue of Traumatic Brain injury to the forefront. Perhaps it is because they may have trained with a unit for years and experienced the intensity of living in the danger of a war zone with their unit, that they feel isolated in their own homes. During deployments, they longed for family and friends with visions of a celebrated homecoming only to find upon their return home that crowds and daily responsibilities are both overwhelming and frightening. After living on the edge of danger for the prolonged deployment periods, life in America seem boring and mundane. Although they care deeply about their families, they are "different" and ill at ease in their everyday existence and can't seem to find their way "HOME".

Along with the "Send Off" ceremonies and the "Welcome Homes", observers began to realize that families left behind experienced difficulties and stress every day of the deployment. Due to modern technology, Internet and cell phones these frustrations and difficulties at home could instantaneously be shared with the deployed military member in combat areas which placed an additional burden on their "mission readiness". Along with readjusting to the absence of the military member and the great unknown of what they would be encountering during their tour of duty, those of us tasked with working with these families came to the realization that there were serious gaps in the system. In addition to the day to day concerns of home repairs, young spouses managing additional duties in the home, environment and financial constraints, families were having difficulties that indicated a need for professional counseling and treatment to cope with the demands and strains they encountered.

In 2003 when I became Commissioner, there were already Iraq veterans living at the State Veterans Home at Rocky Hill because living at home with Mom and Dad was not tolerable after being in combat, families of deployed Active Duty and Reserve were encountering problems with no place to turn for help and severely disabled veterans were coming home to families that had no idea how to care for them. These realizations prompted our Governor, M. Jodi Rell, to charge me to do "what ever it takes" to assure Connecticut was taking care if our veterans and their families.

The 2005–2006 deployment of over 1000 Connecticut National Guard with members from each of our 169 towns in the State underscored the need to decisively address these issues and plan for the future. Connecticut embarked on three major efforts: a) Survey of Recently Returned Veterans conducted in conjunction with the Center for Policy Research at Central Connecticut University; b) Summit for Recently Returned Veterans; c) Military Support Program spearheaded by the Department of Mental Health and Addiction Services. All of these efforts were implemented in 2007. Additionally, Governor Rell has tasked me with convening and Advisory Group of Recently Returned Veterans to identify needs, monitor services and programs provided by the State of Connecticut and recommend changes which will assist and benefit deployed and returning military and their families.

2006 VA Guide "Returning from the War Zone, A Guide for Families of Military Members"

Actually acknowledges that with the return of the veterans from deployments, the entire family will go through a period of transition. Along with many suggested activities, there is specific reference for a need for opportunities to reacquaint families with one another. Part of the transition is expected to be a process or restoring trust, support and integrity to the family circle.

While there is an expectation that "Things have changed" there is also the daunting task of beginning the difficult work of transition from soldier to citizen and reestablishing their identity in the family, work environment and community. Although the publication does a fine job of identifying the circumstances and the perils, the directions are not for family but how family can assist the veterans. Because

services are focused on the military member and/or veteran the options for family members is limited. VA advises "Families may receive treatment for war related problems from a number of qualified sources: chaplain services, mental or behavioral health assistance programs."

An example from our Summit for Recently Returned veterans illustrates the disparity this creates. We learned from one veteran who came back in 2004 that his two years of open enrollment in VA had expired. He felt that two years was too short for coverage because it was hard for him to go to the VA and keep his job. He felt that treatment at the VA was preventing him from getting on with his life which he implied really meant VA was doing the exact opposite of what it should be doing for veterans and their loved ones. He said that for him, not attending the VA meetings "was not about stigma, it's just that the VA is unhelpful." When he did go to the VA for help, his wife went with him, and they (VA) expressed surprise that she and her husband had come in as a couple. The wife was told to stay out of it, that it was "his problem" and not hers. She felt cut off. This spurred a more generalized discussion about how families have no idea how to interact with their veterans and feel lost. What little the VA does for veterans, it does even less for their families.

Central Connecticut State University Survey of Recently Returned Veterans

With the reality that troops being deployed to Iraq, Afghanistan and the Global War on Terrorism represented a striking departure from the mobilization of American troops in previous wars, the pro forma conventional methods and remedies relied on in the past seemed inadequate for addressing the emerging needs of military and veterans in the 21st Century. Thus, we embarked on a survey of returning veterans to "take the pulse" of their thinking, needs and expectations. In order to assess the growing population of returning "Warriors" and "Heroes" specifically problems they were encountering, their expectations for services and the goals they had for their future a mail out survey designed in collaboration with Central Connecticut State University's O'Neil Center for Public Policy and the Yale School of Medicine was mailed to 1000 Iraq/ Afghanistan veterans. We have completed an initial mailing and are finalizing our second wave of surveys. So far we have learned that 63% of the respondents were married, 10% were divorced and 25% never married. Major concerns identified by respondents were: problems with spouses (41%), trouble connecting emotionally with others (24%), connecting emotionally with family (11%) and looking for help with these problems (10%).

Also incorporated in the instrument was a PTSD Scale "Post Traumatic Stress Checklist—Military scale developed by VA National Center for PTSD which indicated that 24% of respondents met the diagnostic criteria. The most salient results fell under the rubric of sizable number of veterans experiencing problems in several domains of interpersonal life issues. Researchers concluded that the data regarding both family and peer relationships, indicated that a sizable proportion of veterans report difficulties in these areas. These problems are undoubtedly exacerbated by the symptoms of PTSD with nearly a quarter of respondents exceeding the diagnostic threshold.

Domestic Violence

In addressing the issue of mental health treatment for families, I would be remiss if I did not reference the increasing body of evidence which links combat veterans, PTSD and violent and abusive traumatic events in the home. Domestic violence has always been a factor in military life. It is not new. What is new is the fact that victims are no longer silent and someone is listening. The American public is not as tolerant as it was decades ago to the litany of brutal deaths suffered in military communities or at the hands of a military member or veteran. While the Pentagon has made efforts to address the issue and offer support and education to families in the military community, this war's heavy reliance on citizen soldiers of the Reserve and National Guard components bring this volatile scenario into every town, every city and every neighborhood of America.

We know that more of our deployed and activated troops are married with families than in wars past. The long separations, multiple deployments and sense of isolation from the very supportive military community creates confusion, anxiety and anger which increases the stress and difficulties experienced by families. The NY Times recently reported "more than 150 cases of fatal domestic violence or child abuse in the United States involving service members and new veterans during the war time period that began in October 2001 with the invasion of Afghanistan". Interestingly, not all of these tragedies were perpetrated by combat veterans. It was noted that "a third of the offenders never deployed to war".

Admittedly, these cases are the extreme. However headlines do not always capture the slow insidious erosions of trust, disruptions of anger, violence and abuse that deeply wounds and destroys families The reality of PTSD in men and women who serve in the Armed Forces also engenders a link between the symptoms of this condition, family estrangements and dissolution of family units.

Military Support Program

In 2004 the Connecticut General Assembly enacted legislation authorizing the Department of Mental Health and Addiction Services (DMHAS) to provide behavioral health services, on a transitional basis, for the dependents and any member of any reserve component of the armed forces of the United States who has been called to active service in the armed forces of this State or the United States for Operation Enduring Freedom or Operation Iraqi Freedom. Such transitional services were to be provided when no Department of Defense coverage for such services was available or such member was not eligible for such services through the Department of Defense or until an approved application is received from the Federal Department of Veterans Affairs and coverage is available to such member and such member's dependents. As you well know, VA is very limited to providing care to any "dependent". The Vet Centers have traditionally been the only program that includes dependents in their scope of practice. After some experience with this program, Governor Rell has proposed that the eligibility criteria for this program be expanded to include veterans of Active Duty service and their families.

Funding for this program ($1.4M) came from a portion of the sales realized when the State sold a decommissioned psychiatric hospital. Once the funding was available, planning began to implement a program that would be responsive to the needs of returning military and their families. From the beginning, this initiative was a collaborative effort between Connecticut's Departments of Mental Health and Addiction Services (DMHAS), Veteran Affairs (CTVA), National Guard (CTNG) Department of Families and Children (DCF) and the Family Readiness Group. Building on the experience DMHAS had gained in assisting families in the aftermath of 9/11, the concept of working with mental health professionals in the community was ideally suited for the broad context of the legislation and the geographical distribution of potential clients.

Also taking from previous "lessons learned", the scope of the program was created not only to include military members, their spouses and children but immediate family members (parents, siblings) and significant others were also eligible for care. With the assistance of the State and Federal Departments of Veteran Affairs and the Adjutant General, 16 hours of training in Military 101, dynamics of deployments and post traumatic stress dirorder including panel discussions by OIF/OEF veterans and their families was provided to 225 volunteer mental health professionals licensed in Connecticut. Only clinicians, completing the training were eligible to participate in the program.

The Military Support Program (MSP) was designed to streamline the process of access to care with an emphasis on confidential services throughout the state. The goal of delivering quality, appropriate, timely and convenient services was further enhanced by a 24/7 manned toll free center, three fulltime veteran outreach workers and State reimbursement for clinical services when there was no other funding available.

Typically, anyone eligible for the program can call the 24/7 number. In this day and age, it is important that a real person answers the call. If the nature of the call does not involve a mental health issue, the caller is directed to an individual at the appropriate agency. For example, a veteran's benefit question would be directed to the Connecticut Department of Veterans Affairs. Should the nature of the call be a request for help with a problem best handled by a mental health professional, the caller is given the names of three clinicians in their immediate geographical area, who have completed the training and are registered with DMHAS. The caller is free to choose which clinician they will see. The strength of using clinicians in the community comes from their availability of provide care after hours and on weekends and obligation to assist in scheduled sessions and/or crisis situations.

We believe that this is a model that can easily be adapted for any State especially rural communities.

Another very attractive aspect of this approach is the fact that families including the military member can have the opportunity to work out their issues together.

Due to the limitations of VA Healthcare, families are often excluded from the therapeutic process which can be counterproductive in the long run. Family therapy is less threatening to a military member who may not seek treatment because of the stigma associated with mental health problems. A 2005 study of Iraq Veterans assigned to the Maine National Guard indicated that 30% of those in the study indi-

cated a likelihood of participating in "confidential services in the community". Responses to the question of who they would be most likely to participate in support groups included "with other veterans (32%), couples' communication skills training (28%) and couples/marital counseling (26%). (Wheeler, 2005) lends credence to the concepts we have implemented.

In the 8 months the Connecticut Military Support Program has been in operation, we have received over 316 calls and made 181 referrals. A particularly important aspect of this program is the fact that callers to the toll free number are contacted approximately 10–14 days after the referral to determine if the client encountered any difficulties in the process.

Connecticut has been caring for veterans since 1863. From that time to this, each generation of Americans, who have shouldered the responsibility of serving in our Armed Forces, has influenced the development of the collective service systems provided by Federal, State and Local governments. Just as the business of conducting war and defending the Nation has changed dramatically, America and this Committee need to rethink the delivery system and the care we extend to those who have borne the battle. The old adage that "if the military wanted you to have a spouse they would have issued you one" has been outstripped by the number of married military members we rely on to protect freedoms. In this day and age, the expectation of caring for our military must include tending to the health of their families.

Prepared Statement of Stacy Bannerman, M.S., Fife, WA, Author, *When the War Came Home: The Inside Story of Reservists and the Families They Leave Behind*

During the few hours it takes for this historic hearing to conclude, another veteran will commit suicide. Most likely it will be a veteran of the Guard or Reserves, "who have fought in Iraq and Afghanistan [and] make up more than half of veterans who committed suicide after returning home from those wars." (The Associated Press, February, 2008) There will be at least seven family members left to deal with the adjustment, loss, anger, and grief. Because their loved one was a citizen soldier, they will do so alone. They will be forced to live with the pain of their preventable loss for the rest of their lives, without the formal and informal mental health services and support available to active duty military families. Just as they did during all phases of their loved ones' deployment.

I am the author of *"When the War Came Home: The Inside Story of Reservists and the Families They Leave Behind."* (Continuum Publishing, 2006) I am currently separated from my husband, a National Guard soldier who served one year in Iraq in 2004–05. Just as we are beginning to find our way back together, we are starting the countdown for a possible second deployment. Two of my cousins by marriage have also served in Iraq, one with the MN Guard, a deployment that lasted 22 months, longer than any other ground combat unit. My other cousin, active duty, was killed in action.

My family members have spent more time fighting one war—the war in Iraq—than my grandfather and uncles did in WWII and Korea, combined. When the home front costs and burdens fall repeatedly on the same shoulders, the anticipatory grief and trauma—secondary, intergenerational and betrayal—is exponential and increasingly acute. Nowhere is that more obvious than in Guard and Reserve households.

Our loved ones perform the same duties as regular active troops when they are in theatre, but they do it with abbreviated training and, all-too-often, insufficient protection and aging equipment. It was a National Guardsman who asked then-Secretary of Defense Donald Rumsfeld what he and the Army were doing "to address shortages and antiquated equipment" National Guard soldiers heading to Iraq were struggling with.

Guard families experience the same stressors as active duty families before, during, and after deployment, although we do not have anywhere near the same level of support, nor do our loved ones when they come home. Many Guard members and their families report being shunned by the active duty mental health system. Army National Guard Specialist and Iraq War veteran Brandon Jones said that when he and his wife sought post-deployment counseling, they were "made to feel we were taking up a resource meant for active duty soldiers from the base." One Guardsman's wife was told that "active duty families were given preference" when seeking services for herself and her daughters while her husband was in Iraq.

The nearly three million immediate family members directly impacted by Guard/Reserve deployments struggle with issues that active duty families do not. The

Guard is a unique branch of the Armed Services that straddles the civilian and military sectors, serves both the community and the country. The Guard has never before been deployed in such numbers for so long. Most never expected to go to war. During Vietnam, some people actually joined the Guard in order to dodge the draft and avoid combat. Today's National Guard and Reservists are serving with honor and bravery, each and every time they're called. But when the Governor of Puerto Rico called for a U.S. withdrawal from Iraq at the annual National Guard conference, more than 4,000 National Guardsmen gave him a standing ovation. ("Troops cheer call for Iraq withdrawal." The Associated Press, August 26, 2007)

These factors are crucial to understanding the mental health impacts of the war in Iraq on the families of Guard/Reserve veterans, and tailoring programs and services to support them.

Several weeks after my husband got the call he was mobilized. There was very little time to transition from a civilian lifestyle and employment to full-time active duty. The Guard didn't have regular family group meetings, and I couldn't go next door to talk to another wife who was going through the same things I was, or who had already been there, done that. Most Guard/Reservists live miles away from a base or Armory, many are in rural communities. We are isolated and alone.

At least 20% of us experience a significant drop in household income when our loved one is mobilized. This financial pressure is an added stressor. The majority of citizen soldiers work for small businesses or are self-employed. Some have lost their jobs or livelihoods as a direct result of deployment. The possibility of a second or third tour makes it difficult to secure another one. Guard members have reported being put on probation or having their hours cut within a few days of being put on alert status for deployment. Some of us have to re-locate. Some of us go to food shelves. Where we once had shared parenting responsibilities, the spouse left behind is now the sole caregiver, without the benefit of an on-base child care center.

During deployment, we withdraw and do the best we can to survive. Anxious, depressed, and alone, we may attempt to cope by drinking more, eating less, taking Xanax or Prozac to make it through. We close the curtains so we can't see the black sedan with government plates pulling into our drive. We cautiously circle the block when we come home, our personal perimeter check to make sure there are no Casualty Notification Officers around. Every time the phone rings, our hearts skip a beat. Our kids may act out or withdraw, get into fights, detach or deteriorate, socially, emotionally, and academically. There are no organic mental health services for the children of National Guard and Reservists, even though they are more likely to be married with children than active duty troops.

There are a growing number of military families with what psychologists are beginning to recognize as Secondary Traumatic Stress Disorder. Secondary Trauma may occur when a person has an indirect exposure to risk or trauma, resulting in many of the same symptoms as a full-blown diagnosis of PTSD. These symptoms can include depression, suicidal thoughts and feelings, substance abuse, feelings of alienation and isolation, feelings of mistrust and betrayal, anger and irritability, or severe impairment in daily functioning. ("Walking On Eggshells." Mary Tendall and Jan Fishler, *Vietnow Magazine.*)

One woman wrote, "My husband is a Reservist and, foolishly or not, we did not expect him to be activated and sent to Iraq. During my husband's deployment I had anxiety, depression, loss of appetite, difficulty sleeping, and hair loss from the stress. I had to cut back on my work hours because I couldn't concentrate."

When our soldiers come home, they are given a perfunctory set of questions about their mental health status, and then they are given back to us. Fifty percent of Guard/Reservists who have served in Iraq suffer post-combat mental health issues, and the government has known for decades that Reservists are at significantly higher risk.

Numerous studies conducted in the 1980's and '90's on the impact of combat deployments in citizen soldiers found that "Being a reservist, having low enlisted rank, and belonging to a support unit increased the risk for psychiatric breakdown. [And] Loss of unit support [post-deployment] was considered a potential major factor for PTSD . . . In a study of National Guard reservists . . . nearly all subjects reported one or more PTSD-specific symptoms 1 and 6 months after returning from the Persian Gulf area." (*Possibilities for Unexplained Chronic Illnesses Among Reserve Units Deployed in Operation Desert Shield/Desert Storm.* Southern Medical Journal, December 1996.)

The VA has done nothing about it. I question the practice of commissioning reports and conducting studies if you're not going to apply what you've learned. Perhaps rather than forking out another $5–10 million for another study to define a problem that somehow never fully gets defined, much less treated, you could use that same amount of money to fund community-based centers providing our military

families and veterans three years of the free services that they are begging for—individual, high touch, weekend and evening, experiential, off-post—but aren't currently available.

Perhaps in addition to soliciting the fee-for-service advice of people with Ph.D.'s in Psychology, you could commission the people with Doctorates in Deployment, the military families and veterans who have lived with it, worked with it and walked through it. They know what's needed, what helps, and what the emerging issues are. I knew the suicide rates of citizen soldiers who served in Iraq were going to be off the charts when I started hearing from their family members more than two years ago.

Although it stands to reason that the branch of service with the highest rates of PTSD would be the same one with the highest rates of suicide, it seems that the Department of Veterans Affairs had to do a formal analysis in order to determine that citizen soldiers are more likely to kill themselves as war veterans. A Military Citizens Advisory Panel could likely have saved lives, dollars and years of pain.

"How Do You Mourn for Someone Who Isn't Dead?"

After our loved ones return from deployments that have all the precursors for post-combat mental health issues, (civilian casualties, longer than six months, significant combat exposure, enlisted rank, citizen soldier, loss of unit support post-combat, etc.) we're given a pamphlet and told to "give it time." While we're reading and waiting, we're losing our veterans, our marriages, and our families. One former spouse said:

> *This war cost me my family. When my husband returned from Iraq it quickly became apparent he was suffering from PTSD. He became increasingly verbally and mentally abusive to not only my daughter and I, but many of his subordinates at work who either quit or he had fired. He refused to admit he had a problem, and since the military does no mental status follow-up [for Reservists] he hasn't received any treatment for his condition. As a consequence, my family is destroyed. My son isn't being raised by his dad and my daughter lost the only father she knew. I know a divorce isn't as bad as losing my husband to death, but I can honestly say the man I married died in Iraq.*

We are also given the option of five free sessions with a civilian provider. Here's what one Guard wife wrote about that:

> *When my husband returned from Iraq, we were offered five free "helping" sessions—they were careful to stress that it was not counseling or therapy—after which, we were on our own. In our first session, my husband talked about the nightmares, the sounds that would trigger a flashback or a rush of fear. Our "helper" chose to focus that particular session on . . . our financial situation. She was a civilian, and was thoroughly unfamiliar with any of the issues facing military families, much less returning vets.*
>
> *And so, my husband entered private therapy, at a cost of $85.00 a week which we often didn't have. I was no longer a part of this process. The impact of his deployments on our family was no longer addressed. We were simply supposed to continue on as if nothing had changed. But we had been changed. Rob came back hardened, angry. I was angry myself, bitter and resentful. We both experienced PTSD.*
>
> *Any reminder of his deployment, such as hearing about a group deploying or returning from Iraq, would send me into sobbing panic attacks. I experience what I called "home-front flashbacks", sudden overwhelming feelings of isolation, fear, depression, helplessness, triggered by commercials, news stories, or a particular song on the radio. What use were these "helping sessions" when our "helper" had no concept of what life was like for a military family?*

This is what life is like for another military family living with a combat veteran:

> *Back in May, Kyle suffered a PTSD disassociative state of mind [and] held me at knife point [and] wouldn't let me leave; he had me and our family sitting on the floor and was speaking to us in Arabic. This ordeal lasted about an hour and a half. He calmed down with the help of a Vietnam veteran friend [on] the phone . . . I took the kids next door and . . . the police showed up, woke my husband and arrested him.*

The veteran's unresolved traumatic re-enactment resulting in domestic violence—which is at least three to five times more prevalent in households with combat veterans—is the nucleus of intergenerational trauma, which the children and grand-

children of these veterans will live with for the rest of their lives. There are countless military family members suffering in silence all across America. The wife of one profoundly injured Marine with polytrauma asked, "How do you mourn for someone who isn't dead?" The physical, financial, emotional and psychological challenges faced by these caregivers are immense, and they have little—if any—support from the system. ("How the U.S. is Failing its War Veterans." Don Ephron and Sarah Childress, *Newsweek,* March 5, 2007.)

The greatest grief is borne by the Gold Star families, and often the parents and siblings have little, if any, support. If the parents are divorced, one inevitably gets pushed aside. This was the case for a grieving mother who contacted me, desperate for help for herself and her surviving sons, she told me, "I will spend the rest of my life in a mild state of depression." Another Gold Star mom wrote:

> *My son, Spec Jeremy W. McHalffey served in the Army National Guard and was killed in Iraq, January 4, 2005. Jeremy's older brother Michael will never get over losing his brother. Jeremy owned a home in Little Rock, Arkansas and I planned to retire there in 5 years to live near both my sons. I don't want to retire to a grave site. We plan a family vacation to the shore each year. We have spent 3 years without Jeremy and it never gets any better.*

But, "the military health system lacks the fiscal resources and the fully trained personnel to fulfill its mission to support psychological health" of the troops and their families, according to a Department of Defense mental health task force report released in June of 2007.

When I went to the VA, I spoke with a program officer, who said, *"It's the wife's responsibility to set the tone for the whole household."* A veteran's advocate asked me, *"Why don't you take care of him?"* The VA's mental health professionals preach to the wives about resilience, but they aren't the ones being woken up at three in the morning because their husband has shot the dog, or is holding a gun to your head, or a knife at your throat.

Expecting the wife or family member to treat the veteran violates the professional standard prohibiting family members from treating their own; places the burden of care on the family; creates a highly unfair and unethical expectation that we are trained mental health providers; discounts our reality; excuses the VA from fulfilling its responsibility to our veterans; and places an immoral burden upon the family member, who is likely already suffering undue mental health and financial consequences as the result of having their loved one deployed.

The legacy of guilt and self-blame this creates is profound. Virtually every family member I have talked to who lost their veteran due to suicide or divorce has said, "I thought if I loved him enough, I could fix him." That the VA and the military continues to lay this on the wives and family members, in practice, if not in policy, is a gross moral and ethical violation and an abdication of responsibility.

It Is a Covenant, and It Has Been Betrayed.

After being denied care, having their symptoms dismissed, or put on waiting lists of up to half a year, dozens of Guard/Reserve veterans have committed suicide, including Jonathan Schulze, Jeffrey Lucey, Chris Dana, Tim Bowman, and Joshua Omvig. Given the documented failure (CBS News, November 2007) of the Veteran's Administration to track and disclose veteran's suicide rates in a timely and forthright manner, and the fact that they don't monitor Guard and Reserve, it is extremely likely that the actual number is in the hundreds, if not a thousand or more.

When the VA repeatedly proves to us that we cannot trust them to take care of our loved ones, we feel betrayed. The 60% of military family members of a veteran who has served in Iraq or Afghanistan and say that the war in Iraq was not worth the cost feel betrayed. (Los Angeles Times/Bloomberg poll, December, 2007) When our loved ones are committing suicide after they are refused treatment by the VA, we feel betrayed. When the Army's mouthpiece, Colonel Elspeth Ritchie, says, "People don't tend to suicide as a direct result of combat . . . failed personal relationships are the primary cause," then goes on to further blame the military families by stating, "Families are getting tired. Therefore, they're more irritable, sometimes they don't take care of each other the way they should, are not as nurturing as they should be." WE FEEL BETRAYED.

There is no dictionary large enough to describe what you feel when you learn that your loved one has fought, died, been wounded, is on the ground or on alert to return to fight in a war that was launched on 935 lies. (The Center for Public Integrity, and the fund for Independence in Journalism.)

According to the wife of an Ohio National Guardsman:

My husband served with his National Guard Unit on Victory Base during 2004. [He] was deployed six months after our wedding. . . . Neither of us believed that this war was just. . . . The rage and anger at the sacrifices being asked of military families, coupled with the severe emotional strain of worrying about my husband in Iraq pushed me to a breaking point. We were able to receive a hardship discharge for him to come home because [of] my severe depression and anxiety. . . . The shadows of the war are omnipresent in our lives still. We both seek therapy.

Mental health experts refer to this as betrayal trauma, which occurs when "the people or institutions we depend on for survival violate us in some way. **Betrayal,** as a form of deception, is the breaking or violation of a presumptive social contract (trust) that produces moral and psychological conflict within a relationship amongst individuals, between organizations or between individuals and organizations." (Wikipedia)

When it is life and death and your loved one on the line, when your husband, father, mother, brother, daughter or son is fighting for country and Constitution, military service is no mere contract. It is a covenant, and it has been betrayed.

The Guard and their families are keeping their promise to this country. It's time for this country, and the VA, to keep its promises to them. Please provide our veterans and families the mental healthcare and services they deserve.

Closing Remarks:

One of the most critical elements in promoting the short- and long-term wellness of the combat veteran is the military family. Yet, Guard and Reserve families are generally left to fend for themselves during and after deployments. In order for the VA to genuinely care for America's veterans, it must attend to the needs of the families who are left behind during combat deployments, enduring the stress, trauma, violence and grief of war, struggle with marriage and family cohesion and reintegration, and serve as the first line of support for the soldier during deployment and for the veteran upon his/her return.

However, within the Veterans Administration, treatment benefits are tied to the veteran. Military spouses cannot access services at the VA until their soldier has acknowledged his/her trauma, registered with the appropriate agency, and provided paperwork/given permission for the spouse to receive assistance or attend a support group, which *may or may not* be available at that time.

The majority of the affected families/loved ones (parents, children, siblings, significant others, etc.) are beyond the scope and scale of mental healthcare and services provided by the military, the Veterans Administration, and Vet Centers. Military ONE Source allows for a maximum of six visits, and Guard/Reserve families, extended family members, siblings and unmarried partners and significant others of the soldier's family often do not have private insurance, cannot afford the co-pay or out-of-pocket expense, and are unable to find an adequate mental health provider. Few accept TRI–CARE (military medical plan); fewer still have the experience, training and awareness to address the particular needs of the military community during a time of war. Such inadequacies put the health, well-being and future of military family members and their veterans at risk.

Gaps in Mental Health Services for Families of Guard/Reserve Veterans:

1. Mental health resources available for military family members are typically designated for active duty dependents.
2. Counseling/support is tied to the veteran, who may or may not be seeking services AND may or may not be willing to provide permission required in order for spouse to obtain care.
3. General disregard for veteran impact on family, reintegration issues, and effect of combat-trauma on family members during and after deployment.
4. DoD/VA subcontractors are often civilian providers with no previous experience with military families or therapeutic skill in counseling individuals struggling with the psychological stressors and strains of all phases of combat deployments.
5. No programs available for parents, extended family members, or gender-friendly events for male spouses/ partners of female Reservists.
6. No weekend or night sessions, when Guard/families are typically available.
7. Lack of ad hoc or informal support opportunities.
8. No exposure to wives/parents/military family members/veterans who have lived through combat deployments.
9. Virtually no services available in rural areas.
10. No regular phased follow-up i.e. 6, 12, 18, 24 months post-deployment.

11. Attempting to apply active duty models to citizen soldiers fails to recognize and address challenges and issues unique to families of citizen soldiers.

RECOMMENDATIONS (Annotated—Proposals Available Upon Request)

The Military Citizens Advisory Panel (MCAP):

Real support for citizen soldier veterans and their loved ones cannot be achieved without the perspectives of those who are directly affected by combat deployments. It is critical that the expertise and experience of military citizens, i.e. family members from all branches of services, retired active duty and reserve, combat and non-combat veterans, etc., who are able to speak about the realities of being a veteran, the effects of combat deployments, and the battles that begin when the war comes home, is brought into the policy, program and oversight processes of the Veterans Affairs Committee. Because they *are* the people they represent, the panel members' primary concern is for service men and women, their families and communities, and the veterans of the Armed Forces. They know first—and most accurately—what is occurring with our veterans, the shortfalls in care and services, emerging issues, suggestions for improvement.

Peer-to-Peer Support Groups: Peer counseling prior to/during/after deployment by wives of combat veterans/military families/parents/combat veterans.

Implement Adopt-A-Family Program: Involve community members in taking a Guard/Reserve family under its wing throughout all phases of combat deployment.

Conduct Home Visits: Many Guard/Reserve families lack transportation or cannot easily travel to Guard Armories, and approximately 40% of veterans live in rural areas.

Fund Community-Based Weekend Retreats/Experiential Programs & Non-Clinical Services, including:

- Veteran Mentoring/Peer Counseling
- Family Group Counseling
- Off post readjustment/reintegration counseling for families of wounded warriors
- Grief Counseling for Gold Star families
- Developmentally appropriate play therapy for children
- Respite & Bereavement Support: Taking care of the caregivers
- Outdoor/Experiential Programs

Develop & Implement Family Systems Theory Programs/Services

By definition, a family system functions because it is a unit, and every family member plays a critical, if not unique, role in the system. As such, it is not possible that one member of the system can change without causing a ripple effect of change throughout the family system. (Source Unknown) "The entire family suffers when a Veteran's mental health needs are not acknowledged and resolved; it can strain even the strongest of marriages . . . the longer the problem is not treated, the complicated the treatment becomes due to complications that arise from the lack of treatment. As a result, our families suffer through crisis on a daily basis." (LTC Carol Seger, WAARNG State Family Programs Director, August 20, 2007)

FAST FACTS: National Guard & Reserve Veterans and Their Families

A. Since the onset of military operations in Iraq and Afghanistan, more than 400,000 members of the National Guard and Reserve have served in the Middle East (counting each deployment as unique), and more than 600,000 have been mobilized since 2001. (Office of the Under Secretary of Defense, September 2007).
B. Assuming that each of those troops has seven immediate relatives—such as parents/step-parents, spouses/partners/significant others, siblings and children—the wars have closely affected more than 2,800,000 Guard/Reserve family members. (Formula adapted from "War's Invisible Wounds." Zak Stambor, APA *Monitor on Psychology,* Vol. 37, No. 1, January 2006).
C. Almost 50 percent of the Guard and Reserve who have served in Iraq are experiencing combat-related mental health problems, as are 38 percent of Soldiers, and 31 percent of Marines. ("An Achievable Vision: Report of the Department of Defense Task Force on Mental Health" June 2007, Defense Health Board, Falls Church, VA, p. 6).
D. "National Guard and Reserve troops who have fought in Iraq and Afghanistan make up more than half of veterans who committed suicide after returning home from those wars." (The Associated Press, February 2008).

E. "No U.S. forces have ever been compelled to stay in sustained combat conditions for as long as the Army units have in Iraq. In World War II, soldiers were considered combat-exhausted after about 180 days in the line." (Lieutenant General William E. Odom, (Ret.) 05 July 2007).

Key Issues: Impacts of Combat Deployments on Military Families.

- The *Journal of the American Medical Association* (JAMA) released a study looking at families of enlisted Army troops with verified reports of child maltreatment. The report revealed that among female civilian spouses, the rate of maltreatment during deployment was more than three times greater; the rate of child neglect was almost four times greater; and the rate of physical abuse was nearly twice as great. ("Child Maltreatment in Enlisted Soldiers' Families During Combat-Related Deployments" Deborah A. Gibbs, MSPH; Sandra L. Martin, PhD; Lawrence L. Kupper, PhD; Ruby E. Johnson, MS. JAMA 2007; 298:528–535; Vol. 298 No. 5, August 1, 2007).
- School counselors, teachers, therapists and military family members report that a growing number of military kids are exhibiting social, emotional, and behavioral problems during and after deployments. These problems are intensified if their soldier returns with a physical or psychological wound. ("Communication is Key for Children of Deploying Parents" Bilyana Atova, *Army News Service,* August 15, 2007)
- Divorce and separation rates among returning Iraq war veterans are fast approaching double the rate of peacetime divorces. ("Deployments Stress Marriages." Christine Metz, *Lawrence Journal-World & News,* October 8, 2007). The wife and child(ren) of the veteran suffer significant impacts of separation/divorce, including a major drop in household income, stress and expense of re-location, loss of friends, loss of sense of identity/connection to military, etc., in addition to the usual stressors associated with the dissolution of a marriage and the break-up of a family.
- According to the Miles Foundation (hometown.aol.com/milesfdn), domestic abuse in military households is already five times greater than the rate of civilian domestic abuse, and the numbers do not take into account assaults that occurred off-base, or involving domestic partnerships/common law spouses, etc. It has been shown repeatedly that violence in the home and on military bases and installations increases during wartime, and spikes in the first year post-deployment, as evidenced in the spate of spousal murders at Ft. Bragg in the first months of redeployment from Afghanistan.
- Preliminary research, self-reports and anecdotal information suggest that upward of 30% of military family members are exhibiting war-related "Secondary Trauma," which shares some of the same symptoms as a full-blown diagnosis of post traumatic stress dirorder, including emotional withdrawal, increased anxiety, depression and poor anger management.
- With an unprecedented wound-to-kill ratio of nearly 16 to 1 and the prevalence of Traumatic Brain Injury (TBI) parents (particularly mothers), spouses, grandparents and siblings are becoming the primary caregiver of their grievously injured veteran and have scant support or services.

Prepared Statement of Peter Leousis, Principal Investigator, Citizen Soldier Support Program National Demonstration, and, Deputy Director, H.W. Odum Institute for Research in Social Science, University of North Carolina at Chapel Hill

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to speak to you this morning about the mental health needs of families of veterans.

Specifically, I want to address the question before the Subcommittee about "the need for the U.S. Department of Veterans Affairs to provide mental health treatment for family members of veterans within VA medical facilities." More broadly, I want to describe the approach our North Carolina initiative is taking to address the mental health needs of Operation Enduring Freedom and Operation Iraqi Freedom veterans and their families.

My name is Peter Leousis and I am the principal investigator for the Citizen Soldier Support Program National Demonstration. The Citizen Soldier Support Program was funded by the Congress to develop model approaches to mobilize and engage community support for members of the National Guard and Reserve and their families. I am currently Deputy Director of the Odum Institute for Research in So-

cial Science at UNC Chapel Hill. Before that, I was Assistant Secretary for Human Services for seven years under former North Carolina Governor Jim Hunt.

I want to thank the North Carolina Congressional delegation and the University of North Carolina's Board of Governors for their support of this work and for their efforts to provide federal funding. I want to emphasize that while we have been laying the groundwork for our mental health initiative for more than a year, many elements of the program are just getting underway. We will have a much clearer assessment of the program in four to six months.

The focus of the Citizen Solider Support Program is on the Reserve Component of the military, which includes the National Guard and Reserves. Whether these service men and women are in the Army National Guard or the Marine Corps Reserve, the Army Reserve or the Air National Guard they are widely dispersed throughout the nation. In North Carolina, the majority of Reserve Component service members do not live near a military installation. In fact, historically many of them have not thought of themselves as military families. In most cases, the formal and informal networks that provide support for families in the Active Component are not available to them.

Rural Communities

Our efforts focus on rural communities and communities that do not have easy access to VA medical facilities and Vet Centers. In North Carolina, for example, there are no Vet Centers west of Charlotte despite the large numbers of Citizen Soldiers and veterans living in that part of the state.

Figure 1—Reserve Component by County: March 31, 2007

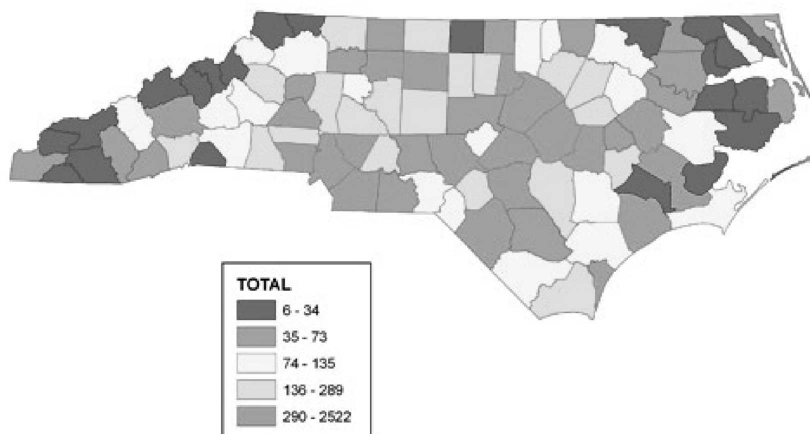
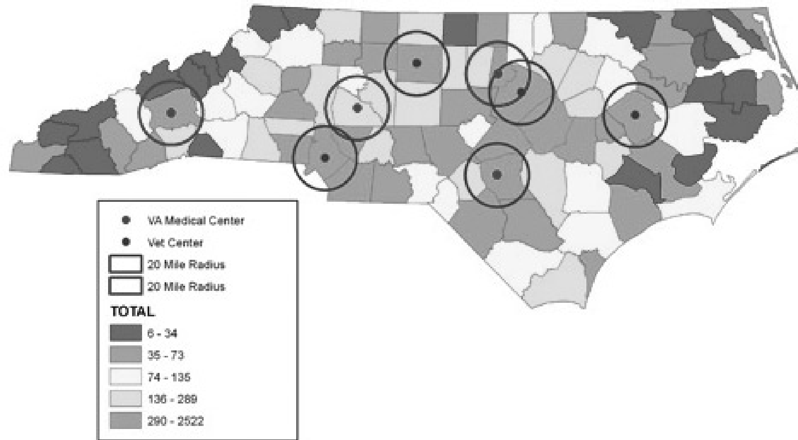


Figure 1 shows the geographic distribution of more than 22,000 Reserve Component service members across North Carolina on March 31, 2007. This does not include more than 8,000 service members in the Individual Ready Reserve.

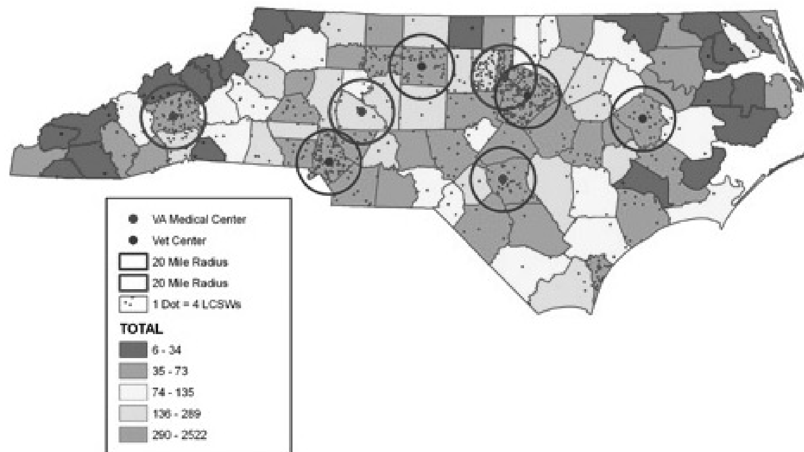
Although some counties clearly have concentrations of Citizen Soldiers, they and their families live in all counties of the state and significant numbers of them live in rural counties in the eastern and western regions of the state.

Figure 2—VA Medical Centers, Vet Centers, and Reserve Component: March 31, 2007



The circles on Figure 2 are centered on VA medical centers and Vet Centers located in North Carolina. The radius of each circle is 20 miles, or approximately 30 minutes driving time. As shown on this map, most Citizen Soldiers do not live near a VA Medical Center or Vet Center.

Figure 3—Licensed Clinical Social Workers and Reserve Component: March 31, 2007



The dots in Figure 3 show the number of licensed clinical social workers in North Carolina. The largest urban counties of Mecklenburg, Wake, Durham, Forsyth, and Guilford have the largest numbers of licensed clinical social workers. But virtually every county has several. These licensed mental health providers and others like them are target groups of the Citizen Soldier Support Program. We focus on building the mental health infrastructure outside urban areas and at locations far removed from VA Medical Centers and Vet Centers through training developed in collaboration with partners who are experts on post traumatic stress dirorder (PTSD) and combat-related mental health issues.

The Mental Health Needs of Families

The Subcommittee has asked about the mental health needs of families of OEF and OIF veterans. We know that the majority of Reserve Component families are resilient. They are able to cope with the demands and challenges of repeated deployments with few lasting effects. But there is mounting evidence that service in OEF and OIF comes at a price for families. We know, for example, that the incidence of child maltreatment in families with deployed parents rises significantly. (*Am J Epidemiol* 2007; 165:1199–1206).

Post-deployment reintegration of veterans can be as challenging for families as for soldiers and Marines themselves. For example, the report of a joint working group composed of the Department of Veterans Affairs Office of Research and Development, the National Institute of Mental Health, and the United States Army Medical Research and Materiel Command concluded that:

> [T]he burden of illness, including the cost of PTSD and other trauma responses, spans beyond symptoms to impairment, altered functioning, and disability, and crosses family, occupational, and social realms. This applies not only to those who have served in the military and suffer from deployment-related problems, but also to their spouses, partners, and children ("Mapping the Landscape of Deployment Related Adjustment and Mental Disorders: A Meeting Summary of a Working Group to Inform Research," working paper 2006; p. 9).

There is evidence that exposure to combat has an even greater effect on Reserve Component service members. According to the "Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War" (*Journal of American Medical Association;* 11/14/2007), "clinicians identified 20.3% of active duty and 42.4% of reserve component soldiers as requiring mental health treatment."

Over 360,000 "citizen soldiers" have served in Afghanistan and Iraq so far. More than 10,000 are from North Carolina alone. They do not return to military installations where the community "gets it" and appropriate services are available, but rather to their hometowns and communities that might not even be aware of their service and sacrifice.

We know that PTSD has a secondary effect on spouses and partners and that the repeated deployments typical of OEF and OIF are having lasting effects on service members and their families. The report of the Mental Health Advisory Team IV published in the December 2007 issue of *Traumatology* notes that:

> Not surprisingly, deployment length and multiple deployments to Iraq were related to soldier mental health and well-being, with soldiers deployed longer than 6 months and soldiers on their second deployment to Iraq being more likely to screen positive for a mental health problem than soldiers who were deployed less than six months or on their first deployment ("The Intensity of Combat and Behavioral Health Status," *Traumatology* 2007; 13; 6).

Clearly, the mental health needs of returning veterans, including but not limited to PTSD, have an impact on their entire family, not just themselves. *The issue is not whether the families of returning veterans may face serious mental health challenges, but how best to make sure they get the mental health services they need when and where they need them.*

When returning veterans and their families have reasonable access to VA medical facilities, mental health treatment should be made available to the entire family, not just the veteran, when it is clinically appropriate. We define reasonable access as living within a 30-minute drive of a mental health treatment provider.

The CSSP Approach

The Citizen Solider Support Program's efforts are guided by three fundamental principles. First, the program seeks to complement and strengthen the work of others and avoid duplicating similar efforts. To that end we have developed a partnership with Dr. Harold Kudler, M.D., VA Mid-Atlantic Healthcare Network, VISN 6. Dr. Kudler and his colleague, Dr. Kristy Straits-Troster, PhD, have been key collaborators and advisors to CSSP.

The steering committee that guided the development of our mental health initiative is listed at the end of my remarks. It includes experts with firsthand knowledge of the needs of returning veterans and their families and key stakeholders in the military and North Carolina's public and private mental health community.

A second guiding principle is that fundamental, lasting change can best be accomplished by taking a "systems" approach. Accordingly, our efforts are focused on leveraging existing mental health training and delivery systems and mechanisms to

reach mental health providers and to enhance delivery of mental health services throughout our state.

A third guiding principle is that there is no silver bullet. Relying on one approach will not work. We have to move forward on many different fronts at the same time. Thus, our mission to ensure that Citizen Soldiers and their families have access to mental health services encompasses five goals:

1. Provide evidence-based, best practice behavioral health training and products for healthcare professionals who render services to Citizen Soldiers and other veterans and their families. This includes primary care physicians and mental health providers.
   Our goal is to train 1,000 health and mental healthcare providers annually until we achieve a 70% to 80% market penetration rate. Currently this training is offered face-to-face to providers through the North Carolina Area Health Education Centers (AHEC) system. There are nine AHECs in North Carolina, and we offered our first full-day training session to 98 mental health professionals in January 2008. We will also make training available online to licensed providers. Ultimately, we plan to replicate this effort in the 40-plus states that have training systems similar to North Carolina's AHECs.
2. Provide specialized health and mental health services to returning Citizen Soldiers and other veterans and their families using the model of Integrated Care at family health clinics in Haywood, Clay and Jackson Counties, three rural underserved counties in Western North Carolina.
   The stigma of seeking mental health treatment is alive and well. Our experience is that offering treatment through family health clinics will reduce the likelihood that service members concerned about their career (and their families) will not seek care. Additionally, evidence suggests that mental health treatment should be provided through a "multidisciplinary approach centered in primary care." A goal of this demonstration is to make the mental health component self-sustaining within three years through TRICARE, third-party payers, and Medicaid.
3. Expand TRICARE participation by primary healthcare and mental health service providers and pharmacies to all 100 North Carolina counties.
   At each of our trainings a half hour is devoted to educating providers about TRICARE and dispelling some of the myths about it. Care must be accessible and *affordable* for returning veterans and their families. We recognize that we must identify "funding streams" to help veterans and families pay for needed services wherever they are available.
4. Address the critical shortage of psychiatric clinicians available to meet the needs of Citizen Soldiers and other veterans and their families in the 50 medically underserved counties in North Carolina.
   Rural healthcare disparities exist throughout the nation, and North Carolina is no exception. One of our goals is to secure long-term funding for a stipend and loan forgiveness program for psychiatric nurse practitioners who in return would agree to practice in underserved rural communities for a set number of years.
5. Provide online access to information about mental health issues. Information for "Military and families" is available through the NC Health Info Web site (http://www.nchealthinfo.org/) and for family practice physicians and mental health professionals through the NC AHEC Digital Library.
   These resources exist today through our collaborative work with the Health Sciences Library at the University of North Carolina at Chapel Hill. We invite Members of the Subcommittee and your staff to explore these Web sites. With very little tweaking, the content information contained in these Web pages could be made available to other states. Information about locally available services could be replaced with information specific to other communities.

   Consumer information for military families is located at: http://www.nchealthinfo.org/health_topics/people/military/MilitaryFamilies.cfm

   Information on military mental health for mental health professionals is located at: http://library.ncahec.net/scMain.cfm?scid=53

Our objective is to implement these goals and strategies in North Carolina, evaluate and improve them, and then help other states replicate those that are successful. We will continue to work with stakeholders such as the VA and private mental health providers, especially those in underserved rural communities, to improve and expand mental health services to Citizen Soldiers and other veterans and their families.

Thank you for the opportunity to speak this morning before the Subcommittee on Health, and thank you for all you are doing to improve health and mental health services for our veterans and their families.

Behavioral Health Steering Committee
Citizen Soldier Support Program

Denisse Marion-Landais Ambler, MD North Carolina Neuropsychiatry, PA, and adjunct assistant professor, Department of Psychiatry, UNC School of Medicine
COL James A. Cohn, North Carolina National Guard
Rev. Dennis Goodwin, District Superintendent, The United Methodist Church; CH (COL) 30th Brigade Combat Team (ARNG Ret.) Chair
Brigadier General Dan Hickman (ARNG Ret.) Executive Vice President, Cape Fear Community College
COL Danny Ray Hill, Officer in Charge, Tactical Operations Center, Foreign Army Training Command 108th Division (Institutional Training) USAR
Harold Kudler, MD, VA Mid-Atlantic Healthcare Network, VISN 6
Michael Lancaster, MD, Chief of Clinical Policy for the NC Division of Mental Health/Developmental Disability/Substance Abuse, NC Department of Health and Human Resources
Peter Leousis, Deputy Director Odum Institute for Research in Social Sciences and CSSP Principal Investigator
Major General Gerald A. (Rudy) Rudisill, Jr. (ARNG Ret.); Deputy Secretary, NC Crime Control and Public Safety
Karen Stallings, RN, NC AHEC Associate Director, Program Activities, UNC Chapel Hill
Flo Stein, M.P.H., Chief, Community Policy Management, NC Division of Mental Health/Developmental Disability/Substance Abuse, NC Department of Health and Human Resources
John Tote, Executive Director, Mental Health Association in North Carolina

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Prepared Statement of Charles Figley, Ph.D., LMFT, Fulbright Fellow and Professor, College of Social Work, Director, Traumatology Institute and Psychosocial Stress Research and Development Program, Florida State University, Tallahassee, FL, on behalf of American Association for Marriage and Family Therapy

Dear Mr. Chairman and other members of the Subcommittee:

On behalf of the American Association for Marriage and Family Therapy (AAMFT), I would like to thank you for shedding light on the need for the Department of Veterans Affairs (VA) to expand VA mental health services to include family members of veterans in addition to the veterans themselves. We are honored to participate in this important dialog. By holding today's hearing; "Mental Health Treatment for Families: Supporting Those Who Support Our Veterans," access to family oriented mental health services will finally be formally addressed, so we can begin to help heal the clandestine wounds increasingly affecting those closest to returning service members.

As background, the AAMFT is a national non-profit professional association representing the interests of the over 52,000 Marriage and Family Therapists (MFTs) across the United States since its inception in 1942. Family Therapists are the ONLY mental health professionals required to receive training in family therapy & family systems. Not only are MFTs licensed in 48 states plus the District of Columbia, but each licensed or certified MFT must meet strict professional requirements including a minimum of a master's degree (~30 percent with Doctorate degrees) in marriage and family therapy or an equivalent degree with substantial coursework in MFT. In addition, all MFTs must complete at least two years of a post-graduate clinical supervised internship.

At the end of 2006, the President signed into law a sweeping veterans' bill that finally added Marriage and Family Therapists (MFTs) as eligible providers of mental health services under the Veterans Administration (VA), Public Law 109–461. As one of the five core mental health professions (designated by the Heath Resources and Services Administration), Family Therapists are trained to treat disorders commonly faced by veterans, including clinical depression, post traumatic stress dirorder (PTSD), and schizophrenia, among others. Despite our on-going collaboration with leadership at the VHA and the law having been in effect for well over a year, the 52,000 U.S. Family Therapists are still awaiting implementation

of our services into the VA system so we can begin to aid our Nation's veterans, as we have served active-duty military for over 30 years. Family Therapists have been eligible to provide medically necessary mental health services to active military personnel and their families under the CHAMPUS/TRICARE program for decades, as well as through the Department of Defense. Additionally, Family Therapist interns serve veterans in VA facilities, but presently cannot continue this care as licensed MFTs since our VA implementation is incomplete.

The impact of mental illness on our veterans and their families is striking. Recognition of the need to expand VA mental health services to include families is growing as the impact of mental health disorders among veterans from OIF–OEF manifest, following their mustering out of military positions. A 2004 study by Hoge, Castro, Messer, McGurk, Cotting, and Koffman, demonstrated the significant mental health consequences from the wars in Afghanistan and Iraq. In *"Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care,"* from the *New England Journal of Medicine,* the estimated risk for PTSD from service in the Iraq War was listed at 18%, while the risk for PTSD from the Afghanistan mission was 11%. According to Sherman, Sautter, Jackson, Lyons, Han, in *"Domestic Violence in Veterans with post traumatic stress dirorder Who Seek Couples Therapy," Journal of Marital and Family Therapy,* October 2006, "domestic violence rates among veterans with post traumatic stress dirorder (PTSD) are higher than those of the general population. Individuals who have been diagnosed with PTSD who seek couples therapy with their partners constitute an understudied population."

Service member deployment length is intrinsically related to higher rates of mental health problems and marital problems. Within the U.S. military report, *"the Mental Health Advisory Team IV," (MHAT IV)* released on November 17, 2006 there have been at least 72 confirmed soldier suicides in Iraq since the beginning of OIF. As with previous MHAT reports, this study also found suicide rates were 28% higher compared with average army rates for those not deployed (16.1 vs. 11.6 soldier suicides per year per 100,000, respectively). For soldiers, deployment length and family separations were the top noncombat (deployment) issues. Marital concerns were higher than in previous surveys among Operation Iraqi Freedom troops, and like other concerns, they were related to deployment length. Those in Iraq more than 6 months were 1.5 to 1.6 times more likely to be assessed as having mental health problems. In addition, troops in Iraq for more than 6 months were more likely to have marital concerns (31% vs. 19%), report problems with infidelity (17% vs. 10%), and were almost twice as likely to be planning a marital separation/divorce (22% vs. 14%).

In post-deployment reassessment data completed in July 2005, Army researchers found that 21% of soldiers returning from combat areas were misusing alcohol a year after their return home; just 13% were found to misuse alcohol prior to deployment. Soldiers with anger and aggression problems increased from 11% to 22%, and the divorce rate rose from 9% to 15%. Those planning to divorce their spouse rose from 9% to 15% after time spent in the combat zone. With the rise in the psychological needs of our veterans, it is critical that they have access to the most appropriate providers, including Family Therapists at Vet Centers as well as at other VA facilities.

This urgency for access to qualified mental health practitioners within the VA is clear: "one of the most troubling problems facing the VA today is the near crippling effects of severe staffing shortages in nearly every conceivable staff category," reports the Eastern Paralyzed Veterans Association (EPVA). More specifically, monthly VA staffing surveys provided to the EPVA by the Veteran's Administration indicate significant shortages of mental health professionals (see position paper "Veterans Healthcare," October 2002).

This leads to an obvious problem hampering veteran access to mental health services—a shortage of qualified mental health providers in rural communities. One sure way of addressing the staffing problem is through increasing access to mental health services provided by practitioners who are widely present in rural communities; Family Therapists. AAMFT data shows that ***31.2% of rural counties have at least one Family Therapist,*** demonstrating our strong MFT representation in rural America. Improving access is crucial, particularly since the National Rural Health Association reports that the average distance for rural veterans to get VA care is 63 miles. This is unacceptable travel time for those who have already traveled the world on our behalf in pursuit of U.S. safety and security. Our service members deserve more than this to help make a seamless transition out of active duty and into veteran status.

The use of mental health services provided by MFTs toward this seamless transition is more than just a geographically logical fit. A meta-analysis of applicable research found that the use of family psychotherapy has been shown to significantly

improve the lives of individuals experiencing clinical depression by addressing the cognitive, behavioral and interpersonal aspects of this debilitating disorder within a systemic context *(Beach, S., M.D. Marital and Family Therapy for Depression: Empirically Supported Treatments and Implications for Clinical Decision Making, 2002).* Don R. Catherall, Ph.D., in *"Family Treatment When a Member Has PTSD"* from *NCP Clinical Quarterly,* indicates that "unlike many forms of individual therapy, families rarely remain in treatment if they can not see its immediate relevance to the concerns which brought them to seek help. Though we may view a family's problems as a result of traumatization, we will not be permitted to successfully probe the trauma unless the family can be helped to see how the presenting problem(s) is linked to the traumatization. When the family therapist can demonstrate such a link, he or she then has a mandate to pursue the traumatized material . . ." Additionally, according to Ralph Ibson of Mental Health America, "VA healthcare, and particularly mental healthcare, would often be more effective if barriers to family involvement were eliminated."

I feel that what has set these most recent wars apart from the Vietnam War is the enduring appreciation and respect for the men and women in uniform who, despite their personal misgivings, answer the call to serve their country in war. We as a Nation and as mental health professionals owe them and their families the very best help possible for as long as it is needed. On behalf of the AAMFT and myself, I trust that this special hearing coupled with our continued collaborations on the expansion of VA mental health services, contributes to that goal.

Prepared Statement of Ralph Ibson, Vice President for Government Affairs, Mental Health America

Mr. Chairman and Members of the Subcommittee:

Mr. Chairman, Mental Health America commends you for scheduling this hearing, and for your and this Committee's ongoing concern about the mental health of our veterans.

Mental Health America (MHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. In partnership with our network of 320 state and local Mental Health Association affiliates nationwide, MHA works to improve policies, understanding, and services for individuals with mental illness and substance abuse disorders, as well as for all Americans. Established in 1909, the organization changed its name in 2006 from the National Mental Health Association to Mental Health America in order to communicate how fundamental mental health is to overall health and well-being. MHA is a founding member of the Campaign for Mental Health Reform, a partnership of 17 organizations which seek to improve mental healthcare in America, for veterans and nonveterans alike.

This morning's hearing raises far-reaching questions relating to the toll of military engagement and the responsibility of our country and its institutions to those who bear the costs of war.

This country has a long, honorable tradition of keeping faith with those who have served in uniform. We can be proud of the comprehensive system of veterans' benefits Congress has established and of its creation of a cabinet-level department that administers those benefit programs. Congress has, of course, long supported the operation of a nationwide healthcare system in the Department of Veterans Affairs dedicated to providing needed care, rehabilitation and readjustment services. That system focuses on the veteran, and, in accordance with law, gives priority and the fullest array of benefits to those with service-incurred health conditions. How should that system respond to war-related mental health needs experienced by families of returning veterans?

Unique Impact of Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) on Families

More than 1 million American troops have served in the Global War on Terrorism. Their service has been unique in several respects. Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) have relied to a greater extent than ever before on the "citizen-soldiers" of the National Guard and Reserve forces. These operations have called on our forces to an unprecedented degree to undertake both extended and multiple deployments. Service members in previous wars were typically young and without families. In contrast, some 58 percent of those in our armed forces are married, and nearly 2 million children have been affected by deployments since Sep-

tember 2001. Increasingly we are coming to realize that the strains this war has placed on our armed forces overall mirror in many respects the strains it has placed on individual combatants and on their families.

While there is widespread recognition of the extent of post traumatic stress dirorder (PTSD) and other war-related mental health problems among those who served in Iraq and Afghanistan, much less attention has been given to the strain these military operations have had on the mental health of service-members' families. We are only beginning to appreciate fully the implications of those problems on veterans' readjustment and mental health.

As many have observed, military deployment, particularly for National Guardsmen and Reservists, can be enormously stressful on families who may have had little time to prepare, and lack military and community support systems. This war has involved unique stresses on service families related to combat exposure, length of deployments, and the high incidence of casualties. These stresses have been compounded in a war marked by repeated deployments (and short turnarounds before redeployment) and in which high percentages of service members have experienced traumatic events. Hoge et al (2004), reporting on a survey of 894 soldiers who served in Iraq, found that 95% had observed dead bodies or remains, 93% had been shot at, 89% had been attacked or ambushed, 65% observed injured or dead Americans, and 48% had killed an enemy combatant. Families experience measurable distress associated with service members planning to redeploy as soon as 12 months after returning from a fifteen-month deployment and from the constant sense of danger associated with graphic media coverage of daily battles and casualty reports. (Flake, et al., "The Effects of Deployment on Military Children", 2007).

The strain that war places on families and marriages does not necessarily end with the veteran's homecoming. The post-deployment period following a joyous homecoming can also be a time of difficult readjustment. As one writer put it, "in many instances, a traumatized soldier is greeting a traumatized family, and neither is 'recognizing' the other" (Hutchinson and Banks-Williams, 2006, p. 67). Clinicians have described adjustment reactions among OIF/OEF veterans that include feeling anxious, having difficulty connecting to others, experiencing sleep problems, strains in intimate relationships, as well as problems with impulse control and aggressive behavior. (Bowling, U.B., & Sherman, M.D. (in press). "Welcoming them home: Supporting soldiers and their families with the tasks of reintegration." Professional Psychology: Research and Practice.) These understandable reactions complicate the process of reintegrating an individual back into family life.

Family reintegration may be still more difficult in instances where veterans are grappling with PTSD or other mental health conditions. In the case of a veteran with PTSD, for example, that disorder has been associated with severe, pervasive negative effects on marital adjustment, general family functioning, and the mental health of partners, with high rates of separation and divorce and interpersonal violence. PTSD can also have a profound impact on veterans' children. Indeed there is cause for real concern regarding the war's impact on these children. Data from a recent study indicate that one in three families with a deployed service member identified a school age child as "at high risk" for psychosocial difficulties (Flake, 2007). While there has not been much research on the effects of war on military children, the literature does show that parental wellness is the single most predictive factor of child wellness.

Clearly, the family has a profoundly important role to play in veterans' readjustment, especially in the case of veterans who have sustained injuries or deep psychological wounds. As VA's Special Committee on post traumatic stress dirorder (a statutorily created panel of clinicians which reports annually to VA and to Congress) has advised, "the strength of a war fighter's perceived social support system is one of the strongest predictors of whether he/she will or will not develop PTSD." But family members who are scarred by the trauma of long separations and multiple and extended tours of duty, and in some cases by their own experience with depression or anxiety, may not have the capacity to provide that needed support.

In assessing the wide range of post-deployment mental health issues confronting veterans and their families, VA's Special Committee on PTSD advised in a February 2006 report that "VA needs to proceed with a broad understanding of post deployment mental health issues. These include Major Depression, Alcohol Abuse (often beginning as an effort to sleep), Narcotic Addiction (often beginning with pain medication for combat injuries), Generalized Anxiety Disorder, job loss, family dissolution, homelessness, violence toward self and others, and incarceration." The Committee advised that "rather than set up an endless maze of specialty programs, each geared to a separate diagnosis and facility, **VA needs to create a progressive system of engagement and care that meets veterans and their families where they live. . . .** The emphasis should be on wellness rather than pathology;

on training rather than treatment. The bottom line is prevention and, when necessary, recovery." Importantly, the Special Committee also advised that **"Because virtually all returning veterans and their families face readjustment problems, it makes sense to provide universal interventions that include education and support for veterans and their families coupled with screening and triage for the minority of veterans and families who will need further intervention."** [Emphasis added.]

Strengthening family relationships can be crucial to a veteran's mental health. But despite recognition in the VA regarding the mental health needs of returning veterans' families and the importance of engaging family members in the veteran's readjustment and treatment, current law and practice limit VA's assistance to, and work with, family members.

Roles for the Department of Veterans Affairs

VA is an integrated healthcare system which offers a relatively full continuum of care and services for eligible veterans. But whether or not VA staff provide counseling or other support to members of the immediate family of a veteran returning from war appears to vary by facility. A veteran with PTSD, for example, could receive services for that condition at a VA medical center, an outpatient clinic, or at one of VA's "Vet Centers" that are operated independently of VA medical centers and clinics. Family therapy is often a component of the readjustment counseling provided at Vet Centers. But veterans who live far from a Vet Center and who rely instead on a VA medical center or clinic often encounter a system that focuses on the veteran-patient (rather than on the veteran as part of a family unit) and generally does not provide counseling and related services to family members. (And yet there are a number of VA medical centers that for years have provided family consultation and education and longer term family psycho-education, employing a program developed by VA clinicians. See Operation Enduring Families, www.ouhsc.edu/safeprogram; Sherman, M.D. (2003)). The S.A.F.E. Program: A family psycho-educational curriculum developed in a VA Medical Center. Professional Psychology: Research and Practice, 34(1), 42–48.)) Such variability in a national healthcare system is perplexing. It is difficult to conceive of a sound programmatic rationale for engaging family support at one particular set of facilities (Vet Centers) and not at VA medical centers and clinics, particularly when each of these facility models provides services to OIF/OEF veterans with PTSD, for example. VA healthcare, and particularly mental healthcare, would certainly be more effective if barriers to family engagement were eliminated.

Current law appears to cause difficulty. In the case of a veteran being treated for a service-connected condition, current law states that "the Secretary shall provide such consultation, professional counseling, training, and mental health services as are necessary in connection with that treatment." (38 U.S. Code section 1782(a)) But with respect to any other veteran, VA may provide such services to family members but only where the services had been initiated during a period of hospitalization and continuation is essential to hospital discharge. (38 U.S. Code section 1782(b).) Under that provision, VA might conclude that family services could not be provided where it is treating an OIF/OEF veteran who has not been adjudicated service-connected and is not hospitalized. But while current law provides broad authority to furnish needed mental health services to family members of veterans who are service connected, we are not aware that any VA facilities are providing (or contracting for provision of) mental health services (other than consultation, education and psycho-education) to family members. Yet current law surely contemplates that VA would provide, or arrange to provide, mental health services to a spouse whose anxiety or depression, for example, compromised the readjustment or treatment of a veteran who is service-connected for PTSD.

Certainly, there is potentially great benefit to a veteran under VA treatment for a mental health problem from having VA also counsel or provide needed mental health treatment to a spouse. We see no compelling reason to foreclose VA from making such services available to family members of OIF/OEF veterans. To the contrary, the family has a unique role to play in providing support, and it is entirely consistent with VA's mission to help family members carry out that role. However the law now makes a distinction, relating to provision of family services, between a veteran being treated for a service-connected and a nonservice-connected condition. But it is noteworthy that VA is authorized to provide medical care and services (subject to a 5-year time limit in the case of veterans) to OIF/OEF veterans who are not otherwise eligible for VA care. This special eligibility effectively treats the veteran who served in a combat theater on what amounts to a presumptive service-connected basis. Given that the law effectively considers health problems experi-

enced by combat veterans as though they are service-connected for treatment purposes, there appears no obvious rationale for treating an OIF/OEF veteran's mental health problem differently for purposes of counseling family members. In fact, the language in current law, linking provision of family services to the goal of hospital discharge appears to be a relic of a long-abandoned provision of a prior eligibility law. Congress should have no hesitation about amending current law to enable family members of OIF/OEF veterans to get counseling and services that would enable them to better support the veteran in his/her treatment.

VA clinicians have pioneered and developed impressive programs that provide family members early intervention and support and aim to prevent long term problems (See Operation Enduring Families). We would hope to see such programs far more widely implemented across the system. But as you recognized, Mr. Chairman, in developing the Veterans Healthcare Improvement Act of 2007, H.R. 2874 (which the House passed last July), many of our veterans—especially in the National Guard and Reserves—live in areas remote from VA facilities and must be provided reasonable access to needed services as well. Importantly, HR 2874 makes provision for partnering with community mental health centers and similar providers where VA cannot reasonably provide that care in its own facilities.

Congress has already established a basic principle that should guide provision of family mental health services for OIF/OEF veterans. As reflected in section 1782(a) of title 38, VA should provide counseling and mental health services to immediate family members when those services are necessary to support the veteran's treatment. Just as long-distance travel may make it necessary for VA facilities to develop sharing agreements or to contract with community partners to provide veterans needed treatment, VA should look beyond its four walls in those instances where it lacks adequate staffing or facilities to provide counseling and related services to family members.

Mr. Chairman, given the importance of outreach and early intervention to ameliorate the potential for more serious and chronic mental health problems among OIF/OEF veterans, we urge Congress to foster the broadest possible efforts to provide counseling, support and services to meet the war-related mental health needs of veterans' families.

Ultimately, however, one might ask a broader question: can and should the Department of Veterans Affairs pursue a broader role than it has to date in meeting the mental health needs of returning veterans, and by extension those of their families? Systemwide, VA has not mounted an effort to engage family members, a particularly striking lapse in the case of OIF/OEF veterans who are service-connected for PTSD or other mental health problems. In our view, the Department has also been timid and unimaginative in looking beyond its own facilities even to meet OIF/OEF veterans' needs, and has been appropriately criticized for a largely passive stance in failing to reach out aggressively to the approximately 500 thousand OIF/OEF veterans and their families—a population at significant risk of readjustment and mental health problems—who are not under VA care for any condition. Despite the limited reach of its facilities in rural America, VA has only minimally pursued opportunities for partnerships with community providers of mental health services, resulting in widespread disparities in access to mental health services. And it has failed to heed the advice of its expert advisory body, the Special Committee on PTSD which urged the Department to mount a program of education and support for all returning veterans and their families. It may be that such an undertaking is beyond the scope of the Department's capacities, but—despite widespread and profound national concern regarding the mental health issues facing many OIF/OEF veterans and their families—VA has clearly neither budgeted for such an initiative nor, to our knowledge, reached out to other potential partners (to include its sister agency, the Substance Abuse and Mental Health Services Administration) to assist in such an initiative.

Mr. Chairman, we would welcome the opportunity to work with the Committee to further develop these issues in support of our troops, and I would be pleased at this time to answer any questions you might have.

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I am here today 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 dirorder 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 heath 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 U.S. 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 Vietnam 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 par-

ticularly 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 Vietnam 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 healthcare 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 healthcare, 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 communization 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% 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 stress dirorder symptoms they bear. Over 29,000 of our veterans have been wounded and 25% 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 overall 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. PowerPoint's 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 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 neurochemistry 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 time frames 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 time frame 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 & 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 healthcare 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 support 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 every day.

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 & I have erected walls around us & 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.

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Prepared Statement of Scott N. Sundsvold, Assistant Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates this opportunity to share its views on mental health treatment for families of veterans. Mr. Chairman, in order to ensure this nation's veterans receive a complete continuum of care, families of those injured must receive the most appropriate treatment to understand, accommodate, and transition with the veteran.

When military personnel are deployed, the families are the most tangible source of trust and disclosure. They are affected by the letters, emails and phone calls from those deployed. Although they aren't the actual personnel deployed, their love and care of those who are in the way of danger may indeed cause permanent stress related issues. When their loved one returns from deployment, there is yet another possible stressor, the transition from military duty to civilian life.

Department of Defense and Seamless Transition

According to a 2005 Department of Defense (DoD) Survey of Health-Related Behaviors among Military Personnel (DSHRB), 74 percent of active duty personnel cope with stress by talking with a friend or family member. Spouses and family members are often the first to recognize when service-members require assistance.

The National Defense Authorization Act for Fiscal Year (FY) 2006 directed the Secretary of Defense to establish a Task Force to examine issues relating to mental health and the Armed Forces and create a report containing an assessment of, and recommendations for improving, the effectiveness of mental health services provided to members of the Armed Forces.

The report's introduction spoke on this nation's involvement in the Global War on Terrorism (GWOT) and the unforeseen demand on military members and their families. It was also stressed that DoD must expand its capabilities to support the psychological health of its service members and their families.

According to the Task Force, data from the Post-Deployment Health Re-Assessment indicate that 38 percent of Soldiers and 31 percent of Marines report psycho-

logical symptoms. Among members of the National Guard, the figure rises to 49 percent; that includes Air Force, Army, and Navy. It further reported psychological concerns were significantly higher among those with repeated deployments.

There were also psychological concerns among family members of deployed and returning Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans, in addition to the hundreds of thousands of children being affected by the deployment of a parent. The vision of this group of professionals was to also ensure service-members and their families receive a full continuum of excellent care in both peacetime and wartime, but particularly when service members have been injured or wounded in the course of duty.

In June 2007, The Defense Health Board Task Force on Mental Health released the report titled, "An Attainable Vision". This report derived from the Task Force's visits throughout the military community at 38 installations worldwide. According to the Task Force, the Military Health System lacked the fiscal resources and personnel to fulfill its mission to support psychological health.

Mr. Chairman, these findings also imply that if the treatment was insufficient during the military member's term of service, the veteran's issues don't vanish upon entry into the civilian community and they often affect the family as well.

However, the Task Force did make several recommendations to improve care for service members and their families, to include, ensuring a full continuum of excellent care for service members and their families, underlined by, continuity of care, which is often disrupted during transitions among providers, as well as filling gaps in the continuum of care for psychological health and addressing which services are offered, where services are offered, and who receives services, especially since the entire family are military health care beneficiaries.

The findings and recommendations reported by the Task Force suggest an elevation of family involvement in mental health treatment. When transitioning from military to civilian life, veterans and their families' full continuum of care should not be stifled by excluding this proven effective treatment.

Department of Veterans Affairs

Currently, the VA does not have the authority to include veterans' family members in treatment for mental health concerns. The American Legion is in agreement with the statement by Secretary of Defense, Robert M. Gates, who stated, "care for our wounded must be our highest priority." This statement includes those affected both mentally and physically.

According to the Task Force report, the cost of mental illnesses extends beyond discharge from military service. Of the 686,306 OIF/OEF veterans separated from active duty service between 2002 and 2006 who were eligible for VA care, 229,015 or 33 percent accessed care at a VA healthcare facility. Of those 229,015 veterans who accessed care since 2002, approximately 83,889 received a diagnosis of or were evaluated for a mental disorder, including post traumatic stress dirorder, non-dependent abuse of drugs, and depressive disorder. With the enactment of Public Law 110–181, OIF/OEF veterans' access to free VA healthcare has been extended from 2 years to 5 years. Therefore, additional potential mental health patients can be expected.

There was also a recognized need for extensive family involvement in the long-term process of rehabilitation and community reintegration, to include close involvement of families in the recovery process, as well as greater responsiveness in the treatment of family members' needs.

Vet Centers as an Example

The VA's Vet Centers, created in 1979, were designed to provide services exclusively for veterans who served in theaters of conflict or experienced trauma within the military.

In 2007, The American Legion conducted site visits to various Vet Centers throughout this nation, to include Puerto Rico.

During these visits, it was reported that successful services provided ranged from marriage/couple's counseling to reunion debriefings. However, no mental health services for family members were provided. Also offered was family therapy for veterans suffering from mental illnesses, ensuring that the veteran's immediate support network is prepared to care for and cope with the veteran's mental health issues, but no mental health support for the veteran's immediate family members.

The success of services provided within VA and their satellite facilities as they relate to veterans and their families should be extended, to include mental health treatment for family members to fully ensure a complete and successful transition into the community.

Conclusion

The DoD and VA have initiated steps to integrate programs for treating service-members who suffer from mental illnesses. To ensure treatment is consistent, the VA's Office of Seamless Transition assigned case managers at major Military Treatment Facilities to identify and assist service-members whose care will be extended to the VA. Currently, a memorandum of agreement (MOA) between DoD and VA provides referrals to VA Medical facilities for health care and rehabilitation for those who have sustained spinal cord injury (SCI), Traumatic Brain Injury (TBI), and blindness.

Mr. Chairman, to ignore the need for mental health support for family members invalidates the meaning of "full continuum of care." The American Legion urges Congress to appropriate sufficient funds for VA to ensure comprehensive mental health services are available to veterans and their family members.

Mr. Chairman and Members of the Committee, The American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you to improve the lives of America's veterans and their families. Thank you.

Prepared Statement of Joy J. Ilem, Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this hearing to consider care and support programs by the Department of Veterans Affairs (VA) for personal caregivers of severely disabled veterans, with a special focus on examining the need to provide mental health treatment for family members of veterans dealing with serious physical injuries and/or post-deployment readjustment issues. We are pleased to appear before the Subcommittee today to discuss this timely and important topic.

Mr. Chairman, as an organization of 1.3 million service-disabled veterans, DAV has a growing concern about the effects of wartime exposures we are seeing in the newest generation of disabled veterans of the wars in Iraq and Afghanistan. Reflecting the current challenges in military service, specifically, frequent multiple deployments for many service members, and the stress-related mental health conditions resulting from wartime experiences and inadequate rest between deployments, we believe these disabled veterans and their families have some new and unique needs that Congress should address to enable VA to begin meeting them.

Many severely wounded and disabled veterans require continuous and intensive family caregiver support that may last from a few months to many years, to a lifetime depending on individual circumstances. In most of these cases, a spouse, parent or other family member, or significant other assumes the role of primary caregiver, often leaving behind jobs, college or other personal goals and responsibilities. The impact of service-related polytraumatic injuries and mental health problems exact a severe toll not only on the veteran but on military and veteran family members as well. Currently VA has limited authority to provide caregiver assistance, counseling and related services but lacks a comprehensive and cohesive program to ensure these families receive adequate support. The one exception is VA's spinal cord injury program, which we believe could serve as an excellent model for polytraumatic injured veterans and their families.

In that exceptional program, family members of spinal cord injured veterans are properly educated and trained to deal with symptoms of, and how to live with someone who has experienced this type of devastating injury. This type of program could easily be adapted to veterans who have polytrauma including Traumatic Brain Injury (TBI), post traumatic stress dirorder (PTSD,) depression and/or anxiety disorders, substance-use disorders, and other post-deployment mental health problems. If left untreated, these conditions can destroy marriages and ultimately separate families, and even result in homelessness and criminal convictions. When such breakdowns occur, these disabled veterans have the potential to become more dependent on VA and other public agencies to provide substitute services, with higher costs and more social consequences for them and society as a whole. Likewise, during this transitional period caregivers themselves are at risk for stress-related mental health disorders and adverse physical health effects. For this reason, we support and recommend that Congress authorize, and VA should be required and funded to provide, a full range of psychological and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum, this benefit should include relationship and marriage counseling, family counseling, technical training and related assistance for the families coping with the stress and

continuous psychological burden of caring for a severely injured or permanently disabled veteran. VA should provide such services at every medical center and substantial community-based outpatient clinic. When warranted by circumstances, these services should be made available through other means, including the use of telemental health technology and the Internet. When necessary because of scarcity or rural access challenges, VA's local adaptations should include consideration of the use of competent, trained community providers on a fee or contract basis to address the needs of these families.

We note that in December 2007, VA announced that it would dedicate $4.7 million to help caregivers through a variety of caregiver assistance pilot programs at VA medical centers across the country. These programs are intended to help expand and improve healthcare education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. VA reported the key services provided to caregivers are: transportation, respite care, case management and service coordination, assistance with personal care related to activities of daily living, social and emotional support, and home safety evaluations. VA also notes that caregivers are taught skills such as time management techniques, medication management, communication skills with the medical staff and the veteran, and ways to take better care of themselves. We are pleased that VA has initiated these important programs and we look forward to a report on their effectiveness and consumer satisfaction rates. We recommend that VA expeditiously develop a long-term comprehensive program based on the best-practices garnered from these pilot programs. We are encouraged that many of the projects use technology, including computers, Web-based training, video conferencing and teleconferencing to support the needs of caregivers who often cannot leave their homes to participate in support activities.

Gaps in services and the issue of more fully addressing the needs of caregivers has also been discussed in the President's Commission on Care for America's Returning Wounded Warriors (Dole/Shalala) and the Veterans Disability Benefits Commission (VDBC). Recommendations from these Commissions include: extending TRICARE coverage for respite and aid and attendance benefits for seriously injured service members; extending the Family Medical Leave Act coverage to family members of a veteran who has a combat-related injury; the need for additional caregiver training and counseling for family members of seriously injured veterans; extension of the Civilian Health and Medical Program of the Department of Veterans Affairs or CHAMPVA program and creation of a "caregiver allowance" for caregivers of severely injured disabled veterans.

The main direct health benefit that accrues to family members of seriously disabled veterans is through CHAMPVA. This program provides health insurance coverage for immediate dependent family members of veterans with disabilities that are permanent and total in nature, and survivors of veterans who die from service-connected disabilities, provided they are not eligible for health benefits under the Department of Defense (DoD) TRICARE program. Within CHAMPVA the so-called in-house treatment initiative or "CITI" program allows family members to use VA medical centers for their care on a voluntary basis, but we understand this program has been nearly phased out in most areas due to lack of available capacity. Other than CHAMPVA, care for immediate family members is limited to care or treatment that furthers treatment goals for veterans under VA care, and bereavement counseling for dependent survivors of a servicemember who dies on active duty. Travel and transportation benefits are restricted to dependents who are CHAMPVA beneficiaries, and to immediate family members receiving counseling, treatment or education on behalf of a veteran who has a service-connected disability. As noted in the VDBC recommendations, expansion of the CHAMPVA program could benefit primary caregivers of veterans with lower rated service-connected conditions such as mild to moderate TBI but who need constant supervision of a caregiver to help with personal care, daily living skills, attending medical and rehabilitation appointments and emotional and advocacy support.

As direct caregivers, immediate family members of severely injured or ill veterans of Operations Iraqi and Enduring Freedom (OIF/OEF) face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical, emotional and mental health issues of the severely wounded or ill veteran, plus deal with the complexities of the systems of care that these veterans must rely on. At the same time, they struggle with disruption of family life, interruptions of personal and professional goals, employment, and dissolution of other "normal" support systems that existed beforehand—all because of the changed circumstances resulting from the veteran's injuries and illnesses. We discussed these challenges in the *Family and Caregiver Support Issues Affecting Severely Injured Veterans* section

of the *Independent Budget* for FY 2009 and refer the Subcommittee to that section for more detail.

Beyond the need for mental health services for family caregivers we agree that as early as practicable every family of a severely injured or ill veteran from OIF/OEF should be assigned a trained, knowledgeable and professional advocate. The advocate's essential function should coordinate military, VA and other federal programs that provide services, benefits and family support services, including inpatient, specialty and primary care, mental healthcare and counseling for veterans and, where needed, family caregivers—rehabilitation, transition and community reintegration assistance, home care, respite care, vocational services, financial services, and child care services. The advocate should be assigned to support each severely disabled veteran for as long as services are required for the family. We note VA's appointment of 100 "patient advocate" positions and recent announcement of the appointment of 10 "recovery coordinators," and appreciate this development and urge additional personnel be assigned to such duties for recently separated disabled veterans as necessary. However, unless a restructured more flexible system of benefits for caregivers is authorized by Congress, we are concerned that these advocates and recovery coordinators may not focus on family-support issues to the extent warranted by their situations.

DAV believes that a strong case management system should be designed to promote a smooth and transparent handoff of severely injured and ill veterans and their family caregivers between DoD and VA facilities. This case management system should be held accountable to ensure uninterrupted support as these veterans return home, when and where family caregivers become their critical link to VA services.

With the wars in Iraq and Afghanistan the demographics, family dynamics and cultural expectations of disabled veterans and their families have changed—and so too should the VA benefits and services package. A severely injured veteran's spouse is likely to be young, have dependent children, and reside in a rural area where access to support services of any kind can be limited. An increasing number of the severely injured are from Reserve components. Their families likely have never lived on military bases and do not have access to the numerous and often vibrant social support services and networks connected with military life, such as the DoD Family Advocacy Program. That program, available only to active duty personnel, pays for counseling for military service members, for services such as counseling for school truancy of their children, provides a variety of counseling and care services for emotional and behavioral problems within families, and is a source of emotional support to families at home during service members' long deployments overseas. Many parents and siblings are included in pre- and post-deployment counseling and reintegration programs by the military services advocacy centers. However, no equivalent VA program exists for veterans, even severely service-disabled veterans. While the circumstances of a military family during deployments are dissimilar to that of families of severely disabled veterans, the changed conditions in these families warrant a new program with similar aims: to care for and comfort these families, and provide relevant and specialized support and counseling services when they need them.

As indicated earlier in this testimony, spouses must often give up their own employment (or withdraw from school in many cases) to care for, attend, and advocate for the seriously injured or ill veteran. This can have a direct impact on their long-term earnings capacity for retirement and other benefits. Caregivers also often fall victim to bureaucratic mishaps in the shifting responsibility for conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA disability compensation and Social Security Disability benefits) that they must rely upon for subsistence in absence of other personal income or savings. Additionally, for many younger, unmarried disabled veterans their primary caregivers remain their parents, who have limited eligibility for military assistance, often are on limited incomes themselves, and have very limited eligibility for VA benefits or services of any kind. They, too, face the same dilemmas as spouses of severely injured or disabled veterans, and we believe Congress should also address the needs of parents who have returned to the basic caregiver role for their severely injured or ill children.

Immediate family caregivers (including parents in many cases) must cope with tremendous personal stress. Unfortunately, the government support systems they may need are limited or restricted, often informal, and are clearly inadequate for the long term. Within the military itself, TRICARE mental health benefits are reported to be inadequate. In VA, the spouse of an enrolled veteran is eligible for limited VA mental health services and counseling but only as a so-called "collateral" of the veteran. Outside the VA's readjustment counseling services program or VET

Centers—such services are infrequent across the VA healthcare system. We understand that one place mental health services are being provided for family members are at VA polytrauma centers. VA clinicians indicate that they are providing a significant amount of training, instruction and counseling to spouses and parents of severely wounded or ill veterans who are already attending to these veterans during their hospitalizations. However, local VA officials are concerned about the absence of legal authority to provide these services to family members, and that scarce resources that are needed elsewhere are being diverted to these needs, without recognition in VA's internal resource allocation system. Thus, medical centers devoting resources to family caregiver support are penalizing themselves in doing so, but they clearly have recognized the urgency of this need and are trying to meet it, despite these concerns. We believe Congress must provide clear permanent authority in the law so that these services can be provided throughout the system when needed.

The most seriously injured or ill veterans and their families embark on a very long and often difficult journey *together*. Without question—these family caregivers are the unsung heroes. We recognize that family support is critical to a veteran's successful rehabilitation; therefore, these families need training and support so they do not become overwhelmed with responsibilities in caring for these extraordinary veterans. We believe our recommendation has equal applicability to families faced with extreme physical challenges as well as those who are challenged by mental illness following wartime service. To this end, VA should establish a specialized respite pilot program that includes a dual track initiative for severely disabled veterans *and* family members. The goal would be to furnish training for family members in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured or ill veterans. Recognizing the tremendous disruption to their lives, the pilot program should focus on helping the veteran and other family members restart their lives (the true definition of "rehabilitation") after surviving devastating injuries or life-changing illnesses. The track for the veteran should focus on rehabilitation and coping skills while an integral part of this program should include family counseling and family peer groups so they can share solutions for the set of common problems they face.

Today, VA's system for providing needed rest or respite care for an immediate family caregiver, generally is governed by local VA nursing home care unit (NHCU) and adult day healthcare (ADHC) policies. We mention this program because we believe that respite care is a necessary mental health benefit for caregivers. Understandably, these programs are targeted to older veterans with chronic illnesses, because the elderly veteran population has been a primary enrollee in VA healthcare. Nevertheless, many veterans who have survived horrific injuries in Iraq and Afghanistan, or bear the long-term mental scars of that combat experience, are still in the early parts of their lives. Thus, VA's NHCU and ADHC programs usually do not include a rehabilitative component and therefore remain unattractive to many OIF/OEF veterans' families. These programs need to be adapted or supplemented with new approaches or model of care to become more acceptable and attractive to this latest generation of disabled war veterans and their families. Caregivers have indicated that they must feel comfortable when they are leaving the veteran during the respite period and want to be assured their loved one is receiving quality care. We note that one of the VA caregiver pilot programs mentioned above offers 24-hour in-home respite care to temporarily relieve caregivers up to 14 days a year. This kind of service—offered in the home—may be an optimal setting for many severely disabled veterans.

We believe VA should establish a new national program to make periodic and age-appropriate respite services available to all severely injured or disabled veterans who need it. This program should be designed to meet the needs of younger, severely injured or ill veterans, as contrasted with the generally older veteran population now served by VA programs. Where appropriate VA services cannot be made available directly because of geographic barriers, VHA should develop contractual relations with appropriate, qualified private or other public facilities to provide respite services tailored to this population's needs. We appreciate the new authority Congress provided for VA to furnish age-appropriate nursing home programs for younger veterans, in section 1707 of the National Defense Authorization Act for Fiscal Year 2008. Nevertheless, we believe that family caregivers need more assurance that VA will also be available to help them actively care for, and will provide appropriate respite periods, as they take on this lifetime challenge of care-giving responsibility.

Based on this testimony and given the nature of these issues, and the unique situation that confronts our newest generation of severely disabled war veterans, DAV believes Congress and the Administration need to address a number of observed

deficits, at least those discussed above, to make a family caregiver's support role more manageable over the long term. This is in the best interests of these families, whose absence as personal caregivers and attendants for these seriously disabled veterans would mean even higher costs to the government to assume total responsibility for their care, and would lower the quality of life for the very veterans for whom VA was established to care for.

To summarize, we urge the Subcommittee to develop legislation or oversight that would accomplish the following goals:

- Provide a full range of psychological and social support services as a benefit to family caregivers of veterans with severe service-connected injuries or illnesses including relationship and marriage counseling, family counseling, and related assistance to the family coping with the inevitable stress and often discouragement attendant to caring for the severely disabled veteran.
- Appoint accountable advocates and case managers to each severely injured or ill veteran's family, empowered to assist with medical benefits and family support services, including vocational services, financial services, and child care services.
- Publish clear policies requiring every VA nursing home and Adult Day Healthcare Program to provide appropriate facilities and programs for respite care for severely injured or ill veterans. Facilities should be restructured to be age-appropriate, with strong rehabilitation goals suited to the needs of a younger veteran population, rather than expect younger veterans to blend with the older generation typically resident in VA NHCUs and ADHC programs.

As we have indicated in prior *Independent Budgets* and in testimony before this Subcommittee, we believe that VA must continue to adapt its services to the particular needs of this new generation of disabled veterans, and not simply require these veterans to accept what services are currently available. Likewise, such services should also be improved and available for previous generations of veterans with similar disabilities. In this matter of family assistance, VA will also need to make a cultural change from a system that focuses only on the needs of a veteran patient to one that embraces the challenges of family caregiving.

Mr. Chairman, this concludes my testimony on behalf of DAV. We hope you will consider our recommendations and develop legislation to deal with family caregiver issues for severely disabled veterans. I will be pleased to address any questions you or other Members of the Subcommittee may wish to ask.

Prepared Statement of Fred Cowell, Senior Health Analyst, Paralyzed Veterans of America

Mr. Chairman, and members of the Subcommittee, the Paralyzed Veterans of America (PVA) appreciates this opportunity to present its views and recommendations concerning how the U.S. Department of Veterans Affairs (VA) can best assist veterans with mental illness by providing counseling and education services to their families.

Mr. Chairman, evidence is growing that the prevalence of mental illness is high in veterans who served in Iraq and Afghanistan. Combat exposure coupled with long and frequent deployments are associated with an increased risk for post traumatic stress dirorder (PTSD) and other forms of mental illness. VA reports that Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans have sought care for a wide array of possible co-morbid medical and psychological conditions, including adjustment disorder, anxiety, depression, PTSD, and the effects of substance abuse. VA reported that of the 299,585 separated OIF/OEF veterans who have sought VA healthcare since fiscal year 2002, a total of 120,049 unique patients had received a diagnosis of a possible mental health disorder. Almost 60,000 enrolled OIF/OEF veterans had a probable diagnosis of PTSD, almost 40,000 OIF/OEF veterans have been diagnosed with depression, and more that 48,000 reported non-dependent abuse of drugs.[1]

The impact of a veteran's mental illness is far reaching and obviously has serious consequences for the individual veteran being affected. However, less obvious are the serious consequences, stemming from a veteran's mental illness, that confront his/her spouse, their children and other family members. Families of veterans pro-

[1] Department of Veterans Affairs, VHA Office of Public Health and Environmental Hazards. *"Analysis of VA Healthcare Utilization Among U.S. Global War on Terrorism (GWOT) Veterans: Operation Enduring Freedom, Operation Iraqi Freedom,"* January 2008.

vide the most basic support network for returning veterans. Spouses of veterans are usually the first to identify readjustment issues, and they are usually the best advocates for guiding the veteran into professional care. However, to provide correct guidance on treatment these family members must have a basic understanding of VA mental health resources and how to access them. This understanding can only come from comprehensive VA family counseling and education services.

Additionally, spouses and other family caregivers who provide love, support and assistance to the veteran must also cope with tremendous personal stress as well. Unfortunately, VA's Mental Illness family support services are limited or restricted. PVA believes that Congress should formally authorize, and VA should provide, a full range of psychological and social support services as an earned benefit to family caregivers of severely injured and ill veterans.

Family counseling support services that are needed by recently returning OIF/OEF veterans are only available, on a limited basis in VA, despite the increasing need for such services. For example, in the most recent survey of soldiers and marines in Iraq, which included a large number of reservists, 20 percent of soldiers and 13 percent of marines indicated that they were planning a divorce, double the rate found just two years ago.[2] Additionally, in a recent anonymous survey of Maine National Guard members, after repatriation from deployments, 36 percent acknowledged relationship problems with a spouse and/or children.[3] Despite this information few VA medical centers or VA community-based outpatient clinics provide any marital and/or family counseling.

Mr. Chairman, VA's Vet Center program has a long history of treating the mental health needs of America's veterans. Family counseling is provided when possible and as needed for the adjustment of the veteran. However, veteran's families represent the "frontline" of the support network for returning veterans. PVA believes, a veteran's successful mental health treatment often depends on the stability and understanding of his/her family unit. Therefore, PVA believes that VA should expand its support services for veteran's families. We support expansion of mental health services for veterans and counseling/education services for families in all VA major care facilities. However, in the near term, Vet Centers should increase coordination with VA medical centers to accept referrals for family counseling; increase distribution of outreach materials to family members with tips on how to better manage the dislocation; improve reintegration of combat veterans who are returning from deployment; and provide information on identifying warning signs of suicidal ideation so veterans and their families can seek help with readjustment issues.

PVA believes that an effective VA mental illness family counseling/education program can improve treatment outcomes for veterans, facilitate family communication, increase understanding of mental illness, increase the use of effective problem solving and reduce family tension.[4] PVA agrees with VA's Family Mental-Health Learning Program (FaMHeLP) when it says, "Working with family members helps both veterans and their families. Research has shown that family members of veterans with mental illness are happier when they fully understand the nature of the illness. Family members also want to learn the best ways to help their loved ones. Family members are often in a good position to help because they know the veteran better than anyone else. Veterans do better in their daily lives at home and work when they live with family members who understand their illness. These veterans are also less likely to have a mental health crisis."

PVA strongly believes that VA must embrace new models of support for the families of this generation of combat veterans. Family counseling support services that are needed by recently returning OIF/OEF veterans must be expanded. The spouse of a veteran with combat related mental illness is likely to be young, have dependent children, and reside in a rural area where access to support services of any kind can be limited. It is additionally possible that other individuals who play significant roles in the veteran's life such as, mom and dad, the significant other, the best friend, a brother or sister or a paid personal care attendant will also require access to these services. Whether the caregiver resides in an urban or rural setting, VA mental health services for veterans and services for veteran's family or caregivers members must be readily available.

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[2] Office of the Surgeon Multinational Force—Iraq (OMNF–I) and Office of the Surgeon General United States (OTSG), U.S. Army Medical Command, Mental Health Advisory Team (MHAT–IV), Operations Iraqi Freedom 05–05 Final Report, 17 November 2006.

[3] Wheeler, E. Self-Reported Mental Health Status and Needs of Iraq Veterans in the Maine Army National Guard. Community Counseling Center, 2007 (unpublished).

[4] FaMHeLP, North Florida/South Georgia Veterans Health System (NF/SGVHS) Psychology Service. For more information contact: Jennifer W. Adkins, Ph.D., Psychology Service (352) 246–1420 or Sheryl A. Conner, Ph.D. LCSW, Social Work Service (352) 246–1282.

PVA also believes Congress should formally authorize, and VA should provide, a full range of psychological and social support services as an earned benefit to family members of severely injured and ill veterans. At a minimum this benefit should include education on mental illness, relationship and marriage counseling, family VA benefit counseling, and related assistance for the family coping with the stress and continuous psychological burden of caring for a severely injured or mentally ill veteran.

As this Subcommittee moves forward with deliberations on how best to provide services to the families of veterans with mental illness it may be worth reviewing VA progress regarding section 214 of Public Law 109–461. Section 214 required VA to implement a pilot program to assess and improve caregiver assistance services. Public Law 109–461 required the VA Secretary to carry out the pilot over a 2-year period within 120 days following enactment of Public Law 109–461. Caregiver assistance referred to VA services that would assist caregivers such as:

- adult-day care
- coordination of services needed by veterans, including services for readjustment and rehabilitation
- transportation services
- caregiver support services, including education, training, and certification of family members in caregiver activities
- home care services
- respite care
- hospice services and other modalities of non-institutional VA long-term care

This list of services is part of VA's basic benefit package and is available to all enrolled veterans. PVA believes that the availability of these long-term care benefits should be a part of any family counseling/education program under consideration. Public Law 109–461 authorized $5,000,000 for each of fiscal years 2007 and 2008 to carry out the pilot project. PVA has made inquiries to VA regarding the status of the pilot project but has yet to receive a detailed briefing of the projects progress.

Finally, Mr. Chairman, PVA has over 60 years of experience understanding the complex needs of spouses, family members, friends and personal care attendants that love and care for veterans with lifelong medical conditions. Additionally, because some PVA members with spinal cord injury also have a range of co-morbid mental illnesses, we know that family counseling and condition specific education is fundamental to the successful reintegration of the veteran into society. Our experience has shown that when the veteran's family unit is left out of the mental illness treatment plan veterans with spinal cord injury who also have mental health conditions experience lifelong reoccurring medical and social problems. However, when family counseling/education services are provided by VA, veterans are more apt to become independent and productive members of American society.

Mr. Chairman, I would like to thank you again for the opportunity to address this important subject. This concludes my statement. I will be happy to answer any questions that you may have.

Prepared Statement of Thomas J. Berger, Ph.D., Chairman, National PTSD and Substance Abuse Committee, Vietnam Veterans of America

Mr. Chairman, Ranking Member Buyer, and other distinguished members of this Subcommittee, Vietnam Veterans of America (VVA) appreciates the opportunity to present our views on the need for the Department of Veterans Affairs (VA) to provide mental health assistance and treatment within VA medical centers for family members of veterans. VVA thanks you for your concern and leadership about the mental healthcare of our veterans' families, and in seeking out the views of veterans' service organizations on this very important, timely, and relevant issue.

As you are well aware, one of the recommendations of the Dole-Shalala Commission was to "significantly strengthen support for families." This will not be an easy task, but VVA believes this hearing can serve as the opening dialog on a very serious concern.

As more and more troops return home damaged emotionally and mentally as well as physically, their families must contend not only with the shock of seeing the physical desolation of their loved ones, but come to grips with the new reality of their lives, which have changed dramatically, and not for the better. Take for example a 35-year-old soldier or Marine with two children who returns home with what is diagnosed as Traumatic Brain Injury (TBI). His impairment affects the future of

the entire family. His, or her, spouse and children have to deal with his/her inability to concentrate, the mood swings, depression, anxiety, even the loss of employment. As you can imagine, the economic and emotional instability of a family can be as terrifying and as real as any difficulty focusing or simply waking and crying in the middle of the night. In cases of severely brain-damaged casualties, spouses, parents, and siblings may be forced to give up careers, forsake wages, and reconstruct homes to care for their wounded relatives rather than consign them to the anonymous care at a nursing home or assisted living facility.

VVA believes that the mental health stresses of war may be even greater for the families of those serving in the National Guard or Reserves in that deployment of these individuals often results in dramatic losses of income along with numerous legal and family complications affecting the children. These can include domestic violence and substance abuse. In addition, unlike family members of active-duty military who often have an established support system available to them on base, family members of Guard and Reserve troops must often struggle to create their own systems of support.

There will be cries that the VA medical facilities (with the notable exception of the VA VET CENTERS operated by the Readjustment Counseling Service) are not authorized to provide mental health treatment for the families of veterans. You will also hear that neither the military nor the VA (including the Vet Centers) has the organizational capacity or personnel resources to provide such. In addition, you will hear that there are issues about the intensity and drains of vitally needed family support that will be hard to sustain, as well as significant issues regarding the complexity of other medical and specialized needs that have to be addressed simultaneously with the mental health needs. All of this was true last year. However in calendar year 2007, thanks largely to the leadership of this Committee, Chairman Spratt, and Chairman Obey as well as the Speaker of the House more than $11 Billion was infused into the VA system, mostly for healthcare. Unfortunately this is only a start, albeit a very good start, toward restoring/building the organizational capacity needed to properly take care of veterans of every generation who have earned the right to healthcare by virtue of their service to country in uniform.

Frankly, much in the way of proper diagnosis of mental health in the veteran does not transpire on the primary care teams because those teams at many facilities are seeing too many veterans per clinician to be able to do the kind of thorough job of which they are capable. We need a funding level for the Veterans Health Administration that is significantly above the Administration's request, by at least $3 Billion (and that is just for health care).

VVA believes that many of these logistical and organizational challenges can be overcome through legislation that authorizes partnerships between the VA and professional mental health organizations (such as the National Council for Community Behavioral Healthcare, which represents 1,400 community-based mental health programs), as is already suggested in H.R. 2874, the Veterans' Healthcare Improvement Act of 2007, and its companion bill S. 38, the Veterans' Mental Health Outreach and Access Act of 2007. A model of such a collaborative partnership involving the VA, the Maine National Guard, and the Community Counseling Center, a local behavioral healthcare provider, has been in operation since 2006 in Portland, Maine, and has achieved positive results. The example of what is happening in Connecticut is another model of the type of creative partnerships and very effective and useful work that can be done when VA does not insist on having total bureaucratic control over all of the activities and care delivery in which they may play some role.

Vet Centers

Certainly, the experience at the Vet Centers, where families of veterans are in fact part of the therapeutic milieu, illustrates the importance and efficacy of providing counseling for family members. This can and ought to be extended, considering the current reality of too many of our troops returning to our shores discombobulated mentally, and too many family members frustrated and seemingly impotent about what to do to help them. Last year there was $20 million added to the VA budget for additional Vet Center staff in the Emergency War Supplemental Appropriation that was never spent to hire an additional 250 fulltime qualified clinicians in the existing Vet Centers, as directed in that legislation. Since the Readjustment Counseling Service did not receive the $20 million from OMB and the business office at VA Central office in time to hire any staff, what they did with the money was to purchase vehicles to do much more rural outreach, and do some long overdue computer enhancements.

VVA understands that the 100 non-clinician peer counselors that work for the Vet Centers have been converted to permanent positions, and that the Vet Centers have finally hired an additional 62 clinicians for existing centers since last summer. How-

ever, that is not nearly enough when you are talking about more than 200 service delivery points. If the Vet Centers are going to be able to utilize those vehicles to do much needed rural outreach and satellite sessions for a day per week at remote sites without taking away from the veterans currently being served by an overworked staff, then they need to hire additional personnel in the Readjustment Counseling Service. Why has the VA continued to refuse to hire adequate staff in the Vet Center system to meet the continually growing demand?

VVA is frankly puzzled as well as frustrated by this inaction on the part of the most senor leadership of the Veterans Health Administration (VHA), as the Vet Centers are our forward aid stations in regard to suicide prevention, PTSD, and readjustment counseling needs of combat veterans of every generation, but particularly those returning home today from Iraq and Afghanistan.

The Vet Centers are also the most studied of any VA program, and have consistently proved to be the most cost efficient, cost effective medical program operated by VA. They by and large do great work, AND they can serve the families as well. However, they can't do it unless VA will use some of the "new" additional funds to expand the size of the clinical staff of the Vet Centers.

Joint Hearings

It may be time to do a joint hearing with the authorizing and/or the appropriations Committees that oversee the Federal dollars that go to local community mental health programs, in order to see if there can be incentive funds made available for those centers to better serve the families of those returnees (as well as the families of those families while the service member is deployed).

Frankly, these citizens are in need now, and there are significant Federal dollars that flow through the Governors to these local communities. Because these problems are due to Federal service of the service member, it is only right that the funds from Health and Human Services (HHS) be increased specifically for this purpose. VVA stresses that these should be "fenced" funds that can only be used for this specific purpose of acquiring proper PTSD clinicians and family counselors, and training/retraining of existing staff of community mental health centers. VA must be mandated to fully cooperate and to provide training where possible to community leaders/clinicians.

This distinguished panel can make a difference by promoting the process of healing—of veteran and family member in a way that has never been done before if there is cooperation across the jurisdictions of the Congress.

I thank you for affording VVA the opportunity to present our views, and thank you for what you are doing to assist veterans and their families. I will be pleased to answer any questions you may have.

Prepared Statement of Todd Bowers, Director of Government Affairs, Iraq and Afghanistan Veterans of America

Mr. Chairman, ranking member and distinguished members of the committee, on behalf of Iraq and Afghanistan Veterans of America, and our thousands of members nationwide, I thank you for the opportunity to testify today regarding the mental health needs of military families. I would like to point out that my testimony today does not reflect the views of the United States Marine Corps. I am here testifying today in my civilian capacity as the Director of Government Affairs for Iraq and Afghanistan Veterans of America.

In my 10-year career as a Marine reservist, I have had the honor of serving in Iraq twice. When I returned home from my tours, I realized that combat deployments are hard on members of the Armed Services, but they are even more difficult for military families.

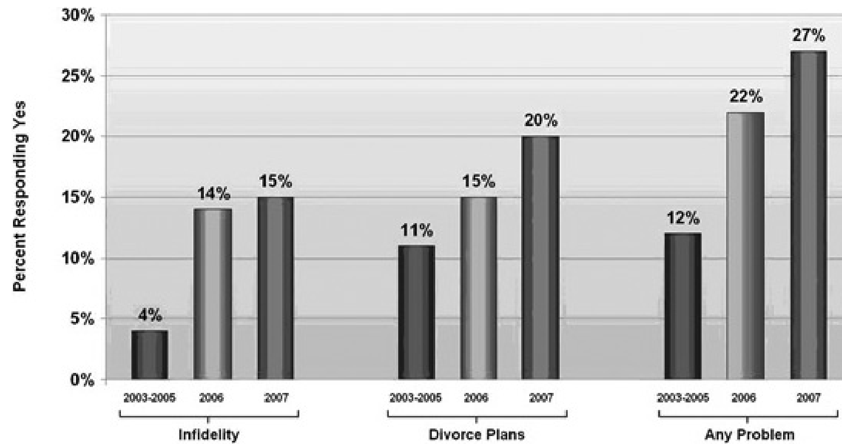
My family was no different. During my second tour in Iraq, I was wounded when a sniper's bullet impacted the scope on top of my rifle. Fragments of the bullet are still lodged in my face today, a constant reminder of how lucky I was on that hot October day in Fallujah. The circumstances surrounding my injury were so fantastic that I knew my parents would eventually hear about the incident. My command, and myself, felt it was important that I contact my family via satellite phone to inform them of what had happened. While this was the correct decision, I knew the impact on my loved ones would be tremendous. Over the phone I told my mother, "You can hear my voice. I'm alright."

But the incident that physically wounded me wounded my mother much worse. She had a difficult time understanding what had happened. In her own words: "I never knew why someone would want to shoot my Todd." While I was completing

my tour in Iraq, my mother needed help at home. My family lives far from the reserve center that I deployed from, and was not involved with any formal family counseling groups. Her only contact with fellow military families was via email or phone. As she struggled to cope with the knowledge of my injury, my mother was more than alone, she was lost. She sought assistance through the only means she was aware of, the mental health counseling covered by her own health coverage.

For the 1.6 million veterans of Iraq and Afghanistan, the stresses of deployment hit home. As the Committee knows, rates of psychological injuries among new veterans are high and rising. According to the VA Special Committee on PTSD, at least 30 to 40% of Iraq veterans, or about half a million people, will face a serious psychological injury, including depression, anxiety, or PTSD. Data from the military's own Mental Health Advisory Team shows that multiple tours and inadequate time at home between deployments increase rates of combat stress by 50%. These deployments, the Mental Health Advisory Team has concluded, also put families under tremendous strain; 27% of soldiers and Marines in Iraq are reporting marital problems.

Marital Problems Among Soldiers in Iraq



Over the course of the war, troops have reported growing concerns about marital infidelity. Twenty-seven% of soldiers now admit they are experiencing marital problems, and 20% of deployed soldiers say they are currently planning a divorce.
Source: Mental Health Advisory Team IV Final Report.

It is not only marriages that are being tested; more than 155,000 children have parents currently deployed in support of the wars in Iraq and Afghanistan, and 700,000 children have had a parent deployed at some point during the conflicts, according the American Psychological Association. According to the Pentagon, almost 19,000 children have had a parent wounded, and 2,200 children have lost a parent in Afghanistan or Iraq.

There are not yet conclusive numbers on divorce rates among Iraq and Afghanistan veterans. But the signs of family strain resulting from mental health injuries are clear. In a recent VA study of new veterans referred to VA specialty care for a behavioral health evaluation, two-thirds of married or cohabiting veterans reported some kind of family or adjustment problem. Twenty-two percent of these veterans were concerned that their children "did not act warmly" toward them or "were afraid" of them. Among those veterans with current or recently separated partners, 56% reported conflicts involving "shouting, pushing or shoving." Moreover, a May 2007 study in the *American Journal of Epidemiology* has suggested that deployments have also led to a dramatic increase in the rates of child abuse in military families.

For all of these reasons, concrete action is necessary to ensure that troops, veterans, and their families have access to mental healthcare. In the media and in Congress, IAVA has been at the forefront of efforts to improve military and veteran families' access to treatment for psychological injuries.

This year, I am proud to announce that IAVA has partnered with the Ad Council, the nonprofit organization responsible for some of America's most effective and

memorable public service campaigns, including “A Mind is a Terrible Thing to Waste,” “Only You Can Prevent Forest Fires,” and “Friends Don’t Let Friends Drive Drunk.” This summer, the Ad Council and IAVA will launch a multi-year campaign to destigmatize mental healthcare for servicemembers and their families. The broadcast, print, web and outdoor ads will encourage those who need it to seek mental healthcare and inform all Americans that seeking help is a sign of strength rather than weakness. We are very excited to partner with Ad Council to help get troops, veterans, and their families the care they need and deserve.

Mental health and support for veterans’ families are also key components of IAVA’s 2008 Legislative Agenda. One of IAVA’s six legislative priorities this year is new funding to combat the shortage of mental health professionals. The VA must be authorized to bolster its mental health workforce with adequate psychiatrists, psychologists and social workers to meet the demands of returning Iraq and Afghanistan veterans, including funding for Vet Centers to alleviate staffing shortfalls. While IAVA applauds the VA initiative to hire new Iraq and Afghanistan veterans as “Outreach Coordinators,” as of April 2007, VA numbers show that more than half of the 200-plus Vet Centers need at least one more psychologist or therapist. IAVA also supports the creation of new VA programs to provide family and marital counseling for veterans receiving VA mental health treatment. For the many military and veteran families who, unlike my family, are among the 47 million uninsured Americans, this may be their only access to the mental healthcare that they need to cope with the effect of the wars on their families.

I thank you for providing me the opportunity to testify before you this afternoon. All the data and IAVA recommendations I have cited are available in our Mental Health report and our Legislative Agenda. I have brought copies of our Legislative Agenda, and our report on Mental Health with me today for your convenience. It would be my pleasure to answer any questions you may have for me at this time.

[The IAVA report entitled, “Mental Health Injuries, the Invisible Wounds of War,” January 2008, will be retained in the Committee files. The report can be downloaded from the IAVA Web site at: http://www.iava.org/documents/Mental_Health.pdf.]

Prepared Statement of Kristin Day, LCSW, Chief Consultant, Care Management and Social Work Service, Office of Patient Care Services, Veterans Health Administration, U.S. Department of Veterans Affairs

Good morning, Mr. Chairman and members of the Subcommittee. Thank you for the opportunity to discuss mental health treatment for families and the Department of Veterans Affairs’ (VA’s) efforts to support those who support our veterans. I am accompanied by Dr. Ira Katz, Deputy Chief, Patient Care Services Officer for Mental Health in the Veterans Health Administration (VHA) and Dr. Alfonso Batres, Director of the Readjustment Counseling Service. I would like to request my statement be submitted for the record.

VA supports caregivers, including caregivers of wounded or ill veterans, by providing assessment, counseling and training related to the caregiver’s ability to provide adequate care. Specifically, this includes education about the veteran’s illness or disability, either mental or physical, and referral to community agencies for services VA is unable to offer. We offer visits to assess the adequacy of the home environment and the need for home equipment or modifications and can offer the same for vehicles. VA can contract for adult day healthcare up to eight hours per day, five days per week to allow family members to leave home for work or leisure.

As more fully described below, VA provides limited services to immediate 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 intent 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 to the veteran’s family in support of that treatment. We diligently extend these services under those circumstances. 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 in furtherance of a post-combat veteran’s successful readjustment to civilian life.

A number of caregiver and family support groups also meet with family members at our 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 limited caregiver authority. Thankfully, many veterans remain independent in the community because of neighbors, friends, and others who step in and provide assistance when family members cannot.

VA supports the families of our veterans every day, but we must continue to adjust not merely to clinical advances, but to demographic ones as well. The aging of our veteran population also represents unique challenges, and we are working with community-based resources to respond to their needs.

Our Voluntary Service 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 such needs.

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a comprehensive health care program in which VA shares the cost of covered health care services and supplies with eligible beneficiaries. CHAMPVA provides coverage, provided the dependents are not otherwise eligible for DoD TRICARE benefits, to the spouse or widow(er) and to the children of a veteran who is rated permanently and totally disabled due to a service-connected disability, was rated permanently and totally disabled due to a service-connected condition at the time of death, died of a service-connected disability, or died on active duty. CHAMPVA provides broad health coverage and includes a $50 annual deductible and 25% co-payment for services.

Turning to specific VHA program areas, 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 (TBI) 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 includes families in over 500,000 units of service. This includes involvement of families in mental health evaluations, participation in treatment planning, and collaboration in monitoring treatment outcomes. Families can be seen 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.

In August 2007, VHA 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 services are needed and where there are few other options available.

In addition, a new position in the VHA Care Management and Social Work Service has been created to develop a more systemic approach to serving caregivers. The position of Caregiver Support National Program Manger has just been filled. This individual will spearhead an internal interdisciplinary Advisory Group tasked with developing educational tools and training modules to assist VA staff in supporting our caregivers as they support our veterans.

In October 2007, VA partnered with the Department of Defense (DoD) to establish the Joint VA DoD Federal Recovery Coordinator Program (FRCP). VA hired an FRCP Director, a 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 Navel 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. The FRCP is intended to serve all seriously injured service members 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 service members and their families across the lifetime continuum of care.

As briefly alluded to above, 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-re-

lated problems, especially among National Guard and Reserve members. 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. 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 service member dies while on active duty, Vet Centers provide bereavement services to the surviving family members. Between 2003 and the end of FY07, Vet Centers have assisted 1,713 family members and 1,136 families of fallen service members, 807 (71%) of whom were in-theater casualties in Iraq or Afghanistan.

VHA works diligently to support veterans, their families and their caregivers. Often without the support of these dedicated family and friends many veterans would not be able to maintain their independence or their preferred community-based lifestyle.

Thank you again for the opportunity to appear here today. My colleagues and I would be happy to answer any questions you may have.

Statement of Barbara Cohoon, Deputy Director,
Government Relations, National Military Family Association, Inc.

Chairman Michaud and Distinguished Members of this Subcommittee, the National Military Family Association (NMFA) would like to thank you for the opportunity to present testimony today on the mental health needs for families who support our veterans. We thank you for your focus on the many elements necessary to ensure quality mental health care for our wounded/ill/injured service members, veterans, and the families who care for them as they transition for care between the Department of Defense (DoD) and the Department of Veterans Affairs (VA) health care systems.

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

1. Wounded Service Members Have Wounded Families
2. Who Are the Families of Wounded Service Members?
3. Caregivers
4. Mental Health

Wounded Service Members Have Wounded Families

Transitions can be especially problematic for wounded/ill/injured service members, veterans, and their families. NMFA asserts that behind every wounded service member and veteran is a wounded family. Spouses, children, parents, and siblings of service members 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 service member'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 two agencies' health care systems should alleviate, not heighten these concerns, and provide for coordination of care that starts when the family is notified the service member has been wounded and ends with the DoD and VA working together to create a seamless transition as the wounded service member 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 service members and their families to life as a veteran and civilian. 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. There is certainly more work to be done by DoD and the VA. 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 Service Members?

In the past, the VA and the DoD have generally focused their benefit packages for a service member's family on his/her spouse and children. Now, however, it is not unusual to see the parents and siblings of a single service member presented as part of the service member's family unit. In the active duty, National Guard, and Reserves almost 50 percent are single. Having a wounded service member is new territory for family units. Whether the service member is married or single, their families will be affected in some way by the injury. As more single service members 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 quality of life and aid in a speedy recovery.

Spouses and parents of single service members 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 fund raisers, shuffled them to soccer and club sports, and helped them with their homework. When that service member 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 travel to the receiving 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 service member must also consider the needs of the spouse, children, parents of single service members and their siblings, and the caregivers. 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 agencies' Secretary. 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 ebb and flow 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. NMFA recommends DoD and VA include mental health services along with physical care when drafting the NDAA FY08's regulations.

NMFA recently held a focus group composed of wounded service members 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 learn 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 fami-

lies relocate to be near the treating Military Treatment Facility (MTF) or the VA Polytrauma Center in order to make 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 who have found a way to embrace the family unit during this difficult time. NMFA is concerned the impact of 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, wounded service members and veterans' quality of life, such as physical, psycho-social, and mental health, would be significantly compromised. They are viewed as an invaluable resource to VA health care providers because they tend to the veteran's needs on a regular basis. And, their daily involvement saves VA health care dollars in the long run. According to the VA, "'informal' care givers 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.

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 service members 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 compensated for the care they provide. 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. These pilot programs, if found successful, should be implemented by the VA as soon as possible and fully funded by Congress. However, one program missing 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 a drop-in child care for medical appointments on their premises or partner with other organizations to provide this valuable service.

NMFA has heard from caregivers 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 service member to execute a Medical Power of Attorney and a Living Will. We encourage this Subcommittee to talk to their Congressional Armed Service Committee counterparts in requesting DoD to address this issue because the severely wounded, ill, and injured along with their caregivers will eventually be part of the VA system.

NMFA strongly suggests research on veterans' families, especially children of wounded/ill/injured OIF/OEF veterans; standardized training, certification, and compensation for caregivers; individual and family counseling and support programs; a reintegration program that provides an environment rich for families to reconnect; and an oversight Committee to monitor DoD's and VA's continued progress toward seamless transition.

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 service members and families experience numerous lengthy and dangerous deployments, NMFA believes the need for confidential, preventative mental health services will continue to rise. 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 service members and their families' transition to veteran status. The VA must be ready. They must partner with DoD in order to address mental health issues early on in the process and provide transitional mental health programs. They 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 service members. 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 and the level of stress they will bring with them as they become veterans. Is the 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? 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.

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 service members and their families. Access for mental health care, once they 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 ready available services. The Vet Centers are an available resource for veterans' families providing adjustment, vocational, and 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 veteran's caregivers unless they meet strict standards. Although 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. NMFA believes this is just a starting point for mental health services the VA should offer families of severely wounded service members and veterans. NMFA recommends Congress require Vet Centers and the VA to develop a holistic approach to veteran care by including their families, as deemed appropriate by the Secretary of Veterans Affairs, in providing mental health counseling and programs.

Thousands of service member 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 service member 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 RAND Corporation to research the impact of war on military children with a report 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 stress can be overwhelming, but are afraid of reaching out for assistance for fear of retribution on the service member. They often choose not to seek care for themselves or their families.

NMFA encourages the VA to partner with DoD and have them reach out to those private and nongovernmental 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's phase of their lives.

NMFA is especially concerned with the scarcity of services available to the families as they leave the military following the end of their activation or enlistment. They may be eligible for a variety of health insurance programs, such as TRICARE Reserve Select, TRICARE, or VA. Many will choose to locate 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 mental health resources and obtaining appropriate care. Isolated veterans and their families do not have the benefit of the safety net of services and programs provided by MTFs, VA facilities, CBOCs, and Vet Centers. NMFA recommends the use of alternative treatment methods, such as telemental health; modifying licensing requirements in order to remove geographical practice barriers that prevent mental health providers from participating in telemental health services outside of a VA facility; and, as the VA incorporates Project Hero, to educate 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 veteran's condition. Veterans' families are on the "sharp end of the spear" and are more likely to pick up on changes contributed to either condition and relay this information to VA providers. VA mental and health care providers must be able to deal with polytrauma—post traumatic stress dirorder (PTSD) in combination with multiple physical injuries. NMFA appreciates Congress establishing a Center of Excellence for TBI and PTSD. Now with the new Center, it is very important DoD and VA partner in researching TBI and PTSD. Also, the VA needs to educate their civilian health care providers on how to identify signs and symptoms of mild TBI and PTSD.

Because the VA has as part of its charge "to care for the widow and the orphan," NMFA was 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 and certain providers have found a way within the reimbursement rules

to provide needed care, but 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 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. The NDAA FY08 authorized an active-duty TRICARE benefit for severely wounded/ill/injured service members 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 service member'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 once they are no longer considered active duty dependents.

NMFA asks you to continue to put pressure on DoD and VA to step up the recruitment and training of mental and health care providers to assist service members, veterans, and their families. 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 mental health needs for families who support our veterans. Military families support the Nation's military missions. The least their country can do is make sure wounded service members, veterans, and their families have consistent access to high quality health care in the DoD and VA health care systems. Wounded service members and veterans have wounded families. DoD and VA must support the caregiver by providing standardized training, access to 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 Subcommittee to assist in meeting that responsibility.

Statement of Hon. John T. Salazar, a Representative in Congress from the State of Colorado

Good Morning Chairman Michaud, Ranking Member Miller and distinguished members of this Subcommittee.

I am proud that we are meeting today to discuss the need for mental health services for veteran's families.

I thank the members of this subcommittee for gathering to discuss an issue that gives due credit to the families who support our veterans every day.

It is critical that we review these issues immediately to keep pace with the demands our military puts on the families of our service members and veterans.

Our nation's responsibility to our veterans and troops must change as the needs of our military change.

Our veterans serve our country honorably and their families are a vital support system while they serve and when they return home.

This issue should be examined fully to ensure that those who served our Nation receive the benefits they have earned.

I look forward to evaluating the current system of mental health services that we have in place and I thank the members of this committee for giving us the opportunity to discuss issues that benefit our veteran's families.