BUILDING BRIDGES BETWEEN VA AND COMMUNITY ORGANIZATIONS TO SUPPORT VETERANS AND FAMILIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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CONTENTS

February 27, 2012

BUILDING BRIDGES BETWEEN VA AND COMMUNITY ORGANIZATIONS TO SUPPORT VETERANS AND FAMILIES

MONDAY, FEBRUARY 27, 2012

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

The Subcommittee met, pursuant to notice, at 4:02 p.m., in Room 334, Cannon House Office Building, Hon. Ann Marie Buerkle [Chairwoman of the Subcommittee] presiding.

Present: Representatives Buerkle, Roe, Runyan, Michaud, Reyes, and Donnelly.

Also Present: Representative Walz.

OPENING STATEMENT OF ANN MARIE BUERKLE, CHAIRWOMAN, SUBCOMMITTEE ON HEALTH

Ms. BUERKLE. Good afternoon, and thank you all for being here this afternoon.

Before we would begin, I would like to ask unanimous consent—although I don't see him here yet, for our colleague, Mr. Tim Walz from Minnesota, to sit at the dais and participate in today's proceeding.

Without objection, so ordered.

Today, we meet to discuss the role of faith-based and community providers in helping servicemembers, veterans, and their families transition from active duty to civilian life and the need to foster better communication, education, and collaboration between the Department of Veterans Affairs and these critical community resources.

The responsibility for each one of us to care for those who have borne the battle has never been so strong with the brutal toll of a decade of war and a bad economy. We continue to hear stories of veterans from past conflicts and our recently returning veterans from Iraq and Afghanistan struggling to find a home, a job, or a helping hand. The need to meet these honored heroes where they are and provide them the care, the hope, and the help they earned has never felt so immediate.

As a Nation, we are uniquely blessed to live in a country with a rich history of civic pride and responsibility, and it is to these communities where our veterans return home, where they have maintained their existing relationships, and, more often than not, where they first turn for help.

While the primary responsibility for caring for our veterans does and should lie with the VA, faith-based and community groups are playing an increasingly key role in supporting the varied needs of our servicemembers, veterans, and their families. They act as a bridge to accessing Federal, State, and local programs and services.

Members of the clergy in particular are often the first point of contact with the veteran grappling with the wounds of war. Data from the VA National Chaplain Center indicates that four out of ten individuals with mental health challenges seek clergy assistance, more than any other mental health providers combined.

We already know that faith-based and community groups can be effective in filling known gaps in VA care and supporting the day-to-day needs of a veteran population. However, a district symposium I held in my home district of Syracuse last December revealed to me a shameful lack of communication, collaboration, and coordination between the VA and these critical community resources and, subsequently, an urgent need to act to establish meaningful partnerships between the VA and nongovernmental organizations.

With more of our servicemembers returning home each day, we cannot afford to let any opportunity to better support our veterans pass us by. Where partnerships exist, they need to be strengthened. Where they don't, they need to be fostered. For a veteran or a loved one in need, every door should be an open door.

Again, I thank all of you for joining us this afternoon. I look forward to a productive and ongoing conversation.

I now recognize our Ranking Member, Mr. Michaud, for any remarks he might have.

[The prepared statement of Ann Marie Buerkle appears on p. 39.]

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD, RANKING DEMOCRATIC MEMBER

Mr. MICHAUD. Thank you very much, Madam Chair.

I, too, would like to thank everyone for attending today's hearing.

This hearing is intended to open up the broader thought process and better understanding on how the VA and community organizations collaborate to support veterans and their families.

More than 2 million servicemembers have been deployed since September of 2001, with hundreds of thousands of them being deployed more than once. As of February 2012, more than 6,000 troops have been killed and over 47,000 have been wounded in action in the recent conflicts.

When these servicemembers come home and take off the uniform, many of them have the expectation that life will just pick up where they left off before they were deployed. However, this is not the case. Many of them struggle to reconnect with their families and communities. They find themselves feeling isolated and unable to cope. The Department of Veterans Affairs reports that half of the OEF, OIF, and OND population that has access to VA health care has sought mental health treatment. Post-traumatic stress disorder is the number one reported mental health concern among this population.

With so many OEF, OIF, OND servicemembers and veterans experiencing psychological wounds, reports suggest that there is an

increase in the rates of suicide, alcohol and drug abuse, homelessness, and domestic violence. For this reason, it is essential that our servicemembers, veterans, and their families receive the help they need and that they have necessary tools to rejoin their communities. These programs and resources would not be possible without the thousands of community organizations across the country that work in partnership with the VA.

At this hearing, I want to hear more about the reintegration challenges that servicemembers, veterans, and veterans' families face as well as the challenges the VA and community organizations face as well in providing support services. We need to identify potential solutions to these barriers and how we can strengthen these partnerships.

Despite historic increases in the VA funding over the past 5 years as the Nation prepares for an influx of returning veterans, reintegration efforts are simply not possible without collaboration between the Federal Government, business sector, and nonprofit organizations; and more needs to be done to facilitate these partnerships.

I would like to take the time to thank our panelists for being here today, this afternoon, and I look forward to working with you as you support the Nation's veterans.

I would especially like to thank Mr. Morris and Mr. McCoy for their service as chaplains in the Minnesota National Guard and the VA's National Chaplains Center respectively.

In 2009, I led a congressional delegation to Afghanistan and came to learn that our servicemembers rely immensely on their chaplains for emotional support. Every trip since then I have come to respect the unique insight that our chaplains possess in terms of mental health, spiritual guidance, and the overall well-being of our servicemen and women. I look forward to hearing your testimony today as well.

I want to thank you once again, Madam Chair, for having this very important hearing this afternoon. Thank you.

[The prepared statement of Michael Michaud appears on p. 39.]

Ms. BUERKLE. Thank you, Mr. Michaud.

Now I would like to invite our first panel to the witness table. With us today is Andrew Davis, a veteran of Operation Enduring Freedom and Operation Iraq Freedom, the Director of the Veterans Services for Saratoga County, New York, and the founder of the Saratoga County Veterans Resource Initiative.

Mr. Davis served in both Afghanistan and Iraq with the U.S. Army 75th Ranger Regiment where he earned the Bronze Star with Valor, the Combat Parachutist Badge, and the Combat Infantryman's Badge and is a true American hero.

Mr. Davis, thank you for your service to this country. It is an honor to have you here today with us, and I very much look forward to hearing your testimony. You may begin.

STATEMENT OF ANDREW DAVIS, VETERAN, DIRECTOR, SARATOGA COUNTY VETERANS SERVICE AGENCY, SARATOGA COUNTY, NEW YORK

Mr. DAVIS. Good afternoon, Chairwoman Buerkle, Ranking Member Michaud, and Members of the Committee. Thank you for the

invitation to discuss the role of community providers and faith-based organizations in helping servicemembers transition to civilian life and the need for the U.S. Department of Veterans Affairs to use these resources and collaborate.

My name is Andrew Davis. I am currently the Director of the Saratoga County Veterans Service Agency and the founder of the Saratoga VRI. I have been a veterans advocate since separating from the service in 2004 where I served as a United States Army Ranger for 5 years, to include two tours of duty in Afghanistan and one in Iraq.

Upon returning to my home in Minnesota to further my education, I was faced with my first taste of how little I knew about being a veteran. In fact, like many of my peers, I was unsure if I even was a veteran. I was on a campus of 40,000 students, and I didn't know any veterans around me. Because of this, I founded a nonprofit veterans support organization on the campus of the U of M to aid returning veterans in connecting with earned benefits and services.

In later roles as a congressional staffer and a Department of Defense Transition Assistance Advisor, I saw firsthand the disconnect between veterans, their families, and the systems that are intended to support them. For the past 3 years, I have spent my career as a veterans advocate, either training accredited benefits counselors or being one myself; and this has provided me a frontline view of what is lacking in outreach and networked support to our veterans and their families.

Last, I am currently an enrolled patient with the Veterans Health Administration in VISN–2 and use both the Albany Stratton VA Medical Center and Clifton Park Community-Based Outreach Clinic regularly.

Veterans and the ways they serve have changed significantly over the last decade, resulting in the need for changes in the way our country, in turn, serves them. The veterans of today tend to be more geographically dispersed and more mobile than previous generations. Families and communities are affected and changed differently than ever before with multiple deployments and the unique use of the Guard and Reserve. Many of these individuals suffer from a lack of a "Fort New York" or a "Fort Minnesota" or a central support system, making the local community even more crucial in the reintegration process.

Despite a constant bombardment of media in all forms that afford the public access to our current wars, issues facing our neighbors, friends, family members, and other local veterans are often invisible to us as communities. Add to this a military culture that can encourage emotional toughness and self-sufficiency, and we face a large potential public health problem.

Last, the uniqueness that makes our military and our veteran population great also means that there is not a one-size-fits-all support system that can be created nationwide. We must garner community support and use community services to serve our veterans and their families completely.

First and foremost, the population of veterans that find their way into the VA system of care or benefits system merely by accident is staggering. I can safely say that approximately five to seven vet-

erans knock on my door weekly for some form of unrelated government service to find they are eligible for veterans benefits or care because of their service to this Nation.

Just last week, a young Marine with two tours of duty in Afghanistan appeared in my office asking for directions to the office that handles unemployment benefits. This Marine outlined he had no idea what services he was eligible for or how to use his 5 years of free health care. So we sat down with him and helped him. If this Marine had not knocked on the wrong door, he would not have met with my staff to turn on his GI Bill benefits or learn where he could get health care.

By all appearances, the U.S. Department of Veterans Affairs has recognized the need for community outreach but holds their hopes in the idea that top-down, one-sided information will filter down to the grassroots folks at the bottom helping individuals. For example, in the VISN–2 of Upstate New York, a few competent and well-trained veterans justice coordinators have been hired and put in place. However, the operative words here are "a few." These people are responsible for numerous counties and for interacting with courts, district attorneys, and law enforcement, when in fact the police officers on the beat may be able to help them immediately.

The correct mindset for reaching veterans must transition to a "no wrong door" approach. This can and should be created through a localized national training by VA, veterans advocates, and other experts to all members of the local communities. These newly created veteran-friendly communities would have the tools to make referrals to the proper resources, whether a veteran walks into a rectory, a tax assessor's office, or is pulled over during a traffic stop.

Additionally, outreach and assistance programs cannot be reactionary in nature. The time to begin helping a veteran in legal trouble, for example, is upon first interaction, not just at sentencing. In fact, in my own transition, it was a police officer who pulled me over for driving in Minneapolis like I had been in Haditha and Bagram and introduced me to my first veterans advocate and helped me to realize that difficulty transitioning was normal. Additionally, I now receive as an accredited service officer a large number of referrals from local police officers that I call my friends.

In sum, we as a Nation must stand committed to ensuring that sustainable and quality supportive services are accessible to veterans and their families right in their communities. I believe this can be done by leveraging resources that largely already exist in a cost-effective manner. The VA has the geographical disbursement and expertise to lead change, but we must think outside the box and look to those who are ready and willing to assist in our own backyards. The requirements to make this successful are not numerous. In many cases, putting out outreach staff and community advance is all it will take. We must begin immediately leveraging relationships and expertise that has long existed.

Thank you again to the Committee for allowing me to speak to these important issues.

[The prepared statement of Andrew Davis appears on p. 40.]

Ms. BUERKLE. Thank you very much, Mr. Davis; and, again, thank you for your service to our country.

I am going to begin by yielding myself 5 minutes for questions.

In your written testimony, you remark that after leaving the military you, as well as some of your peers, were unsure if you were even a veteran. If you look at the overall scheme of things, that is incredible, with the service that you gave to our Nation. I would like you to, if you could, expand on that statement and give us some insight into that.

Mr. DAVIS. Absolutely. I like to point that out, ma'am, at any chance I can.

In my eyes, a veteran was my grandfather at the American Legion who was telling World War II stories when I was a young kid.

Additionally, I think there is a large confusion among our Guard and Reserve population and even those who support these wars from the homeland who may not even think of themselves as a veteran when you consider the folks who are coming home missing limbs or who have served multiple tours in combat.

So an important distinction I like to point out to community members who are interested in helping is asking somebody if they or a family member have ever served in the United States military, as opposed to are you a veteran, because that can be sort of a dicey question.

Ms. BUERKLE. Thank you.

Can you talk about how we can get to that veteran community when they are processing out and they are still active duty? How can we make it known to them that they would qualify for veteran assistance?

Mr. DAVIS. Ma'am, I think one important thing to understand is that, no matter where we separate from, there is a very good possibility that is not where we are going to stay. I can tell you from my own experience separating in Fort Benning, Georgia, and returning to Minnesota, I got every resource available to me to stay in Fort Benning, Georgia, but I wasn't staying there.

So the veteran returning to Syracuse from Marine duty in Camp Pendleton needs to be provided in Syracuse that local contact, whether that is a veterans service agency director or whether it is a VA clinic contact. But they need the contacts at home, not where they are separating from.

Ms. BUERKLE. Can you tell me how you think that the VA's reluctance to integrate with community resources may have obstructed your transition or other veterans' transitions into becoming a veteran?

Mr. DAVIS. Yes, ma'am. I think the important thing that veterans need to understand when they are separating from duty is that every benefit needs to be turned on with the process of an application. For me, going to the University of Minnesota and having to use GI Bill benefits, I guess I just assumed somebody on campus was going to be there to help me, another veteran or somebody who was responsible for this benefit. But there wasn't one out of 40,000 that was there to assist with that effort.

So if the VA had seen that this massive college campus was going to attract veterans, they may have put somebody proactively there or trained somebody. That is just education. But that person could also refer me to a health care resource or something similar.

Ms. BUERKLE. So now you are director of a community program; and I would like you to, if you could, describe for us your interactions with the VA now and what kind of relationship you have and how the VA is treating your group?

Mr. DAVIS. Madam Chair, we come in quarterly to the VA hospital in Albany, and we do get to hear about departmental changes. We get a top-down budget overview of what the VA hospital director is dealing with. It does tend to be a fairly one-sided conversation. We hear about changes to the orthopedics ward or something like that, and we occasionally get to talk about an issue that is facing maybe one of our veterans. But as far as being able to have a two-way conversation about how to improve, that does not take place.

In addition, I would point out that we hold events as county agencies that are for the purpose of outreach. The VA is invited to all of those, and I would be remiss if I told you that they were at all of those. They rarely take advantage of those community activities, at least in my area.

Ms. BUERKLE. I don't mean to ask you to speak or try to be in the mind of the VA, but why do you think there is a reluctance to collaborate with some of the outside groups rather than just the VA?

Mr. DAVIS. Purely speculation, ma'am. I would say they may feel that they are the experts and the veterans should come to them and they can't share that load. But, again, that is purely speculation.

I also would say that maybe it has never happened before, so maybe there is some reluctance to jump in and try something new.

Ms. BUERKLE. And last, if you could—and I just have a few seconds left—what barriers do you see for more effective relationships between the VA and some of the outside service groups?

Mr. DAVIS. Ma'am, I think information sharing is obviously a fear among all agencies, how do we talk about veterans and get the proper consent for issues that they may be facing, whether it be mental or physical health care.

But I also think staffing is something they always fall back on, and I have seen that take place in my area.

Ms. BUERKLE. I thank you very much, Mr. Davis.

I now yield 5 minutes to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair.

I also want to thank you, Mr. Davis, for your service to this great Nation of ours. I appreciate it.

Speaking about mental health, do you have any suggestions for us or the VA on creative approaches to addressing the mental health needs of returning veterans and their families?

Mr. DAVIS. Sir, I appreciate the question. I would say that one thing that comes up often among my veterans is a reluctance to go physically to a VA mental center or even to a VA vet center, which is even more comfortable for that mental care, and a strong leaning toward paying out of pocket for private providers in their own backyard. So if there was some way to leverage that outsourcing, for lack of a better term, I would say that would go a long ways.

But, too, also opening more mental health care to families and children out there where that family dynamic has changed through deployment, sometimes multiple deployments, sir.

Mr. MICHAUD. Thank you.

You mentioned the collaboration between the VA and the local community resources, some of the things that they should do. Is there anything in particular that you can tell this Subcommittee on what can we do to encourage more of that particular collaboration between the two?

Mr. DAVIS. Sir, I think the VA needs to get out into the community a little more. My experience has been that there is not a shortage of people out in my communities that want to help, whether that be mental health providers on the private side or whether it be churches and law enforcement where I get a lot of my referrals from. They are ready to help, but they are not really sure where to send people to, because the VA, at least in my area, hasn't been out in force giving them cards and saying what they do.

Mr. MICHAUD. You made an interesting point, and I actually heard Judge Russell, who is a judge in New York for the Veterans Court, and he made a good point and you just reemphasized that point. A lot of times veterans don't feel that they are veterans, and he rephrases the question now is how many people served in the military.

When you look at outreach, I know the VA is trying to do more in outreach, getting veterans into the VA system, what do you think that we should do for more of an outreach type of program? Because a lot of veterans out there are not signing up because they don't realize that they are eligible. How do you envision us doing a better job in getting people into the VA system?

Mr. DAVIS. Sir, I believe the question does need to be rephrased across the board. I think anytime we are looking to help veterans we need to ask that, have you or a family member ever served in the United States military, and that really breaks the ice. But, too, it allows me as an advocate and all of my peers as advocates to really start to look at what benefits might be available.

I hate to put it this way, but the thing that gets a lot of veterans in my door is you might be missing out on some significant savings financially or on some serious financial benefits, whether it be a property tax exemption or disability compensation or free health care. So money gets people in the door, unfortunately, but also asking the right questions.

Mr. MICHAUD. Do you think the Governors of each State and probably the President ought to do an executive order requiring every Federal agency or State agency that has an interaction, whether it is unemployment benefits, Medicare, or Medicaid, that one of the first questions that they ask is have you ever served in the military and somehow getting that information to the VA so they can reach out to those types of individuals?

Mr. DAVIS. Yes, sir. I think every temporary assistance office, social services department, Medicaid, Medicare, but also every college application at a State-run school should have that question being asked and it should generate some sort of referral. Again, that no-wrong-door approach is crucial in helping these folks.

Mr. MICHAUD. You had mentioned in your testimony that the VA interaction, that there is more of it dealt with on the VHA side versus the VBA side. How do you think the interaction between the two should be between VHA health and benefits side?

Mr. DAVIS. Sir, I think one thing I am up against oftentimes with my clients is explaining the siloed barriers within the VA, that the cemetery administration and the health care administration and the benefits administration are not one entity. So you can actually theoretically get care at the VA hospital for 40 years and never have a disability claim put in, and vice versa, and I think that is confusing to veterans. And I think oftentimes when a veteran has a real problem with a claim within the VBA, they tend to blame the doctor at the hospital at the VHA, and vice versa, and it is not fair to the VA employees, but it is also not fair to the veteran to not understand that disparity.

So I think having a more across-the-board understanding, but also, when we are talking to VHA, VBA and VCA should be in the room as well, and vice versa.

Mr. MICHAUD. Thank you very much.

I yield back, Madam Chair.

Ms. BUERKLE. Thank you.

I now recognize the gentleman from Tennessee, Dr. Roe.

Mr. ROE. Thank you.

I just have a couple of questions for Mr. Davis. Again, thank you for your service to our country. I appreciate that.

I think probably the first time I ever realized I was a veteran was somebody asking me to stand up at a Lincoln Day dinner. I never really thought about it very much. And, obviously, until you need those benefits, you don't.

Last Congress, I went to Afghanistan with Mr. Michaud, and just got back from Afghanistan again on a CODEL I led about 4 months ago. And we stopped in Landstuhl. I think the DoD is doing a better job of informing, at least from when I got out. Really, it was a couple of days and you were gone, not really knowing what benefits you had, if any. So I think they are doing a better job today.

Where is the breakdown? Because there is so much access to information. It is just that our soldiers, when you have made that determination that you are going home, you go home and you don't think about it until you have a problem. Then, like you say, when you are at Benning or where I grew up near Fort Campbell, Kentucky, you have all kinds of support there. But if you move down to Hole in the Wall, Tennessee, you may not.

We have a VA hospital in our community. People know where to go. But that is not necessarily for everyone, there are only three of them in the State of Tennessee. So how would you best get that information out to people? How do you do that?

Mr. DAVIS. Well, sir, as my friend Colonel Morris will probably say, you are given the world's most important information as a veteran at the world's worst time by the world's worst briefers. As you are attempting to move your family and your livelihood back home or to the new location in this country, you are not thinking about those benefits, as you say. So even just having a contact card printed out for you at your transition would be a lot more helpful than a 130-slide briefing on the big picture of benefits.

So the first thing I would say is we need to start teaching people how to be veterans at the beginning of their service and throughout their service, as opposed to right in the last 2 weeks. But the second piece is getting people in who are actually advocates to brief, as opposed to the payers of the benefits, meaning the big-picture VA folks giving us that long PowerPoint presentation.

Mr. ROE. I know our veterans service officers where we are do a tremendous job. And people come in, they really don't know the difference between these acronyms—VBA, VA. I mean, it is all one to them. They just think it is one. You are absolutely right.

I see it all the time in my congressional office. If a disability claim is not moving forward and we get in on it, they don't know that the VA has nothing to do it. The hospital where they are going doesn't have anything to do with that. That is a totally different issue. I don't know that that is important. All the veteran wants is their benefits taken care of.

So you would suggest a simple thing to do would be just be some contact, just a card with contact information. We ought to be able to make that happen pretty easily, if you think that would be helpful.

Mr. DAVIS. I do, sir. I think attached to that DD–214 when you leave Fort Campbell should be here is the six most important people in your home county you need to see: unemployment, veterans advocate at the service office. You know, you name it. But these are the go-to folks when you get home.

Mr. ROE. If you need some help, if the issue comes up, contact one of these people; and, like you said, there is no wrong door.

Mr. DAVIS. Yes, sir.

Mr. ROE. Any of them can open the door.

I am not going to disagree with anything you said, except for one thing. I don't think the needs of veterans have changed at all. I had an aunt that knew my great-grandfather who survived the Civil War, and my great grandmother had said that he was never right after that war, meaning that he had problems. There just were no benefits then. I think veterans have experienced the same things.

I think we are doing a better job. The GI Bill is spectacular. That is all I can say about it. It wasn't kicked out very well, but the Secretary has smoothed out some of those bumps. When a person goes and gets their veterans' benefit for their GI Bill, you are saying that the University of Minnesota, a huge, great university, didn't have any help. I mean, they have thousands of people working at that college, and so do most colleges that are of any size like that. They had no one there who knew what to do for you, where to send you?

Mr. DAVIS. No, sir. And I can say that that has improved greatly across the country. Just 2 years ago, we kicked off a veteran-friendly campus event around New York; and we saw great universities like Syracuse University who have full offices for veterans. But that was not in existence when I separated in 2004.

Mr. ROE. So just in a short time you have been able to see that?

Mr. DAVIS. Yes, sir.

Mr. ROE. Once again, thank you for your service.

I yield back.

Ms. BUERKLE. Thank you, Dr. Roe.

Now I recognize the gentleman from Indiana, Mr. Donnelly.

Mr. DONNELLY. Thank you, Madam Chair; and, Mr. Davis, I too want to thank you for everything you have done for our country. There is no way we can ever repay your hard work, your dedication, and everything you have done for us; and we are very much in your service and in your appreciation.

I wanted to ask about the Saratoga County Veterans Resource Initiative. What role does the VA play in the gatherings that you have when you gather quarterly to check best practices?

Mr. DAVIS. Sir, to date, we have had six meetings, and the VA has been present at one, and it was the second meeting, and that was in the form of the families outreach program that existed at the Albany VA Medical Center. The VHA and the Vet Center have been invited to every meeting and have yet to have much participation.

Mr. DONNELLY. Did they tell you why?

Mr. DAVIS. Every time, sir, it has been that they didn't have the staff or they hadn't gotten approval to attend.

Mr. DONNELLY. Okay. And I apologize if I missed this early on in your testimony, but, at those gatherings, have they proved pretty fruitful for you?

Mr. DAVIS. Yes, sir. At the very beginning, we learned how this room full of people that all knew each other had no idea what any of us did on behalf of veterans, so at that very level it started being helpful.

In addition, I don't go more than 3 days without a call from a fellow member of the Resource Initiative with a referral from a veteran who came into their office. So, yes.

Mr. DONNELLY. So have you found that there is a lot of people trying real hard, but it is like a bunch of cars driving past each other and nobody knows what is going on in the other cars?

Mr. DAVIS. Yes, sir. Exactly.

Mr. DONNELLY. Okay. Well, I promise you we will work real hard with you, take the lessons you have given us, and try to make sure we can spread the things you are doing to the rest of the country. Thank you again, sir.

Ms. BUERKLE. Thank you.

I now yield to the gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you so much for holding this hearing, Madam Chair. I appreciate it.

Thank you for your service, sir.

We are pretty active in our congressional district. I have an advisory council. We have a resource fair on an annual basis. We just finished a jobs fair that was very well attended. I visit the VFWs, as does my staff, American Legions, what have you, and also go to the VA.

But what more can we do as a congressional office. I know that one of the reasons you are here is to testify on behalf of how we can bring the VA closer to our veterans. What more can we do? Do you have any suggestions? You know, we can always do more. What can we do as a congressional office to further that goal?

Mr. DAVIS. Sir, it sounds like you are doing a lot of the things that I would suggest. But one thing I often point out to congres-

sional staff is that veterans, when they come to a congressional staff member, have never, many times, filed a claim or even interacted with the VA for the first time. They are just under that assumption that they are a veteran who is eligible for something and in turn is not getting what they deserve.

So that reverse referral to a local advocate, whether it be an American Legion service officer or whether it be a county person or a State person I think is the first step I would take. Because, oftentimes, your staff is very overwhelmed and may not know everything about the local benefits or the State benefits on top of the Federal, or vice versa. So a reverse referral would be a big suggestion I would make.

Mr. BILIRAKIS. Thank you very much.

I yield back, Madam Chair.

Ms. BUERKLE. I now yield to the gentleman from New Jersey, Mr. Runyan.

Mr. RUNYAN. No questions. I yield back.

Ms. BUERKLE. Thank you.

We will wait for Mr. Reyes.

Mr. Reyes, I know you just joined us. We have Mr. Davis here, if you have any questions.

Mr. REYES. I have no questions.

Ms. BUERKLE. I guess that is it for questions, Mr. Davis. Again, thank you very much for your testimony and for your comments. You are now excused.

Mr. DAVIS. Thank you, Madam Chair.

Ms. BUERKLE. I invite the second panel to the witness table.

With us today is Chaplain John Morris, the Joint Force Headquarters Chaplain from the Minnesota National Guard.

Chaplain Morris is a Colonel in the Minnesota National Guard and is the co-founder of the Beyond the Yellow Ribbon Initiative which facilitates collaborations between the Minnesota National Guard, VA, and local faith-based and community resources to support the reintegration of Minnesota's National Guard combat veterans.

I would like to thank you, Chaplain Morris, for your service to our Nation and for your very important advocacy efforts.

I will now yield to Mr. Donnelly to introduce our next witness.

Mr. DONNELLY. Thank you, Madam Chair; and it is a great honor to have Dr. MacDermid Wadsworth.

Madam Chair, fellow Health Subcommittee Members, I would like to introduce you to Dr. Shelley MacDermid Wadsworth, an Associate Dean of Purdue University's College of Health and Human Sciences. As a Notre Dame grad, it pains me to mention Purdue, but I will do so anyhow.

Dr. MacDermid Wadsworth also serves as director of Purdue's Military Family Research Institute which works to improve the lives of servicemembers and their families in Indiana and across the country by strengthening and supporting the efforts of military and civilian organizations to provide services, education, and training to military families. I just want to mention Purdue has done an extraordinary job with this, and we are incredibly grateful.

We are grateful to Dr. MacDermid Wadsworth, who knows how many people in our State serve and how dedicated the families and

everyone is. And I just want to say that your work is making a difference in the lives of everyone, not only in our State but in the country. Thank you very much.

Ms. BUERKLE. Thank you, Mr. Donnelly, and welcome, Dr. MacDermid Wadsworth.

Also joining our second panel is Dr. David Rudd and Dr. George Ake. Earlier in my opening comments I mentioned we had a symposium in Syracuse, and I was honored to welcome both of you to Syracuse for that event. I don't believe it was snowing that day, and we had a very successful symposium.

Dr. Rudd is the Dean of the College of Social and Behavioral Sciences at the University of Utah, where he also serves as Scientific Director for the National Center for Veterans Studies. In addition, he was recently elected Distinguished Practitioner and Scholar of the National Academies of Practice in Psychology.

Dr. Rudd is also a Gulf War veteran, and I would like to thank him for his honorable service to our Nation in uniform and for his continued dedication to improving the lives of his fellow veterans through his research. Thank you, Dr. Rudd.

Dr. Ake is an Assistant Professor of Medical Psychology at the Duke University Medical Center, and he is here today on behalf of the American Psychological Association.

Dr. Ake is a child psychologist and has worked extensively with the National Child Traumatic Stress Network, where his work has focused on assisting children and families who have experienced stressful and traumatic life events, including a military deployment and its aftermath. He is a recent winner of the Durham, North Carolina, Police Department's Community Service Award, and it is an honor to have him with us today.

I thank you all very much for being here this afternoon. I am eager to begin our discussion.

So, Chaplain Morris, we will start with you. Thank you very much.

STATEMENTS OF CHAPLAIN JOHN J. MORRIS, JOINT FORCE HEADQUARTERS CHAPLAIN, MINNESOTA NATIONAL GUARD; SHELLEY MACDERMID WADSWORTH, PH.D., DIRECTOR, MILITARY FAMILY RESEARCH INSTITUTE, PURDUE UNIVERSITY; M. DAVID RUDD, PH.D., ABPP, DEAN, COLLEGE OF SOCIAL AND BEHAVIORAL SCIENCES, SCIENTIFIC DIRECTOR, NATIONAL CENTER FOR VETERAN STUDIES, UNIVERSITY OF UTAH; AND GEORGE AKE III, PH.D., ASSISTANT PROFESSOR OF MEDICAL PSYCHOLOGY, DUKE UNIVERSITY, AMERICAN PSYCHOLOGICAL ASSOCIATION

STATEMENT OF CHAPLAIN JOHN J. MORRIS

Colonel MORRIS. Chair Buerkle, Ranking Member Michaud, and Members of the Subcommittee, thank you for the honor of being here.

I am Chaplain Morris. I am the State Chaplain of the Minnesota National Guard, and I am fortunate to be the co-founder of the Beyond the Yellow Ribbon Program that you made the national standard for the reintegration of the Reserve and the Guard. I am

a three-tour combat veteran. I am the son of a combat veteran. I am the father of two combat veterans.

I am here as a fan of the VA. I am a customer. I am also a close collaborator, and my daughters are customers. The Minnesota Guard has had a very productive relationship with the VA, and I think we have something to share with the Nation, but I will encapsulate it in this story from Saturday.

I was at an event for 2,500 of our families whose soldiers are now serving in Kuwait. We were feeding them. A mother came up to me and said, you don't remember me. My son came home with a local infantry unit from Kosovo, and you were at the reintegration event, and I asked you to help my son. I want you to see him. He is doing so much better.

I sat down with the young man. I indeed had pulled him out of the registration line that morning 30 days after returning from a 9-month tour in Kosovo. He was high on crack. We immediately took him to the emergency room of the local hospital in Rochester, Minnesota. After a 72-hour hold there, he was taken to St. Cloud VA for inpatient chemical dependency treatment. And he was proud to tell me a year and a half later he was straight, he was sober, he was married, and introduced me to his wife, who was pregnant with twins, and he was facing a tremendous future. That is the collaboration that we have with the VA in Minnesota.

We have done the RINGS 1 and 2 study with our First Brigade, which is on its second combat deployment. The Minneapolis VA has done a tremendous longitudinal study with our soldiers and their families that I think is going to set straight some of the mythology around PTSD and over-reporting of that problem and an under-reporting of the impact that healthy community reintegration-based programs can have on returning veterans.

We have pushed VA teams far forward to enroll our demobilizing soldiers at demob sites around the country. We have had the VA actually train our command and staff—I was a part of this in 2009—preparing to deploy to Iraq. We had the VA train our commanding general and all of our leading staff in the polytrauma unit in Minnesota. We got a first-hand look at what war is really like, the impact of the weaponry of war and on the human body and what combat trauma can do.

So we have a good relationship, but I think the VA could do even better, and so I am here today to talk about some of those problems and some of the solutions.

The VA suffers under the perception of being a very isolated institution, and it has a stigma. All we hear about it is bad things. We rarely hear the great things they do. From loss of laptops and compromise of our security to homeless veterans who commit suicide, the mantra of bad news about the VA is steady, and it really affects the community's view of the VA. And I can say that as a person who deals every day with community leaders throughout Minnesota.

The institutionalism of the VA which Andy Davis so well alluded to is a problem and it keeps the VA inside its building and not always out in the community sharing its knowledge with us who are on the ground working with the majority of the veterans.

I think, unfortunately, the steady mantra about PTSD, 25 percent—whatever it is, the CBO report that came out last week saying 21 percent—I think it is over-reported, and it is not substantiated, and it has created an impression that the VA is the only institution that can solve combat trauma, that all veterans have it, and it is contributing to a double-digit unemployment rate among our veterans—which is truly the problem we have. It is getting work. It is not getting mental health care.

Minnesota is the land of 10,000 mental health and chemical dependency treatment centers. We like to say it is 10,000 lakes, but it is 10,000 treatment centers. There are plenty of people who want to help us with mental health. That is not our biggest problem. And we are caught in some kind of a loop between the VA and Congress trumpeting a problem, when the bigger problem is being underfunded and underaddressed. And we can fix it, and we can do it in Minnesota, and we are going to do it.

We have gotten the VA to come out into the community and work with us, get on to our drill floors and talk to our families. We have had the VA come and meet with our physicians and share the knowledge that the VA has so that the provider out in rural America can take care of families and veterans. We have synchronized services so that when somebody leaves VA care they can tie into Yellow Ribbon communities to get the care they need. And we have asked the VA to not only publish what they know in academic journals but to share with lay people through veterans organizations and through our political and elected representatives so that news can get down and counter the steady stream of bad news.

I think the VA's one important part of the reintegration process—it is not the only part, and it is not the most important part—the most important part of the reintegration process is the community. It is our responsibility to bring our soldiers all the way home and to take care of their families. We sent them to war. It is our job to bring them back. The VA is a partner in that, but it is not a stand-alone partner. It is not the only partner. It is a partner.

Every State that is empowered through its Governor to partner with its VA will be an effective State in reaching its communities and empowering them to bring their veterans all the way home. At the end of the day, we are going to live in communities, we are going to serve in communities, and if we can't learn to be productive in our communities, it won't matter how good the VA is. We still won't be all the way home.

Madam Chair, thank you for this privilege to be here; and, Committee Members, thank you for what you are doing. It is an honor to be here, and it has been a great privilege for me as part of my career to have this chance to share this with you.

[The prepared statement of John Morris appears on p. 43.]

Ms. BUERKLE. Thank you very much Chaplain Morris.

Dr. MacDermid Wadsworth.

STATEMENT OF SHELLEY MACDERMID WADSWORTH, PH.D.

Ms. WADSWORTH. Thank you.

Chairwoman Buerkle, Congressman Michaud, and distinguished Members of the Committee, thank you for convening this hearing;

and thank you to Representative Donnelly for such a kind introduction.

I am proud to be a faculty member at Purdue University, the land grant institution for the great State of Indiana, and also to direct the Military Family Research Institute. I am pleased to report that we were involved in several innovative collaborations involving the VA. Our vision is to make a difference for families who serve.

My institute has created or participates in collaborations involving VA partners in the areas of homelessness, higher education, vocational rehabilitation, behavioral health care, outreach to community partners, and research. Our higher education initiative, for example, is putting mechanisms in place that could help every student, servicemember, and veteran in Indiana and potentially reduce GI Bill costs with the help of VA certifying officials, the Indiana Commission on Higher Education, and others.

The vocational rehabilitation effort for which we serve as the evaluation partner has been a national leader in placing wounded warriors in employment and keeping them there; and, again, without VA professionals at the table, this would not have occurred.

Based on these experiences, I know that successful collaborations are possible, can benefit military and veterans' families significantly, and can contribute substantively to the VA mission.

I identify several keys to success in my written statement but will focus my remarks here on challenges and opportunities that might benefit from policy or legislative attention.

Number one: Create clear points of entry for prospective collaborators in multiple VA tracks. Prospective community partners, particularly those located at a physical distance from a medical center, find it very difficult to determine whom to approach to partner, and the independence of the medical centers means that there must be a local connection. The VA Office of Faith-Based and Neighborhood Partnerships is very important, but there are still many untapped partners who can multiply the reach of the VA.

Number two: Develop mechanisms to separate the "wheat" from the "chaff" among prospective partners. VA professionals are understandably wary of showing favoritism to particular organizations. Unfortunately, this means that reputable partners with much to offer may get held at arm's length, the same as bad actors.

Number three: Reduce structural barriers to collaboration. It is difficult to get information from the VA sometimes. It is difficult for outsiders to engage in research with VA populations. It is difficult for community partners to find and connect with military and veteran families, particularly in low-density areas. Sometimes it feels as though there is a fence around the VA.

Number four: Provide tangible incentives and benefits to community and VA partners who collaborate effectively. Collaborations do take resources, but they also can generate resources by attracting additional contributions of skills, people, money, or information. Compared to the costs of services that don't get used and clients who don't get served, collaborations can be very cost-effective instruments.

It has been our great honor to work to make a difference for military and veteran families. We are inspired by the commitment and

dedication shown by professionals in many sectors who share that mission, and we are eager to continue collaborating to make positive change.

Thank you for all you do to try to make sure that our Nation's veterans receive the care and support they have been promised.

This concludes my statement. Thank you for your kind attention.

[The prepared statement of Shelley MacDermid Wadsworth appears on p. 46.]

Ms. BUERKLE. Thank you very much, Dr. MacDermid Wadsworth.

Dr. Rudd, you may proceed.

STATEMENT OF M. DAVID RUDD, PH.D., ABPP

Mr. RUDD. Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, I very much appreciate the opportunity to testify on behalf of the National Center for Veterans Studies and the University of Utah.

Chairwoman Buerkle, I am very pleased and would tell you enthusiastic about seeing you taking leadership on what I believe to be a critical issue on the reintegration of veterans into society after having served so admirably in terms of our Nation and our needs.

You have my written statement. I am not going to repeat much of what is in the statement. I do want to highlight a few critical points.

I want to comment on Colonel Morris' note about the issue of reintegration and misunderstanding.

I think it is important to recognize that, since the Gulf War, less than 1 percent of Americans have served in the Armed Forces. This is a tremendous shift from World War II when almost 9 percent served; Korea and Vietnam, both greater than 2 percent served. And as we have fewer and fewer Americans serving in the Armed Forces the possibility for misunderstanding, the possibility for difficulty in reintegration is compounded; and I think that probably speaks to the issue that was raised by Colonel Morris, which I think is a vital one.

I would like to speak about a couple of areas of research and highlight a few things that I think sheds some light on the opportunity for reintegration, in two areas in particular: one, universities; and, two, organizations, communities of faith and local churches.

Some recent work by the Pew Research Center revealed that 27 percent of veterans reported that readjustment to civilian life was either difficult, somewhat difficult, or very difficult. The survey also revealed significant burdens of service identified by servicemembers, with 48 percent reporting strains in family relationships, 47 percent frequently feeling irritable or angry, 44 percent reporting problems reentering civilian life, and 37 percent reporting posttrauma symptoms. This doesn't necessarily mean post-traumatic stress disorder but trauma-related symptoms. Despite the fact that many veterans transition from military life with few problems, I think these data indicate the significance of the problem, and it has been fairly profound over the course of the last 5 years.

The Pew data offer insight into the source of the problem as well, particularly in terms of emotional and psychological adjustment.

Among those having experienced combat, 50 percent or more report post-trauma symptoms, a difficulty with family relationships. When they were queried about factors reducing the probability for successful reentry into civilian life, veterans identified traumatic experiences and physical injury as the most significant variables.

Of importance for this hearing, veterans identified attending church at least weekly as the most important variable associated with an easy and successful reentry into civilian life. A remarkable 67 percent identified attending church once a week or more as making reentry easier.

Clearly, the social connections and support offered by religious communities and institutions around the Nation are essential for our veterans. I would tell you that they really possess enormous opportunity to help veterans transition. I think that Colonel Morris spoke to this issue in terms of stigma that is associated with mental health problems, with PTSD in particular. The opportunity for intervention, the opportunity for assistance in local churches is truly remarkable.

I would tell you that, of the veterans that I know, the veterans that I have worked with would much rather go to local clergy than to go to a clinical psychologist, to go to a psychiatrist, to go to a mental health specialist. With the right training, with the right resources, that kind of a partnership is precisely one that we need to pursue; and I would like to see the VA take a lead in that area.

Now, I can tell you a little bit about my own work that I think has helped clarify the severity and the magnitude of the problems in terms of emotional and psychological issues faced by veterans, and a very specific subset of veterans that I would speak to are student veterans.

We recently did a national survey looking at student veterans transitioning from the service back on to university campuses, and I would tell you that, arguably, this is the second-best place to capture veterans, is on university campuses, that outside of the medical centers, outside of the Veterans Benefit Administration, this is where you will find veterans.

If you look at the data that are in my statement, you will find that the numbers are fairly profound in terms of the rates and the magnitude of the reported problems. Now, what is interesting is that those veterans are on campus, those veterans are functioning on campus, and I would tell you that they are functioning quite well, but they need assistance. Making sure that campuses are well prepared is something that is critical for us to do.

So I would encourage you, in terms of looking for partnerships and expanding partnerships that the VA has already pursued, universities are a wonderful place, communities, organizations, institutions of faith, local churches are a wonderful place. Those are places where veterans will go, those are places where veterans don't feel the severity and the magnitude of stigma, and the opportunity to help is tremendous. So I would encourage you to think about those two areas specifically.

I would be happy to talk to you in a little bit more detail if you have questions afterward. But, Chairwoman Buerkle, thank you very much for your time.

[The prepared statement of David Rudd appears on p. 49.]

Ms. BUERKLE. Thank you, Dr. Rudd.
Dr. Ake.

STATEMENT OF GEORGE AKE III, PH.D.

Mr. AKE. Good afternoon, Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee. Thank you for the opportunity to testify on behalf of the 154,000 members and affiliates of the American Psychological Association regarding the collaboration between the Department of Veterans Affairs and community organizations to support veterans and their families.

As a child psychologist at Duke University Medical Center and with the National Child Traumatic Stress Network, my work focuses on assisting children and families who have experienced traumatic life events, including military combat and its aftermath. I am honored to speak with you today about the collaborative work that I and my colleagues are engaged in to support our Nation's military and veteran families.

Collaboration among all sectors of society is needed to support the health and well-being of veterans and their families. This includes key partnerships with policymakers, government agencies, universities, the health care community, and the faith-based community.

Scientific evidence continues to identify psychological and neurological disorders, including post-traumatic stress disorder, depression, suicidal ideation, and traumatic brain injury as some of the signature wounds of recent conflicts. While psychologists and other health professionals play an essential role in helping veterans and families to address these challenges, partnerships and collaborations with other sectors of society are also critical.

While there are numerous specific programs for veterans and their families, many families rely upon the support of faith-based providers as a first point of contact. The members of this community who are here today will address these issues, but I want to underscore the extraordinary value of our collaborative mental health work with faith-based providers related to military and veteran families, a partnership which enriches our work in many ways.

I would like to express my deep appreciation to you, Chairwoman Buerkle, for your leadership in advancing collaboration between the mental health faith-based communities and military and veteran families. The unique military and veterans mental health workshop that you hosted for faith-based providers in your district in December served as a wonderful example of the collaboration that is possible across sectors. I was honored to join the distinguished panel of experts that you assembled. Such events help to break down barriers and foster partnerships that benefit veterans and their families. Replicating this training in other congressional districts could serve as a valuable resource.

Collaboration between military and faith-based and other community systems is especially important as we consider 2010 Department of Defense data which estimates that 44 percent of the 1.4 million active duty and National Guard-Reserve personnel who deployed to combat missions as a part of OEF, OIF, and OND are parents. DoD also estimates that nearly 2 million children in the

United States have parents who are active duty or Reserve personnel, many of whom have experienced multiple combat deployments.

Some military families face severe challenges during reintegration, such as a parent who returns changed due to the winds of war or financial hardship, homelessness, marital discord or violence and other difficulties. Still other families experience the grief and loss associated with their loved one's fatal combat injury or even suicide. These findings highlight the necessity of considering the context and challenges for children and families of veterans, as well as the role of the family in facilitating a successful transition to stateside service or civilian life.

To support veterans, their families need easy access to collaborative programs and supports through VA and many other service sectors. As a member of the National Child Traumatic Stress Network, we are proud to contribute to such efforts.

The NCTSN is an initiative launched by Congress in 2000 to develop a national collaborative network to improve best practices and standards of care for children and families affected by traumatic stress, including military families. Our 130 centers in 40 States collaborate with many organizations, including the VA, DoD, the National Guard, the American Psychological Association, faith-based organizations, and many others.

We offer evidence-based interventions, educational materials, curriculum for civilian providers, and much more, all available on the Web site. My written testimony offers many specific examples of this work, including a Welcome Back Veterans program at the Duke University for training community clinicians, a collaboration with the VA's National Center for PTSD to train providers, including military chaplains, on acute stress interventions, collaboration with the military chaplains, and a family resilience program called FOCUS now being used at more than 20 military installations, a partnership with the TAPS program to help military families after the death of a loved one, and the ADAPT parenting program for Reserve families in Minnesota.

In conclusion, we have seen the collaborative efforts between the military and veteran communities and partners such as faith-based providers, mental health professionals, and others have yielded effective services for our military and veteran families. The American Psychological Association, Duke University Medical Center, and the National Child Traumatic Stress Network all stand ready to continue our collaborative efforts with the Subcommittee, the VA, the DoD, our community-based partners, and the military and veteran community to address these important issues.

Thank you for the opportunity to speak with you today and for your leadership and commitment to our Nation's veterans and their families.

[The prepared statement of George Ake appears on p. 51.]

Ms. BUERKLE. Thank you all very much.

I will now yield myself 5 minutes for questions. I will start with Chaplain—Colonel Morris. As an experienced chaplain and someone who has been in the military and a veteran, first of all, do you think there is value with the faith-based community; but, beyond

that, how can we integrate that transition using faith-based services?

Colonel MORRIS. Madam Chair, there certainly is value in collaboration between faith-based institutions and the VA and being a part of the reintegration process. We do this in Minnesota in a variety of ways. We train clergy in every community that wants to be a yellow-ribbon community in how to help military families during deployments, and then how to help returning combat veterans reintegrate into their community and into their family.

Another thing that faith-based organizations can do is be a part of the employment process. The military does not provide guidance counseling, nor should it, to veterans preparing to leave in how to reenter this free market globally oriented economy. It is a tough transition to find a job here when you have been hauling a rifle around the mountains of Afghanistan. Faith-based organizations have employed people who have done it. Life-to-life transfer, those skills, job-seeking support groups and faith-based organizations are a grass-roots, easy-to-tap sort of a resource that doesn't cost anybody anything, and it provides that sense of community that a veteran needs to hang in there to find that job. This is just a couple of examples. There are plenty more that can be done to tap that virtually untapped segment of our community.

Ms. BUERKLE. Thank you. Dr. Ake, what is, if any, the VA's involvement with the National Child Traumatic Stress Network?

Mr. AKE. To my knowledge there are many different collaborative efforts, including a Webinar tomorrow, a master speaking series from Zero to Three, and the National Child Traumatic Stress Network focused on making sure services are available to veteran families. And so the network often draws on the expertise of many different entities working with military and veteran families to speak on their perspective on how to help them.

Ms. BUERKLE. So that is your group, not the VA. Are you working directly with the VA?

Mr. AKE. I think that is one example as far as drawing on VA speakers for the master speaker series, but there are others related to the Adapt program in Minnesota where there is an after-deployment adapting parenting tools program pulling from several different groups, but I would need to defer to the partners that are actually doing those initiatives.

Ms. BUERKLE. Thank you. Dr. Wadsworth, in your testimony you talk about structural barriers more so with the veteran population. Can you expand on that a little bit?

Ms. WADSWORTH. Yes. I think because the Veterans Administration and those who care about the Veterans Administration care a lot about making sure that veterans privacy is protected, making sure that veterans are never subjected to care that is of substandard quality. There are many rules and policies and restrictions and checks and balances in place to try to ensure that all those things happen, but the result is that it can make it very difficult to move forward in collaboration.

My primary identity is as a researcher. If I would like to conduct a study of a VA population, the study must be led by a Veterans Administration principal investigator, and that is a structural bar-

rier because it means I have to find somebody who would agree to let me partner with them to do the study.

We have a partner who we work with to do outreach. They actually arranged for us to receive the funding instead of them, because we can work with hotels and do logistics more easily than they can. So people find creative workarounds. But these same policies, in many cases that are put in place to protect, end up serving as barriers.

Ms. BUERKLE. Thank you. And last, Dr. Rudd, you mentioned education being the second-best place to serve as a safety net to locate veterans. Do you have any suggestions for how we can integrate that piece into education with our universities and our colleges and our community colleges?

Mr. RUDD. Well, I think there are a number of things we can do. The VA has already implemented the Vet Success on Campus program, which provides actually benefits counselors and rehabilitation counselors that work on university campuses, so they are hired and employed by the VA but actually are placed on the university campus, which is a very good program.

But I would tell you that the kind of barrier that exists is a really simple one. So if you take that program as an example of which the University of Utah just started participating this year, the VA has broadly expanded that program over the course of the last year. One of the issues for us, we ultimately were able to work through it, was that we didn't actually get to be involved in the interview process for the hiring of that employee. So we had two employees hired. We didn't get to participate in the interview process because it is a VA employee, but yet they are going to work full time on our campus. Real partnering means that you participate fully. It doesn't mean we get to make the decision, but it means we get to be intimately involved in that partnership, and I think expanding that program would be wonderful.

The VA is also experimenting with the placement of psychologists in counseling centers, and so if you look in the University of Texas at Austin, this past year they hired a VA psychologist to work specifically in the counseling center to provide therapy, given issues of stigma at local VA medical centers, and these are individuals that are trained very specifically in the treatment of combat-related trauma. That is a wonderful program. It would be nice to see that expanded and, again, to have that be a true partnership so that you don't necessarily get to dictate who is hired but you are involved in the process of hiring and making sure that it is the right person for the campus.

The last thing that I would suggest is that universities as a whole could do a better job at probably the issue that Colonel Morris spoke to, which is really giving credit for military experience. We need to do a better job at giving soldiers credit for life experiences and technical training that they have, and providing college credit for that that facilitates employment.

So I would tell you on the university side, we can do a better job. And actually our center is going to pursue some effort nationally about trying to coordinate that in terms of giving academic credit, facilitating the employment picture for veterans.

Ms. BUERKLE. Thank you all very much.

I now yield 5 minutes to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you, Madam Chair. Once again I would like to thank the four panelists for your testimony this afternoon.

Colonel Morris, what would you say is the biggest difference there is between reintegration between Guard and Reserves as opposed to the Active military?

Colonel MORRIS. Sir, I have done it both ways. Andy and I spent a lot of time talking about this. I think that the Federal soldier, sailor, airman, and marine, the Active Duty or the reservist, have the most difficult challenge. Generally they are returning to a place different than they served, and often if they are a Reservist, their unit has been pulled together from diverse geographic locations, and they are going home alone or in ones and twos. I have gone to war as a person all by myself, the Army of one, and it is not fun to come home as the Army of one. Guard units generally return as a community, out of an armory located in a community; they have built-in camaraderie and community support. I think the Guard actually has an advantage in terms of reintegration.

I think the toughest organization for reintegration is the United States Marine Corps, an elite, proud group. And elite warriors across the services that are serving on Active Duty have a very tough challenge coming back. They leave a very community, they have a lot of secrets, and they come back to a public that absolutely does not understand what they have done, and they are by themselves. They have the hardest challenge, no doubt.

Mr. MICHAUD. Thank you.

Dr. Rudd, you mentioned the Pew Research Center, and part of the study had talked about—you mentioned 44 percent of the post-9/11 veterans say their readjustment to civilian life was difficult by contrast to just 25 percent of veterans who served in earlier eras. What do you distinguish—or do you know in this study why the difference? Is it because if you look at what is happening in Iraq and Afghanistan, a huge influx of Guard and Reserves, or do you think there is a distinction between Guard and Reserves in the readjustment versus Active military?

Mr. RUDD. I think that is a great question. I would tell you, it is somewhat speculative, it is probably a combination of those things. I think reintegration is problematic from one perspective in that fewer and fewer Americans serve in the Armed Forces, and so fewer and fewer understand the issues that military face.

I think, too, I think a larger portion of the combat mission has fallen to Guard and reservists, which makes it a little bit more difficult in terms of reintegration. The primary problem, if you look at the West, if you look at Utah as an example, one of the challenges for our Guard individuals is the dispersion after they return, that they are dispersed into relatively low populated areas, limited access to service, and limited access to one another, so that there is limited access to one another.

One of the wonderful things about student veterans is that they have an opportunity to gather on a campus, they have an opportunity to identify on a campus, and that helps. And I think that that is a part of what churches do. I think that they provide an opportunity to gather, provide that critical emotional support.

So I think it is probably a confluence of factors and that these have been unique wars. It is a unique time in our history, and the way that we structured the military is very much unique relative to Vietnam, relative to Korea, and relative to World War II, and as a result I think the reintegration challenges are unique.

Mr. MICHAUD. Thank you.

Dr. Wadsworth, you discussed in your testimony the structural barriers to collaboration as it pertains to the VA system. Do you find the same barriers are there dealing with the Department of Defense?

Ms. WADSWORTH. There certainly are some barriers. I would say that over the course of this war, DoD has really come to understand that they cannot rely on simply their own resources to meet the needs, particularly of the Reserve component, and with the closing of bases and the increased reliance on the Reserve component, they must partner with communities. I think they still are working out their models, but there are many, many examples of partnerships really permeating throughout the country. For example, an extensive partnership with the cooperative extension system, which means that DoD now has a reach into every county in the country.

Mr. MICHAUD. My last question is for Colonel Morris. How many community organizations does Beyond the Yellow Ribbon Initiative work with? Is it pretty much throughout your State?

Colonel MORRIS. Sir, we have 73 communities that the Governor has officially recognized as yellow-ribbon communities, dozens of corporations and different entities, faith-based organizations, that have been recognized as well.

The adjutant general's plan is that every community in Minnesota that has a National Guard, Army Reserve, Navy Reserve facility will be a yellow-ribbon community. We anticipate being well over a hundred. Each community has to train every aspect of their community: faith-based, law enforcement, behavioral mental health, education and employers. So it is an extensive effort to get every community online to do what they really want to do, and that is go Beyond the Yellow Ribbon and take care of their military families and their veterans.

Mr. MICHAUD. Great. Thank you. Thank you very much, Madam Chair.

Ms. BUERKLE. Thank you, Mr. Michaud. I now yield to the gentleman from New Jersey, Mr. Runyan.

Mr. RUNYAN. Thank you, Madam Chair. I know, Dr. Rudd just kind of answered my question in just giving the opportunity to meet and talk, but I can tell you firsthand in my district there is actually a faith-based hospital system that does a lot of the mental health for the joint base there in my district. And it has been a tremendous help because it really comes on—especially when you talk about the West, but in my district, too, access to care is a huge part of it. And I think what the chaplain is really saying, and I want to ask you this, because that is the ultimate issue is the access, whether it is religious based or whether it is on a college campus.

In the programs you run, what is that initial hurdle? What got that ball rolling to make this a community-based—to get the community involved? Because I know the community on many levels

in the Guard—in dealing with the Guard is involved. But on this aspect of it, what was the one thing that got the ball rolling and allowed it to happen?

Colonel MORRIS. Well, two things, sir. Our previous adjutant general hired me with this statement: I don't want my soldiers treated the way I was when I came home from Vietnam. Go fix that.

Pretty big challenge. But what he was saying is I don't want my soldiers stigmatized by the people who sent them to war. So that put it right down at the community level.

It is very obvious in Minnesota where we have a lot of trained behavioral mental health professionals, chemical dependency professionals, that anybody needing that kind of care is much more comfortable using their TRICARE benefits in their backyard, with people that they know and trust, versus traveling to a large institution that is unfamiliar to them. But helping those people understand what our peculiar set of issues might be, how to get that training, that was a challenge for us at first, because the people with that training are inside the VA. So getting them to come out and share the wealth of experience with the provider at the local level was initially a tough hurdle to overcome, and we have overcome it; and now maybe too well, because now we have a constant message of, "You are mentally ill, you are a victim. You went to war."

Most of us are not mentally ill, most of us were not traumatized in war. The fact of the matter is, after three combat tours, I can certify most of us were bored to death. We never saw anybody to shoot, and we never fired our weapon. We were never fired at. So we have a whole different set of issues to deal with. But we have trumpeted that issue so well that I have a steady stream of mental health providers offering me help, more than I could probably use. Good collaboration with the VA; I just don't have enough employers. That is my next hurdle.

Mr. RUNYAN. I think we would all agree on that as we continue to—our unemployment in our men and women coming home continue to rise. And with that I yield back, Chairman.

Ms. BUERKLE. Thank you. Mr. Donnelly.

Mr. DONNELLY. Thank you, Madam Chair.

This would be to Dr. Rudd and Dr. Wadsworth. When you talk about college programs and college models that you have, is there any effort being put in now to, in effect, almost putting like a college, here is a model college program together, something that can be used at IU or at TCU or at Rice or at any other schools that are out there that they can almost get a turnkey program?

Mr. RUDD. I think there are. I can tell you that actually our center is leading an effort on two fronts. One on the mental health front; but also more broadly, just on student reintegration, we are actually trying to initiate forming a national consortium to do that very thing, to say here are best practices on college campuses both in terms of how you work with distressed students, but more importantly, how you work with transitioning students from their education to employment. And really trying to create community partnerships is a piece of that, so that we can help individuals find jobs and make the transition. So I would tell you that there is some effort.

The other thing I would tell you is that the VA actually has been very proactive in this area. We have the Assistant Secretary for Policy and Planning is going to come visit our campus at the end of March for this very issue. We are looking at exploring how do we partner, how do we get models in place, and then how do we distribute and, most importantly, how do we do that quickly?

Mr. DONNELLY. Dr. Wadsworth.

Ms. WADSWORTH. Yes, I think the data are still not completely clear about exactly which strategies work the best, but we do know promising practices. In Indiana we have actually been working with institutions across the State, so we approached it right from the beginning at a systemic level, and we try to think about it from a life-cycle perspective: What do colleges and universities have to do to be well prepared for students when they first get there, including transfer credit; how do they best support them while they are there; and how do they ease the transition from the campus?

And so we are working with systems of higher education to try to help them remove some of the structural barriers, and that is where the transfer credit issue really can come in.

We also work closely with student veteran organizations who are a key element, I think, in providing a sense of home on campus where student veterans can find each other and help each other.

Mr. DONNELLY. Thank you very much.

Dr. Morris, or Chaplain Morris, one of the areas that has continued to break everyone's hearts here is the suicide of vets, and a lot of these cases you hear afterwards say, Well, I saw one or two people, but they never really understood me.

I just wonder if you have any ideas on what organizations or what people or what are the critical elements to best have someone who can understand that person when they talk to them?

Colonel MORRIS. Sir, first of all, after Indiana beat Minnesota twice this year in basketball, I am struggling with depression.

Mr. DONNELLY. Well, sir, we haven't won a national championship in about 25 years, so we give it a good run ourselves.

Colonel MORRIS. Minnesota tragically leads the Nation in terms of the National Guard in suicide, so this is an issue that has got the entire focus of our Governor, adjutant general, and all the staff. I wish I had a magic answer for you, sir. We have thrown everything against this problem that we possibly can.

I think General Chiarelli, before he retired, his exhaustive report to the Army on this issue highlighted several things. We need to do a better job screening before people come into the military because we know that we have seen suicides of people who brought preexisting conditions to us. In the Minnesota Guard, most who committed suicide never had deployed. Some committed suicide prior to ever going to basic training. Something was going on in their lives before they came to us.

Now, how can we all be more alert? We focus most of our effort on that. Is it the first sergeant, the first line leader, is it the company commander, is it the chaplain? We have decided to train them all down to the squad level leader.

We have also decided to train families, and so we are working aggressively in all our reintegration academies to train our families in suicide prevention. That is a step we have never considered be-

fore. We are doing that full fledged. We train local clergy, we train the local behavioral mental health providers. But, again, we are cognizant that we are fearful that we are going to create a stigma against the people we are actually trying to help, that, again, we are all mentally ill, and we know we are not. We know that society has a suicide problem, not just the military, but we are owning this problem, and we are facing it head on because these are precious soldiers who we have invested so much in and want so much to retain, but we haven't found the magic bullet of the person to solve the problem.

Mr. DONNELLY. Well, thank you very much for your efforts on this, and obviously it is a concern to all of us because these men and women come back having served our country, and they reach out, and what you hear time after time is, "I couldn't find anybody who really understood what I am going through."

And so we will stay after it, but thank all of you for your help. Madam Chair, I yield back. Thank you.

Ms. BUERKLE. Thank you, Mr. Donnelly. I now yield to the gentleman from Texas, Mr. Reyes.

Mr. REYES. Thank you, Madam Chair. I appreciate the opportunity to be here. I am wondering, if we go back even to the days of the Romans, if they didn't deal with these same kinds of issues. And I say that because I came back from Vietnam after serving with some really bad guys that society had said, "You have a choice, go to jail or go to the Army." And those were very good soldiers that exemplified, the bad cards that they were dealt for many different reasons.

Obviously I don't know what happened to them after we came back from Vietnam. I can only use my example that having come back under the circumstances that we came back under, where we weren't received well, we each individually wrestled with the question, what I did for the past 13 months, was that worth it for these people that are ungrateful? But what got me through was my family. My family and a priest that my mom said, You know, you need to go to Father Velazquez and have him help you through this. So community and family are an important part of the healing process.

But I am wondering, for those soldiers that were dealt the bad hand, that went and excelled under the most difficult circumstances anybody who has been in combat can tell you it sucks. It is the most difficult challenge you will ever face. But they did it, and they excelled. I don't know if it was because they came from the inner cities or they came from gangs, or whatever the situation was. I can tell you, they were very good soldiers that knew how to fight, and fought and distinguished themselves.

So you fast-forward to today, and the situation is dramatically different. The country appreciates the all-volunteer force. I am a little bit troubled, Chaplain, by the fact that you make a statement that some of these people had issues when they joined the military. I thought we had a way of screening, because these are all volunteers in today's military. They are supported, at least in my community, 110 percent by the people of El Paso, Texas; including Fort Bliss, White Sands, and Holloman.

So I am wondering, should the VA be doing some kind of research that includes either case histories or organizations or a community's role in how you embrace your soldiers? Wel send them into combat on the drop of a hat and therefore, we better be there for them when they come back with nightmares and, all the things that a lot of us experienced but got through because of our family and because of a priest or a rabbi or another religion figure. Sometimes a buddy would do help get you through an experience.

So should the VA be doing some kind of comprehensive research? You know, here it is centuries after the Roman legions, and before that the Vikings. I am just thinking, if you were in combat, no matter whether it is modern or ancient, that is pretty tough stuff that you have to deal with. So anybody have any thoughts on that?

Colonel MORRIS. Sir, Chaplain Morris. First of all, thank you for your service and welcome home. I want to tell you something about your generation, sir. Referring back to my general's challenge to me, don't let this generation be treated like me. It was pointed out to me very quickly by Vietnam veterans that despite the stigma of America, you now lead this Nation in every area of productivity; you run our universities, our hospitals; you are our political leaders; you have attained the highest offices in the land despite the stigma heaped on you. And I keep using that illustration with my young veterans: If you could attain the position you have today, despite all you went through, we should be able to go to Mars and back with all the goodwill that we have today, and all the gains we have today are because of the pain of the Vietnam veteran. So, sir, I salute you and your colleagues. Welcome back, you have done a great job.

Should the VA study this issue? They are, sir. The Minneapolis VA, the RINGS 1 and RINGS 2 study will be the definitive study on the challenges of reintegration, and has within it the seeds for understanding how to successfully bring soldiers all the way back. This brigade that is in Iraq today from the Minnesota Guard is under the research of the Minneapolis VA, and I think when this longitudinal study is put together, we are going to have the answers to the questions that you raise. But I do think, sir, we have to do a better job in the all-volunteer Army screening for prior mental health issues.

I intervened personally in Iraq in five cases where soldiers were suicidal. They were on medication prior to enlisting in the military, knew they couldn't enlist if they took and owned up to what they were on under the care of a psychiatrist. They stopped taking the medication, made it through basic, made it through advanced individual training, got into combat, and spiraled to become suicidal. They should have never been on the battlefield.

We do not provide much screening for mental health issues other than to ask you, Do you have a history and are you taking any medication? That is a pretty low bar. So undoubtedly, I am telling you from firsthand, we have taken people in and we are taking people in who should not be in the military because of conditions that they are afflicted with. We have to do a better job on the front end if we want to see that suicide rate go down.

Mr. REYES. Thank you. Madam Chair, maybe that is something that we can pursue via a hearing at a later date, because I really

do think it is important, especially if we have that sense that there are those that are coming into an all-volunteer force. Maybe we ought to find out what percentage you would think that they were. But it is something worth pursuing.

Ms. BUERKLE. It certainly is worth pursuing. Thank you all very much for your testimony and for answering our questions, and you are all dismissed. Thank you.

I invite the third panel to the witness table. Joining us on our third panel is Reverend E. Terri LaVelle, director of the Center for Faith-Based and Neighborhood Partnerships in the Office of the Secretary for the U.S. Department of Veterans Affairs; and Chaplain Michael McCoy, Sr., associate director for the National Chaplain Center for Veterans Health Administration in the U.S. Department of Veterans Affairs.

Before we begin your testimonies, I would like to thank Chaplain McCoy for his service to the Navy.

Reverend LaVelle, you may proceed.

STATEMENTS OF REV. E. TERRI LAVELLE, DIRECTOR, CENTER FOR FAITH-BASED AND NEIGHBORHOOD PARTNERSHIPS, OFFICE OF THE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND CHAPLAIN MICHAEL MCCOY, SR., ASSOCIATE DIRECTOR, NATIONAL CHAPLAIN CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF REVEREND E. TERRI LAVELLE

Reverend LAVELLE. Chairman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, thank you for the opportunity to appear before you today to discuss VA's outreach to faith-based, nonprofit community leaders and organizations to better equip them to work with our veterans, their family survivors, and caregivers.

As director of the Center for Faith-Based and Neighborhood Partnerships since September 2009, every day I draw on my experience as a registered nurse, ordained minister, and program director to connect faith-based nonprofit and community leaders to the people, programs, and services VA offers our veterans. Our primary goal, focus, and mission is to get our veterans the help they need and deserve.

The Center for Faith-Based and Neighborhood Partnerships, along with VA colleagues from across the country, work hard to develop strong partnerships with faith-based, nonprofit and community leaders and to provide them with the information on VA services and invite them to participate in VA programs.

Every day, servicemembers are returning home to stay, some after multiple deployments. After returning home—returning home can be challenging. Often I hear stories about how difficult it is for these veterans to connect with family, settle into a new routine, and find work. These challenges may seem commonplace to us, but they represent unique stresses for our veterans. Many veterans seek help and support from family, their place of worship, or their community. When they do, we at the Center for Faith-Based and

Neighborhood Partnerships make sure these individuals are well equipped to provide information on VA's programs and services.

Just as important, we make sure that every leader knows at least one VA staff person he or she can call on when working with a veteran, someone who can act as a resource and help them help the veteran in need and find useful VA programs and services. We do this by cohosting outreach events across the country to introduce faith and community leaders to the programs and services VA provides. We try to help these leaders understand how to work with VA and other partners and, in doing so, expand and enhance the ministries and programs they currently have in place that can serve veterans.

For example, sometimes the only thing keeping a veteran from getting the health or mental health or benefit services he or she needs from the VA is not having a way to get to the necessary clinic or office, so an organization may want to provide transportation through their existing transportation ministry, providing each veteran with a dependable free ride. The organization can work with VA's voluntary service office, which is located at every VA medical center, to coordinate a volunteer transportation program. Volunteer services is ready with all the information the organization needs to spring into action.

In addition, many faith-based organizations have counseling ministries or programs unfamiliar with the unique challenges veterans face returning home—and their families. VA chaplains and social workers will provide training to community leaders, pastors, lay leaders, and support staff to help them understand the unique needs and challenges veterans may be facing. In all of our outreach efforts, VA includes both local and regional VA staff as panelists and roundtable participants and a VA chaplain who can provide an understanding on the special needs of veterans returning from deployment.

We grow our relationships with community and faith-based leaders by hosting quarterly conference calls, maintaining an informative Web site, and sending information out on a regular basis to over 1,200 Listserve members, and our Listserve is growing all the time. We know our veterans come from a variety of different backgrounds, cultures, and faith traditions and that they represent the diversity that makes up our great country, so we continue to expand our outreach by developing new relationships with diverse communities.

Madam Chairwoman, I believe that, without a vision, that people perish; but under the leadership of Secretary Shinseki and the Center for Faith-Based and Neighborhood Partnerships, our veterans will not perish. We offer a vision and a plan for preparing faith-based and community leaders with the tools they need to serve our veterans in their communities.

I would also like to extend my thanks to all of my fellow panelists and our elected officials who have served in our military for your service and your sacrifice.

I am now prepared to answer any questions.

[The prepared statement of Reverend LaVelle appears on p. 54.]

Ms. BUERKLE. Thank you very much, Reverend LaVelle.

Chaplain McCoy, you may proceed.

STATEMENT OF
LIEUTENANT COMMANDER MICHAEL MCCOY, SR.

Lieutenant Commander MCCOY. Chairwoman Buerkle and Ranking Member Michaud, and Members of the Subcommittee, thank you for the opportunity to speak about the Department of Veterans Affairs (VA) Chaplain Service's outreach efforts with community and faith-based organizations.

As a VA chaplain over the last 21 years and a former Navy chaplain, I have found one of my greatest joys has been working with veterans and providing meaningful programs to aid them in their healing. My testimony today will cover three programs created by VA chaplains to help build bridges between VA, the faith-based communities, and neighborhood leaders to aid in the spiritual care of our returning veterans and their families.

The VA National Chaplain Center started the Veterans Community Outreach Initiative to educate community clergy about the spiritual and emotional needs of our returning veterans and their families. Nationwide, VA chaplains have conducted over 200 training events and provided education to approximately 10,000 clergy through this effort. As a result, clergy across the Nation are learning to help veterans identify and cope with readjustment challenges the veterans and their families face following deployment, identify the psychological and spiritual effects of war trauma on survivors, and serve as a trusted and knowledgeable resource for veterans to use to connect with VA.

Just a week ago I received a phone call from a local pastor in Virginia who had attended one of our outreach events. He said, "I am very impressed by the passionate commitment and excellent resources available to veterans, and I need your help. Today a member of my church, whose son recently returned from deployment in Iraq, called me, hopeless, his father did, and in despair. He said the young man had just been arrested and put in jail in Richmond, Virginia. His father said his son was clearly experiencing PTSD, but he didn't know how to help him. Can you help me link the veteran to the VA services he needs?" I promptly made the call linking the veteran to VA providers who could most effectively care for him.

This is just one among many veterans who has benefited from the Veteran Community Outreach Initiative events that our chaplains are sponsoring to establish collegial relationships between VA chaplains and community clergy. I truly believe that a worthy goal of this program is for local clergy across the Nation to say, "I know the local VA MC chaplains. They are devoted to care for veterans and their families. If I call them, they will help me connect families who have come to me for guidance to the VA resources they need."

Each clergy who attends a VCOI event receives a tool kit, prepared by the National Chaplain Center, of books, brochures, information packets and important phone numbers and Web sites to aid them in providing a helpful support to the veterans and his or her family.

My time here is short, so I will just briefly mention two other important VA programs. Our marriage enrichment program was developed based on concerns over the large number of stress marriages experienced by our veterans who are returning. We have dis-

covered that all too often the spouse who has gone to war and returned may have physical, emotional, and spiritual wounds that have not yet healed. These stresses often led to family crisis and divorce, so we began a program called Getting It Back, reclaiming your relationship after combat deployment. It is designed to help married couples develop healthy ways of interacting and relating with one another. Community leaders and faith-based volunteers collaborating with VA chaplains, psychiatrists, and social workers have contributed in making the program a success.

Finally, I will mention our Heal the Healer program for returning National Guard and Reserve chaplains home from recent deployment. The program offers an open forum to share the experience and emotions associated with employment, introduces them to other chaplains with similar experience, and offers insight on how we may intervene in the future to provide appropriate and timely care for our chaplains returning from combat zones. The stories and tears in these sessions are many. And we, working and caring for our veterans, they too have changed our chaplains who have worn our uniforms in caring for partnerships and creating partnerships with local clergy, our faith group endorsers and community faith group leaders, working together to reach out and offer support to returning chaplains, veterans, and family.

Madam Chair, thank you for the opportunity to share this opportunity with you to speak on these concerns, and I am now prepared to answer any questions.

[The prepared statement of Reverend McCoy appears on p. 56.]

Ms. BUERKLE. Thank you both very much for your testimony. I will now yield myself 5 minutes for questions.

Reverend McCoy, the 200 or so training events that were conducted throughout the country, can you just expand on that a little bit? How do you choose the sites, how many people attend, and is followup done after those events?

Lieutenant Commander MCCOY. Yes, thank you for the opportunity to respond to that question. We have offered actually 233 of these training events throughout the country really, where our VA medical centers primarily are located. What we have done in these particular programs is to identify the readjustment challenges that veterans and their families face following deployment. The goal is to identify psychological and spiritual effects of war trauma, of survivors, consider appropriate pastoral care interventions with the local clergy so they can have some idea, when we talk about PTSD and when we talk about brain injury, that they kind of understand something about these and the signs of these particular diseases.

We had a community clergy to brainstorm with us how we can partner together in order that we can provide the best of care to our returning warriors. We refer veterans to local VA health care facilities. We always give them a packet of information, Web sites, phone numbers, and books that they can have, that is free, and these have been very beneficial in making veterans connect to the VA, and it created relationships among the chaplains with local clergy throughout their various communities.

Ms. BUERKLE. Thank you very much.

Does the VA chaplain group have a strategic plan? For instance, I have a VA facility in my district. We have a wonderful VA hos-

pital in Syracuse, and we had an event where we targeted the clergy. We had a distinguished panel come in and instructed our clergy as to what to look for, what the signs and symptoms are, family involvement. It was very comprehensive. Now, we probably invited maybe 600 members of the clergy, all denominations. No one mentioned your organization. So maybe this is where the disconnect is.

We are talking about all these parallel initiatives going on. How do you get your word out? Do you have a strategic plan to hit all of the communities throughout the country?

Lieutenant Commander MCCOY. Yes, we are expanding that, Madam Chairman. We have a strategic plan, and we have efforts, and the local clergy at that particular VA, and we have a template for them to follow. Our numbers for this outreach is increasing.

I understand you are from the New York area. I think we have had 22 of these veteran outreach programs with clergy in the New York area to this date.

Ms. BUERKLE. We are in Upstate, so that may be different than the New York area. We are in the country.

Lieutenant Commander MCCOY. One of the things we are, if I can—we have started a rural program, and our initiative, rural initiative, is to target some of the rural areas where there is not perhaps VA hospitals, but perhaps where we can use—where we can go near CBOCs or various clinics and so forth where we can offer these services. We always bring in various speakers, not just chaplains, but the clergy. We also have a psychiatrist, a social worker, somebody perhaps from the faith-based community, all to intersect in creating this partnership with us.

Ms. BUERKLE. Thank you very much.

Reverend LaVelle, I understand that much of your outreach efforts center on educating the community about programs and services available through the VA. How do you—what kind of outreach is done with the VA so that they know that you exist and that they know of your services that are available?

Reverend LAVELLE. Well, we have a steering committee, and all three administrations are represented on our steering committee. A representative from the three VA administrations and the VA program and staff offices, and our steering committee meets quarterly. We also do quarterly conference calls where we have internal and external partners that are a part of our Listserve, which includes VA staff. We also work with veterans benefits administrations, vocational rehabilitation and employment service, and four times a year we do outreach events at four different regions throughout the country in partnership with the regional office in that host city. So that is how we get the word out and work collaboratively within VA.

Ms. BUERKLE. Thank you both very much. I now yield to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you, Madam Chair. This question is for both. Colonel, you touched upon it, but what is being done specifically to address the support needs of our veterans that reside in rural areas or underserved areas of the country? Let's start with Reverend LaVelle.

Reverend LAVELLE. Well, one thing. Last year I requested from the Vocational Rehabilitation Employment Services field office that

when they choose the four sites for the fiscal year 2012 roundtables, that one of those sites be a rural area. So that is the one thing we have done. But I also know that our Chaplain Service has had a rural initiative where they have been working with rural clergy.

The other thing I did is that in our quarterly conference call in September of 2011, there is a VA medical center chaplain in Arkansas, in Little Rock, who has started an initiative with rural clergy. We had him as a guest speaker so that he could describe his program so that others on the call could learn how to work with rural clergy.

So those are some of the things that our center has done as relates to outreach to the rural areas.

Lieutenant Commander MCCOY. Thank you for that opportunity to respond. We as chaplains have begun a rural clergy program with a strategy, and this—as a matter of fact, next week we are having one, I think it is going to be in the Roanoke area, and we are moving throughout the country and we will expand that program, and I think there will be several this year, but we will expand it in rural areas. We are actually targeting these areas. We are sending out hundreds of invitations and letters. We are working with the community clergy to also—sometimes, I found out, when other clergy sometimes talk to other clergy, you get better attendance. So we are using word of mouth and using the presidents of some of the clergy associations to help us bridge this gap.

Mr. MICHAUD. Reverend LaVelle, you mentioned the four areas. Which area is the rural area? You mentioned you did outreach in four areas. What one is going to be in the rural area? What is your definition of what area is the rural area?

Reverend LAVELLE. Well, I don't have—I don't know the definition of a rural area. But I just made the request to the field office for Veterans Benefits Administration to say one of the areas needed to be a rural area, and the four cities that they gave us back for this year was Huntington, West Virginia; Albuquerque, New Mexico; Lincoln, Nebraska; and Boston, Massachusetts. And if I am not mistaken, it is the Huntington——

Mr. MICHAUD. I think there is a definition problem because those are not—none of them are rural.

Reverend LAVELLE. Okay. Then I will go back and check with them, but I specifically requested.

The other problem is that—it is not a problem, I shouldn't say that. They sent me an email maybe a week ago, and I have been away on travel, that some of those cities are changing. So they must have—because I reiterated, but those are the initial cities they sent me for fiscal year 2012. I apologize. I don't have in my head the definition of "rural."

Mr. MICHAUD. Well, I mean, when you mentioned one of those four areas should be rural, I mean the fact that you just said all four are cities, you know, that is not rural. When you look at what is happening with our Active military as well as the veterans that actually do live in rural areas, I think they should not be left behind. So since you are the director of the VA Center for Faith-Based and Neighborhood Partnerships within the VA system, have you talked to the Office of Rural Health?

Reverend LAVELLE. Yes, I have met with them once. Yes, I met with them, and I will go back, and really for my own benefit get the—what they define as rural, so that I make sure when I get the information again from the field office that there is a meeting of the minds and that we are both speaking the same language.

Mr. MICHAUD. You said you met with them once?

Reverend LAVELLE. When I first came on board.

Mr. MICHAUD. How long have you been on board?

Reverend LAVELLE. It has been 2½ years.

Mr. MICHAUD. Two-and-a-half years.

Reverend LAVELLE. But the field offices are the people that actually work with them and provide me with the locations. I don't make that determination. But I will definitely follow up, and if you want me to, I can get back to your office with the definitive information.

Mr. MICHAUD. Thank you. You talk about collaboration with faith-based organizations. To the best of your knowledge, do these faith-based organizations, do they charge veterans to access whatever help that they might need, do you know?

Lieutenant Commander MCCOY. May I answer that? No. Most are volunteers. They actually, out of their compassion and their love and willingness to help the veterans, they have went into their pockets often to provide services for our veterans, either transportation or various types of programs that they are offering in the communities.

Reverend LAVELLE. The organizations that I have worked with, the churches that have transportation ministries, have said we are more than willing to say that so many days a week, so many hours, we will use our current transportation ministry to get veterans to and from appointments. Churches that have counseling ministries or support groups have said, "We are more than willing to develop a support group if you can provide us with people to come in and talk to us specifically about the unique challenges of veterans returning from combat."

Like my home church here in D.C., our entire counseling ministry consists of Ph.D.s and licensed clinical social workers, but their expertise has not been in dealing with veterans per se, so they are open to having VA chaplains and/or our social workers come in and do training so that they are better equipped as our veterans return and become a part—and return to the church, to work with them and their families without any charge.

Mr. MICHAUD. Thank you. I see my time has run out. Thank you very much.

Ms. BUERKLE. I now yield to the gentleman from Texas, Mr. Reyes.

Mr. REYES. Thank you, Madam Chair. You mentioned the four cities in 2012. Did you have four cities in 2011?

Reverend LAVELLE. Yes, the Center for Faith-Based and Neighborhood Partnerships has been collaborating with VBA, Vocational Rehabilitation and Employment Service since 2005 in these efforts, yes.

Mr. REYES. So in 2011 what were those cities; do you have that information?

Reverend LAVELLE. Yes, I do.

Mr. REYES. The reason I ask is because, traditionally, Texas and California have the most veterans and the most Active Duty——

Reverend LAVELLE. The center was in Waco, Texas, twice. Once in Waco, Texas, as a result of VBA and the center's collaboration, but then the Waco Foundation requested that we come back and do another roundtable. And so then when I came on board we went back to Waco, Texas. We were in——

Mr. REYES. Just out of curiosity, why can't your outreach programs be part of every VA director's duties? For instance, I have a VA clinic, what they call a super clinic, in El Paso. Joan Ricard is our director. Why can't your programs be part of the menu of services, or have her be responsible to provide information? As the chairwoman said, in her case she actually convened people at a meeting and your programs never came up. I find that a little bit troubling.

So why can't it be part of every Veterans Administration director? Albuquerque is good, they are 386 miles northwest of El Paso, but they serve a different clientele than the El Paso VA clinic. And if not by the VA director, why not the VISN? But there has got to be a way to send the information out because veterans desperately need these kinds of support systems.

Lieutenant Commander MCCOY. Thank you for that question because we are collaborating with the Office of Rural Health and with our programs and chaplains, and we also are collaborating with mental health and other agencies. All of our chaplains who worked for various VA medical centers have been basically mandated to provide this type of program.

Now, in terms of the rural health, we at the National Center, with chaplains of course, move out into various other areas.

Mr. REYES. So is the closest chaplain to El Paso in Waco?

Lieutenant Commander MCCOY. Yes.

Mr. REYES. It is? That is 600 miles. Albuquerque is closer to me than Waco, and that is what——

Lieutenant Commander MCCOY. Now, you do have clinics. And so we have chaplains that will visit occasionally those clinics. And we also are going to expand the program where we will have—actually, hopefully, we will have programs in the clinics—that is our directions—and to go out to the various locations.

Now, all of the faith-based activities do not happen, or these clergy events do not happen in a VA hospital or a VA facility. They are happening in churches, educational buildings, and that type of thing.

Mr. REYES. I understand that, but I have a veterans meeting every month. It is a citizens advisory panel for veterans.

Lieutenant Commander MCCOY. Yes.

Mr. REYES. And Joan Ricard goes there every month. She is very good about attending. But the times that I have been, we have never heard the information about your programs. So is there a reason why you can't designate the VA directors in our respective areas to provide information and a process? I think it makes perfect sense for Joan Ricard to have these programs and to select maybe a clergy board or some other system where there is a chaplain or chaplains, because we have a facility that is going to grow

to 45,000 soldiers and they are all coming back from multiple tours in Iraq and Afghanistan.

I hear it from the priests, the ministers, and the rabbis of the work that they are doing to support the military, both soldiers and their families. And I also hear it from judges that are working in the family courts where there are divorces going on, and they are asking me why isn't there some kind of an intervention program that provides counseling for these families that are being torn apart because of multiple tours and things like that? I think this would be a great way to at least try to do that, and I don't understand why the VA wouldn't want to impart that authority or that responsibility to our VA directors. I certainly hope you would take that back, and maybe we can follow that up and make that happen somehow.

Reverend LAVELLE. I can—I will definitely send an email to the chief of staff for VHA, who is someone I have worked with closely when I am getting VA staff to speak at these regional events, and bring this issue to her attention.

The other thing, though, is that at every medical center there is what is called a minority veterans program coordinator, and as an ancillary duty, it is not part of their paid job. But every medical center has a coordinator, minority mentors program coordinator, who part of their responsibility is to do outreach. So maybe sometimes we are not getting the information to the right person.

What would be helpful for my center is if we could find out who the faith liaison is at either here in D.C. for every congressional office, because then we could at least let them know what we are doing and, when we have events, get the information to them to say let the faith leaders of your community know this is what we are doing, and we can get information out that way. That would be one step to kind of bridge this divide between at least your Representatives within the congressional districts or at least starting here in D.C. or in your congressional district. Like there are some people that I know in different offices, so I automatically send them stuff just because I have known them.

Mr. REYES. That tells me that there needs to be——

Reverend LAVELLE. We need to broaden that. I will contact the staff of VHA and say this is an idea that came up, how do we get some kind of relationship going with your medical center directors so they have our information on hand and can disseminate it and work more closely with the faith communities, and then keep us abreast, and we figure out how to help them develop those relationships.

Mr. REYES. Especially when, as Congressman Michaud was talking about, when it is the rural areas, there are huge gaps out there. You are talking about States like Idaho, Wyoming, Colorado that have a lot of rural areas. Texas in the panhandle and all of—most of West Texas that is not El Paso, that is all rural area.

Lieutenant Commander MCCOY. Yes. And, sir, I agree that we need—we can expand that. But I think that one of the things, that all chaplains in the VA work for a director of a VA medical center. So I think with that in mind and with our policy from the National Chaplain Center, I have went to many—several of these events,

and the director has been the one who has given the opening welcome at the event for the clergy.

Mr. MICHAUD. Thank you, Madam Chair.

Ms. BUERKLE. Thank you both very much. I must say I am a bit chagrined, and, maybe worse than that, concerned because when we did our symposium on faith-based providers and invited the clergy, we did have the VA there because we wanted them to be able to tell the clergy members what services are available. And even the VA didn't mention your offices. They made no mention of it at all, that either program existed. I think we have a really big disconnect here in knowing what is available and what is out there.

If I could, Chaplain McCoy, I would ask that you provide for us the template that you spoke about earlier and the tool kit that you spoke about earlier so we can see what it is you are doing.

Lieutenant Commander MCCOY. Yes.

Ms. BUERKLE. To make sure we get our veterans the services they need.

Lieutenant Commander MCCOY. I will.

Ms. BUERKLE. Thank you both very much for your time and answering our questions. You are both excused. Thank you.

In closing here today, I think that Chaplain Morris said it best: we really do need a community effort to make sure that our veterans have what they need. We expect and look to the VA to be a leading partner in this. That is their mission.

It is going to be important for all of us to look to our communities and make sure every section is covered. And Mr. Runyan has left, but I think his comments, and Chaplain Morris' comments about employment and making sure our economy gets back on track so when our veterans come home, there is a good, viable alternative and that they can seek an engaging good job. With regard to the universities—those who choose to go back to the universities and be educated—that there be that safety net that Dr. Rudd spoke of, and that they are equipped to know and appreciate and understand what the veterans are up to—and what they are up against, I should say.

With that, I ask unanimous consent that all Members have 5 legislative days to revise and extend remarks and include extraneous material. Without objection, so ordered.

Ms. BUERKLE. Thank you again to all of our witnesses and to our veterans who have served our Nation so courageously, and to each of our audience members for joining today's conversation. This hearing is now adjourned.

[Whereupon, 6:04 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Ann Marie Buerkle, Chairwoman, Subcommittee on Health

Good afternoon and thank you all for being here.

Today, we meet to discuss the role of faith-based and community providers in helping servicemembers, veterans, and their families transition from active-duty to civilian life and the need to foster better communication, education, and collaboration between the Department of Veterans Affairs (VA) and these critical community resources.

The responsibility of each one of us to 'care for those who have borne the battle' has never felt so poignant with the brutal toll of a decade of war and a bad economy.

We continue to hear stories of veterans from past conflicts and our recently returning veterans from Iraq and Afghanistan struggling to find a home, a job, or a helping hand. The need to meet these honored heroes where they are and provide them the care, the hope, and the help they earned has never felt so immediate.

As a Nation, we are uniquely blessed to live in a country with a rich history of civic pride and responsibility and it is to these communities where our veterans return home, have maintained existing relationships, and, more often than not, where they first turn for help.

While the primary responsibility for caring for our veterans should and does lie with VA, faith-based and community groups are playing an increasingly key role in supporting the varied needs of our servicemembers, veterans, and their families. They act as a bridge to accessing Federal, State, and local programs and services.

Members of the clergy in particular are often the first point of contact with a veteran grappling with the wounds of war. Data from the VA National Chaplain Center indicates that four out of ten individuals with mental health challenges seek clergy assistance, more than all other mental health providers combined.

We already know that faith-based and community groups can be effective in filling known gaps in VA care and supporting the day-to-day needs of the veteran population.

However, a district symposium I held in my home district of Syracuse, New York, last December, revealed to me a shameful lack of communication, collaboration, and coordination between VA and these critical community resources. And, subsequently, an urgent need to act to establish meaningful partnerships between VA and nongovernmental organizations.

With more of our servicemembers returning home each day, we cannot afford to let any opportunity to better support our veterans pass us by.

Where partnerships exist, they need to be strengthened. Where they don't, they need to be fostered. For a veteran or loved one in need, every door should be an open door.

Again, I thank you all for joining us this afternoon. I look forward to a productive and ongoing conversation.

Prepared Statement of Hon. Michael H. Michaud, Ranking Democratic Member, Subcommittee on Health

I would like to thank everyone for attending today's hearing. This hearing is intended to open up the broader thought process and better understand how the VA and community organizations collaborate to support veterans and their families.

More than 2 million servicemembers have been deployed since September 2001, with hundreds of thousands of them being deployed more than once. As of February 2012, more than 6,000 troops have been killed and over 47,000 have been wounded in action in the recent conflicts.

When these servicemembers come home and take off the uniform, many of them have the expectation that life will just pick up where it left off before being deployed. However, this is just not the case.

Many of them struggle to reconnect with their families and communities. They find themselves feeling isolated and unable to cope. The Department of Veterans Affairs reports that ***half*** of the OEF/OIF/OND population that has accessed VA health care sought mental health treatment.

Post-traumatic stress disorder is the number one reported mental health concern among this population. With so many OEF/OIF/OND servicemembers and veterans experiencing psychological wounds, reports suggest that there is an increase in the rates of suicide, alcohol and drug abuse, homelessness, and domestic violence.

For this reason, it is essential that our servicemembers, veterans, and their families receive the help they need and that they have the necessary tools to rejoin their communities. These tools, programs, and resources would not be possible without the thousands of community organizations across the country that work in partnership with the VA.

At this hearing, I want to hear more about the reintegration challenges that servicemembers and veterans face, as well as the challenges the VA and community organizations face in providing support services. And we need to identify potential solutions to these barriers and how we can strengthen these partnerships.

Despite historic increases in VA funding over the past 5 years, as the Nation prepares for the influx of returning veterans, reintegration efforts are simply not possible without collaboration between the Federal Government, business sector, and nonprofit organizations. And more needs to be done to facilitate these partnerships.

I would like to take the time to thank our panelists for being here with us this afternoon and for the work that you do every day to support our Nation's veterans. I would especially like to thank Mr. Morris and Mr. McCoy for their service as Chaplains in the Minnesota National Guard and at VA's National Chaplain Center, respectively.

In 2009, I lead a Congressional delegation to Afghanistan and came to learn that our servicemembers rely immensely on their chaplains for emotional support. And on every visit since, I've come to respect the unique insights that our chaplains possess in terms of mental health, spiritual guidance, and the overall well-being of our service men and women.

I look forward to hearing from all of our distinguished guests today. Thank you, Madam Chair, and I yield back.

Prepared Statement of Hon. Silvestre Reyes,
Democratic Member, Subcommittee on Health

Thank you Chairwoman Buerkle and Ranking Member Michaud for convening this hearing.

Over the past decade, our Nation has seen the effects of two wars in both Iraq and Afghanistan. Over 2 million servicemembers have been deployed to these regions during that time period and have selflessly served our Nation. These brave men and women and their families have endured a lot.

After completion of their honorable service, many of these men and women will leave our military and return to civilian life. The process of reintegration into the local community is nothing new, as we have had countless numbers of veterans leave military service over the years to seek civilian employment.

Unfortunately, this process of reintegration has not always gone smoothly. Many Vietnam veterans did not receive the care and respect they deserved once they left the military. This cannot occur with our veterans today. Therefore, we must ensure that our servicemembers, veterans, and their families receive the help they need and that they have the necessary tools to re-join their communities.

Reintegration is a cooperative effort among the Federal Government, the business sector, and community organizations, ensuring that our veterans are welcomed back into the local communities where they can contribute as proud, hard-working citizens. They must receive the care and consideration they have earned.

Prepared Statement of Andrew Davis, Veteran

Good afternoon, Chairwoman Buerkle, Ranking Member Michaud and Members of the Committee. Thank you for the invitation to discuss the role of community providers and faith-based organizations in helping servicemembers transition to civilian

life and the need to foster better communication, education, and collaboration between The U.S. Department of Veterans Affairs (VA) and these resources.

My name is Andrew Davis, and I am currently the Director of the Saratoga County, NY Veterans Service Agency and the Founder of the Saratoga County Veterans Resource Initiative. I have been a Veterans Advocate since separating from service in 2004. I served as a United States Army Ranger for 5 years to include two tours of duty in Afghanistan and one in Iraq.

Upon returning to my home in Minnesota to further my education, I was faced with my first taste of how little I knew about being a veteran. In fact, like many of my peers, I was unsure if I even was a veteran. Because of this, I founded a nonprofit veteran support organization on the campus of the University of Minnesota to aid returning veterans in connecting with earned benefits and services. In later roles as a congressional staffer and Department of Defense Transition Assistance Advisor I saw firsthand the disconnect between veterans, their families, and the systems that are intended to support them. For the past 3 years I have spent my career as a veterans advocate either training accredited benefits counselors or being one myself. This has provided me a frontline view of what is lacking in outreach and networked support to our veterans and their families.

Last, I am currently an enrolled patient with the Veterans Health Administration (VHA) in VISN–2 and use both the Albany-Stratton Veterans Administration Medical Center (VAMC) and the Clifton Park, NY Community-Based Outreach Clinic (CBOC) regularly.

Opening Remarks:

Veterans and the ways they serve have changed significantly over the last decade, resulting in the need for changes in the way our country, in turn, serves them. The veterans of today tend to be more geographically dispersed and more mobile than previous generations. Families and communities are affected and changed differently than ever before with multiple deployments and the unique use of the guard and reserve. Many of these individuals suffer from the lack of a "Fort New York" or central support system, making the local community even more crucial in the reintegration process.

Despite a constant bombardment of media in all forms that affords the public access to our current wars, issues facing our neighbors, friends, family members and other local veterans are often invisible to us as communities. Add to this, a military culture that can encourage emotional toughness and self sufficiency, and we face a large potential public health problem.

Last, the uniqueness that makes our military and our veterans population great, also means that there is not a one-size-fits-all support system that can be created nationwide. We must garner community support and use community resources to serve our veterans and their families completely.

Accessing Traditional Veterans Resources:

Issue

First and foremost, the population of veterans that find their way into the VA system of care or benefits delivery system, merely by accident, is staggering. I can safely say that approximately 5–7 veterans knock on our door weekly for some form of unrelated government service(s) to find that they are eligible for veterans benefits because of their service to this Nation. Just last week a young Marine with two tours of duty in Afghanistan appeared in my office asking for directions to the office that handles unemployment benefits. This Marine outlined, that although his home of record on his discharge stated Saratoga Springs, NY, he had no idea who his local contacts in Veterans Services were, or where he could take advantage of his 5 years of free health care from the VA. Nobody, from his pastor, to his friends and family in the community knew how to connect him to his earned benefits and services. If this Marine hadn't knocked on the "wrong" door he would not have met with my staff to turn on his GI Bill benefits or learn where he could enroll in health care.

By all appearances, the U.S. Department of Veterans Affairs has recognized the need for community outreach but holds their hopes in the idea that top down, one sided information will filter down to the grassroots folks at the bottom. For example, in the VISN–2 area of upstate NY, a few competent and well trained veterans justice coordinators have been hired and put in place. However, the operative words here are "a few veterans justice coordinators." These people are responsible for numerous counties and for interacting with courts, district attorney's and law enforcement, when in fact the police officers on the beat and on our streets and highways are where the first difference can be made.

Solution

The correct mindset for reaching veterans must transition to a "no wrong door" approach. This can and should be created through a localized, national training by VA, Veterans Advocates and other experts to all members of local communities. These newly created "Veteran Friendly Communities" would have the tools to make referrals to the proper resources whether a veteran walks into a rectory, a tax assessor's office or is pulled over during a traffic stop.

Additionally, outreach and assistance programs cannot be reactionary in nature. The time to begin helping a veteran in legal trouble for example, is upon first interaction, not just at sentencing. In fact, in my own transition, it was a police officer who pulled me over for driving in Minneapolis like I had in Hadithah and Bagram that introduced me to my first veterans advocate and helped me realize that difficulty transitioning was normal. Additionally, I now receive as an accredited service officer, a large number of referrals from local police officers that I call my friends.

Local Solutions to a National Issue:

While much of our conversation has always revolved around what VA and DoD does, can do and should do better, the reality is that much of the care delivered to veterans in NY and across this country is done through private providers and other not for profit and public sector providers or other forms of government assistance. By urging VA to reach out to these providers, a referral and information sharing system can be implemented to ensure veterans are maximizing their earned benefits and services.

As a veterans advocate, I can and do certainly play a role in culling these local resources. For example, we have created the Saratoga County Veterans Resource Initiative, which gathers local elected officials, college administrators, veterans advocates, private mental health providers, non-profits and others on a quarterly basis to familiarize all with what we do and how referrals can work between organizations. However this is an uphill climb for us because the impression that most of the citizenry has, is that taking care of veterans is solely a VA or Federal Government role. When in reality the transition back to civilian life is a community process. I believe this to be caused by the generally one-sided dissemination of information by the VA to the general public as opposed to community engagement.

Local Engagement Opportunities:

1. The VA has in place a network of county and State veterans benefits counselors that when given a level of training and funding, can and should serve as community liaisons. While the U.S. Department of Veterans Affairs may be our Nations experts on veterans related issues, our community leaders will be who brings veterans back into the fold of everyday life. My experience as a veterans advocate has been that the information sharing is largely one-sided from the VHA to us with little opportunity to engage with the Veterans Benefits Administration (VBA) and the VHA on real issues and improvements. Veteran's advocates are on the "front lines" doing a large amount of VA's enrollment and benefits delivery and are a valuable and many times an undervalued asset.
2. Our country is filled with competent mental health care professionals that are constantly volunteering to treat and see veterans. VA reluctance to use these community-based providers in many instances turns veterans and their families away from treatment at all. VA should look for ways to engage these highly trained professionals so veterans can be treated comfortably in their community.
3. In our county's communities, local law enforcement, clergy and educators have been more than willing to learn about veterans issues and provide referrals to care and benefits. This is merely the first step, but giving those who are willing and able to help an education can go a long ways in figuring out where the legitimate gaps are in the Federal systems. Simply put, existing organization many times do not realize they are already serving veterans. Understanding veterans perspectives and service needs will improve the overall delivery of benefits and services at all levels.
4. Associations such as PBA's, Association of Sheriffs, First Responders and Firefighters typically meet annually and regionally. In both Minnesota and New York we have had little difficulty getting in front of these groups to introduce ourselves and what we do as advocates. The VA should be at these events to not only help veteran members, but to continue to expand their "free" outreach team.
5. The VA has come a long ways in a short amount of time in the use of technology, social media and non-traditional forms of outreach. However, VA must continue to leverage these resources at a localized level to engage a new generation of veterans who is mobile and tech-savvy.

6. The VA can work together with service organizations with mutual benefit to VA, veterans and local posts and chapters to modernize an out-dated model. Veterans of this generation no longer find themselves gathering in mass at their local Legion, but instead gathering via Facebook and Skype. However, the power of gathered voice and advocacy these national organizations provide could be crucial if used properly.
7. The VA's implementation of MyHealth*e*Vet and E–Benefits portals is a step in the right direction, but the centralized and physical nature of enrollment have made it difficult for a financially and employment challenged veterans population to take advantage of these systems. Providing enrollment in the community or even outsourcing enrollment to CBOC's and accredited veterans advocates would assist in these matters greatly.
8. My experience to date has shown me that VA employees in any part of the VA lack a basic understanding of local and State benefits and services. These can range from veterans property tax exemptions like we have in NY to local transportation to medical appointments. Not only are the numerous people taking advantage of these benefits a good place to find potential patients and enrollees, but they are simple, quality of life benefits that can really help a veteran engage the system for the first time.

Conclusion:

In sum, we as a Nation must stand committed to ensuring that sustainable and quality supportive services are accessible to veterans and their families' right in their communities. I believe this can be done leveraging resources that largely already exist and in a cost effective manner. The VA has the geographical disbursement and expertise to lead this charge, but must think outside the box and look to those who are ready and willing to assist in our own backyards. The requirements to make this successful are not numerous. In many cases putting outreach staff at community events is all it will take. We must begin immediately leveraging relationships and expertise that has long existed.

Thank you again to the Committee for allowing me to speak to these important issues.

Prepared Statement of Chaplain John J. Morris

Chairman Buerkle, Ranking Member Michaud, distinguished Members of the Subcommittee, I am honored to appear before you today.

I am the State Chaplain for the Minnesota National Guard. I am the co-founder of the Beyond the Yellow Ribbon initiative. I have spent the last 7 years of my military service facilitating the collaboration of the Minnesota National Guard, faith-based and community organizations and the VA resources of the Midwest VA Health Network (VISN 23) to support the reintegration of over 20,000 Minnesota National Guard combat veterans.

I am a consumer of VA medical care as an enrolled veteran with the Minneapolis VA. I am the father of two combat veteran daughters who are receiving medical care through the VA system.

I am an ardent supporter of the VA and the resources it provides to our veterans.

The Minnesota National Guard Beyond the Yellow Ribbon Collaboration With the VA

In 2005 Major General Larry Shellito, then Adjutant General of the Minnesota National Guard, hired me to create a reintegration program to help the Minnesota National Guard combat veterans successfully transition from warriors to productive citizens.

The first institution we turned to for help was the Minneapolis VA medical center. We wanted our veterans to receive medical care if needed and benefits if earned. We knew that the demobilization process used at that time was ineffective in connecting veterans with the VA process. We were concerned that a majority of our veterans would not access all that was available to them in terms of VA services.

We found a very willing partner in the Minneapolis VA medical center. Our partnership grew to include the VA medical centers in St. Cloud, MN; Fargo, ND; Twin Ports in Superior, WI and Sioux Falls in SD. We expanded our partnership to include the Vet Centers in Fargo, ND; St. Paul, MN; Sioux Falls, SD and Duluth, MN. Today we enjoy a close collaboration with the leadership of VISN 23 and all the VA entities in Minnesota.

We have successfully collaborated with the VA on the following initiatives in support of our returning combat veterans:

1. Expedited enrollment of our demobilizing soldiers, at their demobilization site, by MN VA personnel. This is insures our veterans are enrolled in the VA in the catchment area they live in and they are provided initial appointments.
2. RINGS 1 and RINGS 2, (Readiness and Resilience in National Guard Soldiers), Research studies on the soldiers/families of the 1st Brigade, 34th Infantry Division. These longitudinal studies have focused on the role of the community in facilitating successful reintegration and mitigating the effects of combat stress.
3. Collaborative training of local clergy utilizing VA Chaplains and Vet Center staff.
4. Collaborative training of Minnesota Army National Guard Chaplains and Chaplain Candidates in Clinical Pastoral Education utilizing the Supervisory Chaplain of the St. Cloud, MN VA. We have trained 15 chaplains and chaplain candidates, to date.
5. VA Behavioral Mental Health providers from the OIF/OEF outreach clinic providing satellite service at Camp Ripley, MN during annual training periods of the Minnesota Army National Guard.
6. Vet Center Staff and VA OIF/OEF outreach personnel present at every Minnesota National Guard reintegration event, pre- and post-deployment.
7. Minneapolis VA Suicide Prevention Specialists regularly provide training to the Minnesota National Guard and participate in clergy outreach training with the Minnesota National Guard Chaplain Corps.
8. The Minneapolis VA Polytrauma Center Staff provided training for the 34th Infantry Division Command and Staff prior to their deployment to Iraq in 2009.
9. The Recruiting Command of the Minnesota Army National Guard provides soldiers trained by the Minneapolis VA to visit wounded warriors in the Minneapolis VA polytrauma unit.
10. The Vet Centers of Minnesota have collaborated with the Minnesota National Guard to provide training for marriage and family therapists, as well as licensed social workers, and psychologists at community outreach events hosted by the Minnesota National Guard Beyond the Yellow Ribbon program.
11. The Minnesota National Guard and the Minneapolis Regional Pension and Disability Claims Office work collaboratively to provide the medial records of soldiers seeking disability compensation.

The Minnesota National Guard Beyond the Yellow Ribbon Program and Community Partnerships

The underlining operating principle of the Minnesota National Guard reintegration initiative, (also known as, "Beyond the Yellow Ribbon") is that it takes the entire community to help a warrior return from war, reunite with his/her family and resume a productive life as a civilian. Consequently, while partnering with the VA the Minnesota Guard has also worked to partner with business, social service, education, and faith-based organizations in every community in Minnesota that is host to National Guard facility.

The Beyond the Yellow Program, under the purview of Governor Pawlenty (2005–2010) and Governor Dayton (2011-present), thru the Minnesota National Guard as program manager, has a formal process for synchronizing the services of Federal, State and county agencies for the benefit of returning combat veterans and their families. In addition the program provides training for community organizations on how to support military members, veterans and their families. To date twenty-five Minnesota communities have been certified by the Governor's office as 'Yellow Ribbon' communities. The program synchronizes the good will and services of the agencies of the government and community organizations to support military families during the duress of deployments and the returning combat veteran during reintegration, post combat.

We have garnered tremendous support for our military families and returning combat veterans. The Beyond the Yellow Program has synchronized the agencies of the Federal, State, and local government with the services of our communities to result in providing the support needed by our military families. This has resulted in more productive combat veterans and reduced pathology as demonstrated by the VA's Rings 1 study.

The Challenges and Opportunities the Beyond the Yellow Ribbon Program Presents for the VA System

The VISN 23 VA organizations and institutions have been significant partners in our Beyond the Yellow Ribbon initiative. I believe they could play even more significant roles. They have vital information to share with civilian medical providers, clin-

ical social workers and faith-based leaders. They have expertise to share with community-based organizations. The involvement of the VA and their synchronization into Beyond the Yellow Ribbon reintegration efforts will enhance the initiative and result in healthier combat veterans and their families.

There are significant challenges to overcome, however, in order for the VA to truly be a 'community partner.' I will outline those challenges:

1. Perception and Stigma.—My experience with community leaders has been that they perceive the VA to be a distant and closed institution. By virtue of the fact that relatively few citizens are veterans most Minnesotans have no experience with the VA, thus the 'mystery' surrounding the institution. Combined with anecdotes shared by the media of controversy with the VA, (e.g., inadequate care, lack of resources, theft of computers resulting in Social Security numbers of veterans being lost, etc.) and perception becomes reality in the minds of community leaders.
2. Institutionalism.—The VA is a Federal bureaucracy. Consequently, its system is foreign to outsiders. This is a significant bar to inclusion in community outreach and synchronization of services with community-based organizations. I can illustrate this in several ways:
   a. The Minneapolis VA has a world-class polytrauma unit providing the finest medical care to our most severely injured warriors. It has deservedly received positive media coverage and accolades. However, on numerous occasions, when community organizations have wanted to donate goods, gifts and goodwill to the families/wounded warriors they have met with hurdles too high to overcome. At the core of the problem is HIPA. The VA's understandable need to protect truly vulnerable wounded warriors' results in them being shut off from the support of the community. I have personally witnessed this on at least a dozen occasions. From inability to donate professional sports team tickets to wounded soldiers to the recent inability of Best Buy Corporation to personally deliver care packages to wounded warriors the community is shut off from working closely with this world class program.
   b. The VA is not staffed to conduct effective community outreach. While mandated to provide training for civilian providers and clergy I have personally attended ten VA outreach events, none of which was able to garner more than a handful of community members. The VA does not know how to effectively meet, greet and share with the community the tremendous work they do and the wonderful services they offer.
   c. The VA appears to lack a means to share their vast experience of working with veterans with their civilian counterparts in the fields of medicine, behavioral mental health and faith-based institutions. An example would be the growing body of knowledge surrounding traumatic brain injury. Health care providers in the greater community need to know what the VA knows about this wound, its symptoms, impact and treatment. Symposiums, media messaging, training outreach events and community forums would be ideal means for transmitting the VA experience to the greater community. To date, I know of few of these events. In a similar vein VA chaplains have much to share with their colleagues in the civilian community.
   d. The VA lacks the means to connect returning wounded warriors, that have received in patient care in their hospitals, with the greater community. I have personally witnessed four severely injured OIF/OEF veterans struggle tremendously in readjusting within the community, post VA care. They were isolated and the VA social worker was unable, due to large case load, to meet often enough with the veteran to help them connect successfully to community.

PROPOSED SOLUTIONS

In Minnesota the simplest way to address the issues I have outlined would be for the VA, in all of its configurations, to become an official Beyond the Yellow Ribbon partner under Governor Dayton's model of partnership.

—Have the VA receive the community training all community leaders receive and have the VA meet all the program requirements that other partners in the community meet.
—Have VA leadership join their civilian colleagues at Beyond the Yellow Ribbon community leaders' events.
—Have the VA partner with community and faith-based organizations for more effective synchronization of support for veterans and military families.

In the area of working with faith-based organizations the VA needs to invite faith-based leaders onto their campuses and into their facilities for orientation tours, seminars and collaborative sharing of information about the needs of veterans and pastoral care of veterans.

Minnesota is blessed to be the home of four major theological seminaries that train faith-based leaders. The VA would be well served to introduce itself to the leadership of the seminaries and to find ways to partner in the sharing of knowledge.

—Have the VA officially partner with the Guard leadership in each State. In Minnesota the Adjutant General, Major General Nash, has a personal relationship with the VA Medical Center directors in Minneapolis, MN; St. Cloud, MN and Fargo, ND. He has been in their facilities and knows their capabilities. He has personally authorized the Rings 1 and 2 studies of his soldiers. He monitors the results of the study and insures its findings inform the best practices of the Minnesota National Guard. He has invited the VA to the drill floors of his units and relies on the VA for the first class service they can provide. This type of senior leader partnership results in great access to service, smoother facilitation of the claims process and greater care of veterans. This could be replicated nationwide.
—In times of fiscal austerity the Fischer Houses of the VA system could easily synchronize their efforts with the Family Programs Office of the Guard. This would result in the families of veterans residing at the Fischer Houses receiving the good will of the communities that flows through the Family Programs of the Guard. The Guard, as America's local military force, most immediately receives the support of the community. The Guard Family Programs has access to community resources that the Fischer Houses need, but often have to find on their own, with limited knowledge of the local community capabilities. Collaboration saves money, helps families and enhances the effectiveness of the VA and the Guard Family Programs.

Closing Remarks

In closing I would like to reiterate my support and admiration for the men and women of the Veterans Administration. As a veteran I know we are truly blessed by their service. I believe they have a vital role in the reintegration of our veterans and welfare of the families of our veterans. I believe the VA's effectiveness can be increased by its inclusion in our greater community and enhanced collaboration with all segments of the community that seek to support our military families and combat veterans.

I appreciate the opportunity to be here today and invite your questions and comments.

Prepared Statement of Shelley MacDermid Wadsworth, Ph.D.

Chairwoman Buerkle, Congressman Michaud, and distinguished Members of the Committee, thank you for convening this hearing today and for inviting me to share my thoughts about "Building Bridges between VA and Community Organizations to Support Veterans and Families."

I am proud to be a faculty member at Purdue University, the land grant institution for the State of Indiana. I am also proud to direct the Military Family Research Institute and the Center for Families at Purdue. Each of those organizations works to address all three missions of the university: generating new research knowledge, helping students to learn, and most important for this hearing, reaching beyond the campus to collaborate with others to solve community challenges. I will speak today based on my own experiences and those of my staff, however; I am not speaking on behalf of the university.

The Military Family Research Institute (MFRI) was created at Purdue in 2000 through funding awarded competitively by the Department of Defense's Office of Military Community and Family Policy. Today we continue to have significant funding from DoD and other Federal sources, but are funded primarily by private philanthropy. I mention this because it is this funding that has made it possible for us to invest so heavily in community collaborations. Our mission is to 'make a difference for families who serve.'

We are located in West Lafayette, Indiana, which is in VISN 11, along with parts of Michigan, Illinois, Indiana, and Ohio. I am pleased to be able to report that MFRI is engaged in many collaborations with organizations in the civilian, military, and veteran communities. We carry out an average of more than one event or activity each week aimed at helping to make our State a better place for military and veteran families. Our recent collaborations involving VA partners include the following:

a. With regard to **homelessness**, in November 2011, as part of our university's participation in President Obama's Interfaith and Community Service Campus Challenge, we organized the first Stand Down for homeless and nearly homeless

veterans in our community, and the first organized by a university in our State. More than 100 community organizations participated, including both campus and community faith-based groups, and more than 100 student volunteers, including students from Hospitality and Tourism Management who managed food service, and students from the School of Nursing who provided an onsite health clinic guided by several of their faculty including a military veteran. A number of VA entities joined in this effort, including representatives from the Illiana Suicide Prevention, Healthcare, and Minority Programs offices. VA Roudebush Medical Center sent representatives, as did VA benefits, and a VA Mobile Veteran Center. We were very pleased at this initial effort and are seeking out collaborators to make this a statewide effort with Stand Downs in several communities leading up to Veterans Day 2012.

b. As **researchers**, we are collaborating with VA colleagues in Minneapolis and Ann Arbor, working together to obtain funding and gather data.

c. In the area of **higher education**, we work with colleges and universities throughout our State to help them strengthen their supports for student servicemembers and veterans. In that capacity, we work closely with VA certifying officials, the Indiana Commission on Higher Education, institutional leaders, the Servicemembers Opportunity Colleges, and others.

d. In the area of **vocational rehabilitation**, we work with the Career Learning and Employment Center, a pilot project set up in our State as a collaboration established initially between community groups, the Crane Naval Station and the NAVSEA command, VA vocational rehabilitation officials, and several State offices. This project for which we are the evaluation partner, helps servicemembers who must leave their military careers because of life-altering wounds or injuries, transition to education and employment in an environment of full support and assistance for their families and themselves as they relocate, enter or re-enter educational training, leave their military careers, and begin new jobs as civilians.

e. In the area of **behavioral health**, we serve as a training partner for the Indiana Veterans Behavioral Health Network. Funded by a grant from the Health Resources and Services Administration, IVBHN is a network of community-based behavioral health clinics working to extend services to rural veterans using telehealth technologies. We also are working together to create a designation for agencies to indicate to military and veteran families that providers within the agency have received significant training in working with that population, to complement a training system and registry we have already created with the Indiana National Guard to improve the behavioral health infrastructure in our State. VA collaborators include the Department of Mental Health Patient Care Services, the Psychiatry Ambulatory Care Clinic, the Seamless Transition Clinic, and the Information Technology Department at Roudebush VA Medical Center, as well as the VISN 11 Medical and Information Technology staff.

f. Finally, in the area of outreach, we work closely with the Seamless Transition Team at the Roudebush VA Medical Center to implement an annual statewide meeting focused on growing awareness, motivation, and skills among helping professionals in a variety of communities to support veterans and their families. In September 2011, this meeting was attended by over 250 professionals from Indiana, Illinois, and Kentucky. The Indiana National Guard director of family programs reported that his staff described this as the best training event they had attended in many years.

Based on these experiences, what are some lessons we've learned about successful collaborations between community organizations and the VA?

First, there are great opportunities for success, and I know that there are success stories happening around the country. I have been pleased by the enthusiasm we have experienced from many of our VA partners.

Second, all of the successful partnerships we know involve partners who have come to know and trust each other. Until partners know each other well enough, it is difficult to trust. Without trust, it is very hard to collaborate. It can take several years to exchange sufficient knowledge and build sufficient trust to be willing to embark on a more extensive collaboration. Without that ground work, it is much less likely that the collaboration will be successful and sustainable.

Third, we have learned that mutual transparency, responsiveness, and accountability are important for successful collaborations. Each of these of course ties back to basic trust—perhaps 'trust but verify' is an apt phrase.

Fourth, we think successful collaborations do a good job of taking advantage of each organization's unique strengths. MFRI contributes something different to each of the collaborations I described earlier—sometimes our research expertise, sometimes our skills as educators, sometimes our convening power, and in each case our VA partners are contributing expertise that complements ours.

Fifth, I believe that successful collaborations result when each partner can enthusiastically pursue their self-interest while they work together to achieve a shared goal. Collaborations that require one or both partners to work against their self-interest will not last long.

Sixth, in the spaces in which we operate, cultural translators are very important. Partners who can explain military or veteran experiences and culture to civilians, or who can explain the environment within which civilian community organizations operate to members of military or veteran organizations, play key roles in helping collaborative partners learn to see the world through one another's eyes.

A **final** ingredient for success is leadership, but we believe that it may be servant leadership that is the most important. At MFRI we believe that leadership is as much about taking and distributing minutes, arranging meetings, and sending out reminders as it is about crafting vision and facilitating strategic planning. We are just as happy to try to be the glue that holds initiatives together and the lubricant that keeps them moving forward, and we are fortunate to have found funders who share our belief.

Although the scientific literature about collaborations among community organizations or with the VA is quite limited, the studies that are available reinforce our observations. For example, one study of collaborations between faith-based and health organizations found that passion and commitment for their shared goals, mutual trust and respect, and the convening power of faith-based organizations were seen as key to their success (Kegler, Hall, & Kiser, 2010).

Policy-Related Challenges and Barriers

What about the challenges and barriers that make it difficult for community collaborations with the VA to become established or successful? Many of these are no doubt familiar to you.

The landscape both inside and outside the VA can be very crowded and confusing. Prospective community partners, particularly those located at a physical distance from the VA facility with which they would like to collaborate, can find it very difficult to determine whom in the institution to approach. As a test, I conducted a search for the word 'collaborate' on the main VA Web site, which yielded a single hit, for the Center of Excellence on Implementing Evidence Based Practice. From vantage points inside the VA it may be just as difficult, again particularly in far-flung communities. The not-for-profit sector is full of agencies with alphabet-soup names, sometimes with considerable turnover, and idiosyncratic local variations. VA professionals are understandably wary of showing favoritism to particular organizations, getting involved with organizations that might prove unreliable, or taking time away from other duties to establish and maintain community partnerships. These challenges could be reduced by making sure that there are clear points of entry and information for prospective collaborators on key Web sites, and some regular mechanism for prospective partners and VA leaders to learn about one another.

There are structural barriers to collaboration. For researchers, these come in the form of requirements that projects involving the VA be led by VA researchers. For all collaborators, a serious barrier is the inability to share data. Sometimes this impediment makes it very difficult to connect VA patients and their families with community services; for researchers, it is very difficult to gain access to data for analyses. In our work with higher education, we have found it very difficult to get information about schools in our State, or even our State as a whole, because only data aggregated across an entire region are available. We have also found it very challenging to secure answers to questions from at least one office, even though some of the information we are seeking is not at all sensitive and could probably be made publicly available on the Web. Community collaborators find it very frustrating when they train up to increase their capacity to serve military and veteran families, but then can never find any of those families to serve nor be sure those families will learn about their availability. This is especially frustrating when it is so clear that there is far more work to do than the VA can handle alone. I'm not certain how this problem can be solved, but I believe it is resulting in a staggering waste of resources, with more work to do than the VA can manage by itself, servicemembers and families who want help, and community partners who want to be of use, all separated by gaps and barriers that should be avoidable. We are working on a collaboration with the Indiana National Guard that is aimed at addressing this problem for military families, but the challenge for veterans is much larger and even more complex.

Of course securing resources is always a challenge. Community collaborators may not have excess capacity sitting unused on the shelf that can easily be diverted to military or veteran families, and need to know that if they incur expense to serve servicemembers and veterans that they can recoup those costs. While DoD and VA

have seen their budgets grow significantly in recent years, many community-based not-for-profits have seen their resources decline. VA professionals who want to collaborate with community partners may have to do so 'out of their back pockets' and on top of their regular duties. Building the bridges of collaboration that you seek will require resources, and ideally those resources will be made readily apparent to community partners so that proposals can be solicited, evaluated, and selected. Ideally, resources will be structured to provide tangible incentives and benefit to community and VA partners who collaborate effectively.

It has been our great honor to work to make a difference for military and veteran families. We are inspired by the commitment and dedication shown by military and veteran professionals in many sectors who share that mission, and we are eager to continue collaborating to make positive change. Thank you for all you do to try to make sure that our Nation's veterans receive the care and support they have been promised.

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Prepared Statement of M. David Rudd, Ph.D., ABPP

Good afternoon, Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee. I greatly appreciate the opportunity to testify on behalf of the National Center for Veterans Studies at the University of Utah and the countless American veterans that have served and sacrificed. I want to thank Chairwoman Buerkle for providing much needed leadership on an issue that will become increasingly important given the end of combat operations in Iraq and the planned reduction of forces in Afghanistan. The successful reintegration of many of our troops into civilian life will require thoughtful and coordinated efforts between the Department of Veterans Affairs (VA) and community organizations, with communities of faith offering particular promise. I am grateful for Chairwoman Buerkle's efforts to draw attention to the problem of reintegration, particularly given that there is an intellectual and emotional disconnect between those that have served and the rest of society. Since the Gulf War, less than 1 percent of Americans have served in the armed forces, a dramatic shift from World War II (almost 9 percent), Korea, and Vietnam (both greater than 2 percent). The remarkably small number of Americans choosing to serve in the Armed Forces compounds the potential for misunderstanding.

As a veteran of the Gulf War era and a clinical psychologist, I am keenly aware of the issues faced by servicemembers both engaged in combat and returning from war. Over the last decade, I have been involved in the treatment of servicemembers experiencing emotional and psychological problems secondary to combat and serving during wartime. In particular, I have directed treatment research focusing on active

duty servicemembers that have made suicide attempts. Although my research is only partially complete, what has become clear is that many servicemembers (and families) need assistance in order to make a successful transition from military life. My work has been focused on that portion of the veteran population that has struggled and experienced emotional and psychological problems. It's important to point out, though, that this is only a portion of the population, with many making a seamless transition to civilian life.

A recent survey of veterans by the Pew Research Center (2012) revealed that 27 percent of veterans reported that readjustment to civilian life was either "somewhat difficult" or "very difficult." The survey also revealed significant "burdens of service" with 48 percent reporting "strains in family relations," 47 percent "frequently feeling irritable or angry," 44 percent reporting "problems re-entering civilian life," and 37 percent reporting "post-trauma symptoms." Despite the fact that many veterans transition from military life with few problems, these data indicate that many have difficulty making the shift.

The Pew data offer insight into the source of the problems as well, with emotional and psychological adjustment at the forefront. Among those having experienced combat, 50 percent or more report post-trauma symptoms and difficult family relations. When queried about factors reducing the probability for successful re-entry into civilian life, veterans identified traumatic experiences and injury as the most significant variables. Of importance for this hearing, veterans identified "attending church at least weekly" as the most important variable associated with an easy and successful re-entry into civilian life. A remarkable 67 percent identified attending church "once a week or more" as making re-entry easier. Clearly, the social connection and support offered by religious institutions around the Nation are essential for our veterans. The Pew study also reported that churches were second only to the military itself as "institutions" in which veterans have a "great deal" or "quite a lot" of confidence. Clearly, communities of faith offer a unique and critical opportunity to connect with veterans transitioning from military life. If aware and appropriately trained, clergy can serve a critical role in assisting veterans struggling with emotional and psychological symptoms. Available data suggest communities of faith as a critical linchpin in helping veterans transition to civilian life.

My own work has helped clarify the severity and magnitude of the emotional and psychological issues faced by a particularly large subset of the veteran population, student veterans. Nearly two million veterans will return home from overseas deployments as part of Operation Iraqi Freedom, Operation Enduring Freedom and Operation New Dawn. A large number of them will make use of the Post-9/11 GI Bill and transition quickly to college and university campuses. My recent study of student veterans nationwide revealed that many student veterans struggle with psychological symptoms, consistent with the data reported in the Pew survey. More specifically, I found that almost 35 percent of participants reported suffering "severe anxiety," 24 percent experienced "severe depression" and 46 percent reported "significant symptoms of post-traumatic stress disorder." Somewhat alarming, my data indicate that 46 percent reported thoughts of suicide, with 20 percent having a plan. Further, 10.4 percent reported thinking about suicide "often or very often" and almost 8 percent reported making an attempt, almost six times the frequency of the general student population.

From the limited data available to date, it would appear that problems with psychological and emotional adjustment are perhaps the single greatest barrier faced by returning veterans transitioning to civilian life. Of particular importance for this Committee, two community resources offer a unique opportunity to engage and connect with veterans, communities of faith and college and university campuses. Veterans hold religious institutions in high regard, reporting that regular contact and participation help "ease" their transition, offering critical support and assistance. Similarly, college and university campuses are arguably second only to the VA itself as institutions where the largest numbers of veterans gather.

The VA has already expanded efforts to actively collaborate with college and universities around the country, including an increase in positions allocated to the Vet Success on Campus program and the new VA campus grant program funding projects meant to extend services to student veterans and extend outreach on campus, with five projects funded to date (Veterans Integration to Academic Leadership Initiative—VITAL). I would also like to mention and applaud VA efforts to explore additional partnerships with colleges and universities. I recently participated in a meeting with the Assistant Secretary of the VA for Policy and Planning, Dr. Henze, along with a collection of other campus leaders to discuss possible collaborations to meet identified veteran needs. The VA has been proactive on this front, an effort that should be commended.

Let me emphasize my support for efforts on both fronts; that is, working directly with communities of faith around the Nation, along with college and university campuses. There is empirical evidence indicating a significant need, along with data to suggest these two domains offer unique opportunities and promise to help ease the transition to civilian life. Training is needed in order for communities of faith to effectively respond to the demand. Many clergy members are already aware, sensitive to, and equipped to respond to the psychological and emotional needs of veterans. Large numbers, however, are not. Given the serious nature of the problems identified (e.g. suicidality) thoughtful and thorough training is needed. The National Center for Veterans Studies would welcome the opportunity to assist in any such effort.

As with communities of faith, many colleges and universities around the country are unprepared to meet the psychological and emotional needs of student veterans. Although some entities offer training for college counseling centers, such as the Department of Defense Center for Deployment Psychology, resources are limited. Greater resources are needed to meet the growing demand. In response to this need, The National Center for Veterans Studies will be launching an effort to form a national higher education consortium targeting student veterans. We would welcome the chance to partner with any similar efforts around the country, including any launched by this Subcommittee.

Thank you again for the opportunity to address the Subcommittee. These issues are critical and the needs of many of our veterans transitioning to civilian life are profound. The National Center for Veterans Studies is poised to help. I am happy to respond to any and all questions.

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Prepared Statement of George Ake III, Ph.D.

Good afternoon, Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee. I wish to thank you for the opportunity to testify on behalf of the 154,000 members and affiliates of the American Psychological Association (APA) regarding collaboration between the Department of Veterans Affairs (VA) and community organizations to support veterans and their families. As a child psychologist at Duke University Medical Center and with the National Child Traumatic Stress Network, my work focuses on assisting children and families who have experienced stressful and traumatic life events, including military deployment and its aftermath. I am honored to speak with you today about the collaborative work that I and my colleagues are engaged in with a variety of partners around the country in support of our Nation's military and veteran families.

Collaboration among all sectors of society is needed to support the health and well-being of veterans and their families. This includes key partnerships with policymakers, government agencies, universities, the health care community, and the faith-based community. Scientific evidence continues to identify psychological and neurological disorders, including post-traumatic stress disorder (PTSD), depression, suicidal ideation, and traumatic brain injury (TBI), as some of the signature wounds of the conflicts in Iraq and Afghanistan. While psychologists and other health professionals play an essential role in helping veterans and families to address these challenges, partnerships and collaborations with others sectors of society are also critical.

Despite a proliferation of programs for Active Duty, National Guard, Reserve Component, and veterans and their families, many families rely upon the support and counsel of faith-based providers as a first point of contact. In some communities, particularly small towns and rural areas, faith-based services are more prevalent and accessible than health care services. In theatre, on base or post, at the VA, and in local communities, veterans and their families not only approach faith-based providers on spiritual, religious, and moral issues, but also issues of reintegration, spousal relationships, and parenting. Chaplains and other faith-based providers can play a key role in addressing concerns about stigma related to mental and behavioral health services and supports as well as providing linkages and referrals to appropriate community and professional resources.

I would like to express my deep appreciation to you, Chairwoman Buerkle, for your leadership in advancing collaboration between the mental health and faith-based communities with regard to military and veteran families. The unique military and veterans mental health workshop that you hosted for faith-based providers in your district in December served as a wonderful example of the collaboration and partnership that is possible across sectors. I was honored to join the distinguished panel of experts that you assembled, including Dr. David Rudd of the University of Utah's National Center for Veterans Studies, Drs. Judy Hayman and Caitlin Thompson from the VA, Jason Hansman of the Iraq and Afghanistan Veterans of America, and Retired Air National Guard Chaplain Tim Bejian. Such events help to break down barriers and foster partnerships that benefit veterans and their families. Replicating this training in other congressional districts could serve as a valuable resource.

The importance of collaboration between military and community systems, and among health professionals and faith-based providers, is especially important as we consider data from the 2010 Department of Defense (DoD) Profile of the Military Community, which estimates that 44 percent of the 1.4 million Active Duty and National Guard/Reserve personnel, who have deployed to combat missions as part of Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and/or Operation New Dawn (OND), are parents. This same report noted that there are almost 2 million children in the U.S. who have parents in Active Duty or Reserve services. Many of these children and families have seen their military parents and spouses serve multiple combat deployments to Iraq and Afghanistan. A number contend with a parent who returns changed due to the wounds of war. Some of these families suffer financial hardship, homelessness, marital discord, violence, and other difficulties during their reintegration into civilian life. Still other families experience the grief and loss associated with their loved one's fatal combat injury, or even suicide. Taken together, these findings highlight the necessity of considering the context and challenges for children and families of veterans returning from combat, as well as the role of the family in facilitating a successful transition to stateside service or civilian life.

To support the veteran and strengthen the family, veteran families need easy connection to collaborative programs and supports through VA medical centers, vet centers, community mental health and faith-based services, and professionals from a variety of disciplines, such as psychologists, pediatricians, clergy, educators, and case managers who are familiar with the military/veteran culture.

As a member of the National Child Traumatic Stress Network (NCTSN), I would like to highlight some of our efforts to support such collaboration. The NCTSN is an initiative launched by Congress in 2000 with the goal of developing a national collaborative network to improve best practices and standards of care for children and families affected by traumatic stress. Since 2001, the NCTSN, which is administered by the Substance Abuse and Mental Health Services Administration, has delivered direct services to children and families who have experienced all forms of traumatic stress, including our Nation's military families. Between 2002 and 2009, NCTSN members reported serving over 320,000 children through direct clinical services, with many more reached through outreach efforts, community educational programs, and provider training and consultation. Our work is done in partnership with all child-serving systems, including military service branches, faith-based organizations, child welfare, and community mental health agencies.

In 2008, the National Center for Child Traumatic Stress (NCCTS), the NCTSN coordinating center co-located at Duke University and the University of California Los Angeles (UCLA), embarked on a partnership with the Center for the Study of Traumatic Stress of the Uniformed Services University of the Health Sciences, to expand and enhance the level of support provided to military children and their families. Other major government partners include the VA, the DoD, and the National Guard. Civilian partners include the American Psychological Association, the National Association of Social Workers, and other community health care providers.

Of the more than 100 NCTSN funded and affiliate member sites in 40 States, more than 60 percent serve military children and families. The NCTSN Military Families Program brings together high-level experts from multiple disciplines (i.e., mental health, military, and public health) to address the challenges facing military children, their families, and the providers who serve them. The NCTSN has modified interventions to meet the unique needs of military families, has conducted outreach to them in a variety of settings, and has produced educational and informational materials designed especially for their needs. Using Web-based, interactive media (e.g., podcasts, speakers series, and teleconferencing), the NCTSN Military Families Program offers more than a dozen educational presentations developed by key experts on psychological trauma and military issues. The NCTSN has developed

a useful curriculum for civilian providers, called *Essentials for Those Who Care for Military Children and Families*, which addresses subjects such as military culture, the impact of combat on families, the needs of children, programs and services for veterans and National Guard and Reserve members and their families, behavioral health services, frameworks for interventions, and family violence. Further, we created a Web-based *Master Speaker Series* cosponsored by the NCTSN and Zero to Three, which provides an opportunity for leading authorities from the VA, DoD, and university settings to discuss military culture, mental health issues, resilience, and wellness. In fact, tomorrow, the topic of our monthly webinar will be *Expanding Services to Veteran Families* and includes panelists from the VA and Zero to Three. These resources are available on the NCTSN Web site.

In addition to providing evidence-based, trauma-informed treatment, the 27 sites of the NCTSN Military Families Program are actively engaged in research, community outreach, and partnerships with State and local agencies that serve Active Duty military, Guard, Reserve, and veterans. My colleagues at Duke University are implementing a Welcome Back Veterans program, which is an initiative of the McCormick Foundation, Major League Baseball, and the Entertainment Industry Foundation. This national program is intended to develop models for training community clinicians to offer accessible and effective mental health services to military and veteran families in local communities.

Other colleagues with the Duke Evidence Based Implementation Center have been leading quality improvement collaboratives with VA teams. One of these collaboratives is based at the Durham VA Medical Center with teams focused on improving coordination between mental health services and veteran-centered care to improve access to services. The other collaborative based out of VISN 6 with Community-Based Outpatient Clinic teams focuses on increasing patient access to services and enhancing workflow efficiencies.

Our NCTSN partners at UCLA developed and disseminated a program called Families OverComing Under Stress (FOCUS). The FOCUS program is designed to enhance the inherent resiliency of military families. The program has addressed family adjustment to parental deployment at more than 20 U.S. military installations, including Camp Lejeune, for which I provided consultation to their resiliency trainers on the implementation of FOCUS. The NCTSN has also collaborated with the VA's National Center for PTSD to train military and civilian providers on acute stress interventions such as Combat Operational Stress First Aid that address principles of safety, connectedness, hope, calming, and self-efficacy. Our NCTSN and VA colleagues have provided training specifically to military chaplains as the training has embedded components relevant to the work of clergy working with servicemembers and veterans.

Further, other NCTSN colleagues at Allegheny General Hospital in Pennsylvania have partnered with the Tragedy Assistance Program for Survivors (TAPS), the National Military Family Association, Zero to Three, the Center for the Study of Traumatic Stress, and the Center for Health and Health Care in Schools to educate professionals about the most appropriate resources for aiding families coping with the death of a loved one in the military. Resources from this program have been widely disseminated and are available on the NCTSN Web site for faith-based organizations to use or adapt when working with military and veteran families in the aftermath of loss.

The NCTSN also has a strong program in support of military families through the Ambit Network at the University of Minnesota, which has developed the ADAPT (After Deployment, Adaptive Parenting Tools) program. This groundbreaking initiative specifically meets the needs of Reserve Component servicemembers and their families. The 14-week, Web-enhanced group parenting program addresses key challenges faced by deployed parents and their partners, including dealing with the transitions of deployment, responding to emotional challenges of deployment and reintegration, and enjoying children during stressful times. The program is now being tested in a National Institutes of Health-funded randomized controlled trial of 400 families with children ages 4–12.

Finally, Catholic Charities of Hawaii, an NCTSN Community Treatment Services Center, has reached out to military partners at Tripler Army Medical Center and Schofield Barracks to provide training on evidence-based treatments for children experiencing traumatic stress.

In conclusion, we have seen that collaborative efforts between partners such as chaplains and faith-based providers, mental health professionals, physicians, educators, and the military and veterans community have resulted in a growing evidence base and increasingly high quality services for our military and veteran families. The American Psychological Association, Duke University Medical Center, and the National Child Traumatic Stress Network all stand ready to continue our col-

laborative efforts with this Subcommittee, the VA and DoD, our community-based partners, and the military and veterans community to address these important issues.

Thank you for the opportunity to speak with you today and for your leadership and commitment to our Nation's veterans and their families.

Prepared Statement of Reverend E. Terri LaVelle

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, thank you for the opportunity to speak about the Department of Veterans Affairs (VA) Center for Faith-based and Neighborhood Partnerships' (CFBNP) outreach efforts to and with faith-based and community organizations. As Director of VA's CFBNP since September 14, 2009, I have had the opportunity to engage first-hand with faith-based, non-profit and community leaders and organizations.

My testimony today will provide background information on the VA CFBNP, the collaborative outreach work the Center has engaged in beginning in 2005 with faith-based, non-profit and community leaders and organizations, internal VA partners, and the White House Office of Faith-based and Neighborhood Partnerships.

Background

VA's Center for Faith-based and Community Initiatives was established on June 1, 2004, by Executive Order 13342. The objective was to coordinate agency efforts for the elimination of regulatory, contracting, and other programmatic obstacles to enable faith-based and community organizations to access resources they need to provide social and community services.

In February 2009, President Obama amended Executive Order 13199 to establish the White House Office of Faith-based and Neighborhood Partnerships (OFBNP). The name change reflects the emphasis and importance of developing and cultivating partnerships, through intentional outreach, with those in the community that already provide services and meet the needs of so many of our citizens.

The VA CFBNP is one of thirteen Faith-based and Neighborhood Partnerships Centers in the Federal Government.

Mission

The mission of VA's CFBNP is to develop partnerships with and provide relevant information to faith-based and secular organizations and expand their participation in VA programs in order to better serve the needs of veterans, their families, survivors and caregivers. VA's CFBNP cultivates and develops relationships with faith-based and secular organizations, working with them as collaborative partners to serve our veterans, their families, survivors and caregivers. CFBNP outreaches to external partners to expand their understanding of, and participation in, VA programs.

Outreach Collaboration

Since 2005, nationwide, VA CFBNP has conducted pro-active outreach events interacting with over 1,200 faith-based, nonprofit and community leaders and organizations. The outreach events consisted of roundtables, conferences, and workshops.

Since its inception in 2009, VA's CFBNP has proactively outreached to faith-based, nonprofit and community leaders and organizations, often collaborating and/or partnering with internal and external stakeholders. The internal partners for outreach events include the Veterans Benefits Administration (VBA) Vocational Rehabilitation and Employment (VR&E) Service, VA Chaplain Service, VA Homeless Program Office, National Cemetery Administration (NCA), Veterans Health Administration (VHA) Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Coordinators, and VA's Voluntary Service. The Center's external partners include Good Will International; American Red Cross; Habitat for Humanity; Salvation Army, USA; State Veterans Organizations; and Catholic Charities in Chicago, IL.

Fiscal Year (FY) 2011 and 2012 Internal Outreach Collaborations

VA CFBNP and VBA VR&E Service have partnered with local VBA Regional Offices to co-host Veterans Roundtables with the target audience being faith-based, nonprofit and community leaders and organizations. Local and regional VA staff serve as panelists and roundtable discussion participants. These events provide members of the local community an opportunity to meet and interact with VA staff and to know their local contacts and resources for assisting veterans. The Veterans

Roundtables were held in Jackson, MS; Seattle, WA; Newark, NJ; Waco, TX; Las Vegas, NV; Cleveland, OH and Louisville, KY. The attendee total at the Veterans Roundtables was 450. These VA Regional Roundtables have two primary goals:

- To facilitate collaborative working relationships among faith-based and secular organizations, VBA, NCA, and VHA so that holistic service can be provided to veterans, their families, and survivors in the community where the Roundtable is held.
- To inform attendees of the number of veterans in their community, what their current needs are, and potential funding available to faith-based and secular organizations who can demonstrate an ability to meet those needs in collaboration with the VA.

VA CFBNP is coordinating with VBA to co-host roundtables in FY 2012 at VBA VR&E Service and Regional Offices in Montgomery, AL; Lincoln, NE; Albuquerque, NM; and Boston, MA.

FY 2011 and 2012 External Outreach Collaborations

The VA CFBNP helped plan and conduct workshops at two outreach events with external partners. One was with the State of California Department of Veterans Affairs and the California Statewide Collaborative for Our Military and Families and held in San Jose. The other was the "Battlemind to Home II" Symposium conducted with the local VA medical center, the Department of Labor and the Military Family Research Institute (MFRI) of Purdue University in Indianapolis, IN. The number of persons who attended these workshops respectively was 120 and 95.

The VA CFBNP participated in five "Connecting Communities for the Common Good" Conferences in collaboration with the White House OFBNP, local officials from the host city, and the Faith-Based and Neighborhood Partnership Centers from other Federal agencies. The conferences were held in Philadelphia, PA; Detroit, MI; New Orleans, LA; Chicago, IL; and Denver, CO.

In order to support local organizations as they tackle community challenges, the regional events have three key goals:

- To build and strengthen relationships between community and faith-based groups, and with local, regional and Federal Government partners;
- To highlight relevant Federal and public/private partnership opportunities, and to connect groups to these opportunities; and
- To open the door and tell the story of the Faith-based and Neighborhood Partnerships.

At each "Connecting Communities for the Common Good" Conference, VA CFBNP moderates a workshop and facilitates a roundtable discussion. Each workshop and roundtable consists of local and regional VA staff as panelists and roundtable participants. Having local and regional VA staff present begins building relationships at the local level between VA and the faith-based, nonprofit and community leaders and organizations in attendance. The average attendance at each VA CFBNP workshop and roundtable discussion was 50 people. The CFBNP reached over 300 faith-based, nonprofit and community leaders and organizations.

As the CFBNP Director, I have attended, presented, and conducted training on VA programs and services at the following events. These outreach events provide information about the needs of our veterans, their families, survivors, and caregivers. Information is also presented on the opportunities available to faith-based, nonprofit, and community leaders and organizations to become collaborative partners with VA to meet the needs of veterans, their families, survivors and caregivers. Examples of my activities as CFBNP Director include:

- Speaker at the MFRI's November 2011 conference "Battlemind to Home II Symposium." The goal of the conference was to reduce community reintegration barriers for returning servicemembers and their families by increasing community knowledge and awareness of challenges faced and the supports available from a collaborative perspective.
- Participant at the Working Together to Strengthen Guard and Reserve Couples and Families Forum sponsored by the Annie E. Casey Foundation and the National Healthy Marriage Resource Center. The Forum was held in Charlotte, NC, August 15–16, 2011.
- Presenter at the Church of God in Christ (COGIC) AIM (Auxiliary in Ministries) Conference held in Houston, TX, August 6–9, 2011.
- Speaker at the Veterans Roundtable sponsored by the CA Collaborative for Military and Families of San Jose, CA, March 23–24, 2011. This is a collaborative of over 200 faith-based and community organizations.

- Keynote speaker at a Douglas Memorial United Methodist Church's Pastor's Forum—Veteran Women Resource Center. The Pastor's Forum was held in Washington, DC, March 26, 2011.
- Panelist at Forging the Partnerships: DoD/USDA Family Resilience Conference held in Chicago, IL, April 27–28, 2011. This was a clergy panel with representatives from the National Guard, Air Force, Army, Marines and Coast Guard.

The VA CFBNP will join the White House OFBNP "Connecting Communities for the Common Good" Conference in several cities beginning in March 2012. Center staff is serving on the "Battlemind to Home II" Symposium 2012 planning team. The CFBNP joins with the local VA medical center, the Department of Labor and the Military Family Research Institute (MFRI) of Purdue University in Indianapolis, IN, to convene and co-host the 2012 Symposium.

Conclusion

The VA CFBNP increases veterans participation in VA programs through outreach to, and partnerships with, faith-based, and community organizations. CFBNP collaborates with internal and external partners, creates partnerships between government agencies and faith-based and community organizations. CFBNP uses outreach events and internal and external partnerships to provide VA's program information to faith-based and community organizations which enables them to inform and serve veterans, their families, survivors and caregivers.

The VA CFBNP is consistently reaching out to, engaging, and educating faith-based, nonprofit and community leaders and organizations on the role and work of the Center. The Center is open to diverse ways for developing collaborative partnerships with faith-based, nonprofit, and community leaders and organizations that will best serve our veterans, their families, survivors and caregivers.

Madam Chairwoman, this concludes my prepared statement. I am prepared to answer your questions at this time.

Prepared Statement of Chaplain Michael McCoy, Sr.

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, thank you for the opportunity to speak about the Department of Veterans Affairs (VA) Chaplain Service's outreach efforts with community- and faith-based organizations. As an Associate Director of VA's National Chaplains Center and a past President of the Military Chaplains Association of the United States of America, I have had the opportunity to engage first-hand with community and faith-based organizations.

My testimony today will provide an overview of three programs: The VA National Chaplain Center's Veteran Community Outreach Initiative (VCOI); the marriage enrichment retreats; and the "Heal the Healer" program. VA chaplains have created these initiatives to collaborate and build bridges between VA, the faith-based communities, and neighborhood leaders to aid in the spiritual care of our returning veterans and their families.

VA National Chaplain Center's Veteran Community Outreach Initiative (VCOI)

In 2007, the VA National Chaplain Center started the VCOI to educate community clergy about the spiritual and emotional needs of our returning veterans and their families. Nationwide, VA chaplains have conducted over 200 training events and provided education to approximately 10,000 clergy through this effort. As a result, clergy across the Nation are learning to:

1. Identify readjustment challenges that veterans and their families face following deployment;
2. Identify psychological and spiritual effects of war trauma on survivors;
3. Consider appropriate pastoral care interventions for the spiritual and theological issues that veterans and families often encounter;
4. Brainstorm ideas for a community clergy partnership between VA chaplains and local clergy; and
5. Refer veterans to local VA health care facilities by being a trusted and knowledgeable resource for veterans to use to connect with VA.

In 2011, VA's National Chaplain Center made available to the Chaplain Services in VA's 152 medical centers clergy training materials, program brochures, curriculum and slides, and DVDs on spirituality. These materials were presented to local clergy for use as resources to support returning veterans and provide informa-

tion on referring veterans and their family members to local VA medical centers, community-based outpatient clinics, Vet Centers, and other related resources.

Marriage Enrichment Program

Our marriage enrichment program began in February of 2009 and was initiated by the Chaplain Service at the Charlie Norwood VA Medical Center in Augusta, GA. This program was developed based on concerns over the large number of stressed marriages experienced by our returning veterans; these stresses often led to family crises and divorce. For example, in June 2005 an article in the *USA Today* stated, "The number of active-duty soldiers getting divorced has been rising sharply with deployments to Afghanistan and Iraq. The trend is severest among officers. Last year, 3,325 Army officers' marrages ended in divorce—up 78 percent from 2003, the year of the Iraq invasion, and more than 3½ times the number in 2000, before the Afghan operation, Army figures show. For enlisted personnel, the 7,152 divorces last year were 28 percent more than in 2003 and up 53 percent from 2000. During that time, the number of soldiers has changed little."

Centered on the theme, "Getting It Back: Reclaiming Your Relationship After Combat Deployment," the program is designed so that married couples can develop healthy ways of interacting and relating with one another. We have discovered that all too often, the spouse who has gone to war and returned may have physical, emotional, or spiritual wounds that have not yet healed. On the other hand, the spouse who was not deployed also needs support, understanding, and relief from the stress of trying to maintain some kind of normalcy at home. Family and friends mean well as they try to offer support, but they often do not understand what the couple is experiencing. This program use material from the Practical Application of Intimate Relationship Skills (PAIRS) Foundation to help couples address these issues. The program focuses on topics such as constructive conflict resolution, emotional literacy, and communication and intimacy in stressful situations. Facilitators spend an average of 17 hours working with the couples over a 2.5 day weekend. Two VA chaplains developed this ministry by using community resources and collaborating with local organizations to sponsor these programs. The community leaders and faith-based volunteers, collaborating with VA chaplains, have contributed in making the programs a success. More information, including some best practices for the program, is available online at: *www.va.gov/chaplain*.

Heal the Healer

In August 2008, VA's National Chaplain Service introduced the "Heal the Healer" program for our returning National Guard and Reserve chaplains. Some of these chaplains have served multiple deployments. After realizing that several were experiencing trauma from their experiences overseas, we developed a program designed to:

1. Help those returning from deployment in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) as military reserve chaplains be assured that the chaplain community at home cares about them and their families;
2. Provide chaplains returning from deployment as military reserve chaplains in OEF/OIF/OND with the opportunity to share openly their experiences and emotions associated with their deployment;
3. Meet other chaplains with similar experiences from the theater of operations;
4. Provide an educational awareness of combat operational stress and how to deal with it;
5. Build a network for military reserve chaplains who were deployed in support of OEF/OIF/OND and a support system upon which they may call;
6. Provide a realistic review of lessons learned; and
7. Gain insight on how we may intervene in the future to provide appropriate and timely care for our chaplains returning from combat zones.

The stories and tears that are shared in these sessions reinforce the importance of our ongoing role to support the chaplains who have worn our Nation's uniform. These men and women have voluntarily placed themselves in harm's way to provide the full range of ministry for our warriors. In caring for our veterans, they too have changed. Some also bear the wounds of war. Chaplains fill a vital role, and we must be prepared to help those who assist others in the process of spiritual healing. VA chaplains, in partnership with local clergy, our faith group endorsers, and community faith group leaders, work together to reach out and offer support to returning chaplains and their families.

Conclusion

In conclusion, these three programs develop community partnerships and work with faith-based and community organizations to bring attention to the needs of our veterans and their families. Today, we understand better the evils and horrors of war that can afflict them. We recognize that their service-related experiences can cause deep wounds to the spirit, conscience, and soul. Chaplains, community clergy, and communities of faith can make a great difference in helping to heal our warriors and the families who love them.

Madam Chairwoman, this concludes my prepared statement. I am prepared to answer your questions at this time.

Statement for the Record, Consortium for Citizens With Disabilities, Veterans, and Military Families Task Force

Chairwoman Buerkle, Ranking Member Michaud, and other distinguished Members of the Subcommittee, thank you for the opportunity to submit testimony for the record on behalf of the Consortium for Citizens with Disabilities (CCD) Veterans and Military Families Task Force regarding efforts to establish meaningful relations between the Department of Veterans Affairs (VA) and community organizations to assist disabled veterans and their families.

CCD is a coalition of over 100 national consumer, service provider, and professional organizations which advocates on behalf of people with disabilities and chronic conditions and their families. The CCD Veterans and Military Families Task Force works to bring the disability and veterans communities together to address issues that affect veterans with disabilities as people with disabilities. Task force members include veterans service organizations and broad based disability organizations, including organizations that represent consumers and service providers.

Since its creation, the CCD Veterans and Military Families Task Force has sought to connect veterans and military service organizations with the disability community to allow for cross collaboration and the application of lessons learned to new populations of people with disabilities. Because of the intersection of the disability and veterans communities that occurs when a veteran acquires a significant disability, the task force is uniquely suited to bring a holistic perspective to issues impacting disabled veterans.

Many CCD member organizations provide vital services to veterans with disabilities that might not otherwise be readily accessible to them. These programs complement the wide array of services and supports available to our Nation's veterans through VA, but should be viewed as supplementary. We believe that disabled veterans must have access to needed health care services through the VA health care system, including accessible physical and appropriate mental health services, as well as long-term services and supports. Specifically, we recognize the concerns expressed by the veterans' community in documents such as The Independent Budget (IB) about proposals to contract out core missions of the VA health care system.

At the same time, however, the IB acknowledges that veterans will always receive health care services through multiple sources but recommends that VA retain a role in coordinating that care. The CCD Veterans and Military Families Task Force believes that public-private partnerships allow VA to effectively augment services available to veterans, particular those who live in rural and remote areas. Increased development of these partnerships allows VA to go to the veteran.

These partnerships also allow VA to ensure that disabled veterans have access to the support models that are widely available in the community, but with VA's oversight. For example, community-based organizations have developed best practice models to facilitate the long-term support needs of people with disabilities. Through partnerships with community organizations, the VA can integrate new services into the existing VA systems for populations that are requiring new types of services, including veterans with significant disabilities.

The Need for Community and Faith-Based Organizations

VA estimates that more than 1 million active-duty personnel will join the ranks of America's 22 million veterans during the next 5 years.[1] In many cases, these men and women will return home with unique challenges that often go unmet despite the enormous effort and reach of VA. This Subcommittee has focused on some of these challenges, including recent hearings on the suicide rate among veterans and

[1] U.S. Department of Veterans Affairs Press Release, February 13, 2012 (*http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2263*).

their lack of access to mental health services. The U.S. Government Accountability Office (GAO) reported[2] that "logistical challenges" was one factor that may hinder veterans from accessing mental health care. The report cited "distances to obtain treatment" as one of the barriers, particularly for veterans who live in rural areas. Another increasing concern is the homeless problem among women veterans. The GAO reported in a December 2011 study[3] that the number of homeless women veterans has doubled in 4 years and found that women veterans lacked awareness of VA programs, services, and benefits. A separate 2011 report[4] echoed those findings and recommended that solutions to address women veterans' transition challenges should be "informed, holistic, collaborative, and community-based."

The unmet needs of current veterans combined with the projected rise in the veteran population make leveraging the existing social services community to supplement the VA network more critical than ever. We believe that no veterans or their families should suffer from a lack of access to or understanding of how to navigate reintegration services. Many community service providers have the expertise, experience, and local capacity to more fully partner with VA through its important veterans initiatives.

Since the issuance of an executive order in 2004,[5] VA has made working with the nongovernmental organizations (NGO), nonprofits, and faith-based communities a priority. The objective of the VA's Center for Faith Based and Neighborhood Partnerships is to coordinate agency efforts for the elimination of regulatory, contracting, and other programmatic obstacles that often prevent these organizations from providing community-based veterans' services through VA funding and contracts. In 2009, VA announced a new NGO Gateway Initiative[6] to "tap the power of communities" and help NGOs extend services to veterans. The VA reiterated its commitment to fostering and expanding partnerships with Federal, State, and private sector agencies and faith-based and community organizations in its fiscal year 2013 budget request to Congress.[7]

Examples of Successful VA and Community-Based Organization Partnerships

Members of the CCD Veterans and Military Families Task Force have successfully partnered with VA in certain areas to meet the needs of disabled veterans and their families. Below are three examples that illustrate the positive impact that VA partnerships with community-based organizations can have on addressing the issues facing today's veterans and their families.

Center for Independent Living Care Coordination

An example of a successful care coordination model between VA and a community-based organization involves the Veteran Directed Home and Community-Based Services (VDHCBS) program offered through the Sioux Falls VA Medical Center (VAMC). Launched in August 2010, the VAMC contracted with the local Minnesota River Area Agency on Aging (MnRAAA) to provide case management, fiscal management services, and assessment services for veterans seeking to obtain long-term services and supports in the community.

Because of previous outreach efforts by the South WestCenter for Independent Living (SWCIL) to the VAMC, National Guard Family Assistance Center and other veterans' groups, the MnRAAA program managers were familiar with SWCIL and its services to people with disabilities in rural Minnesota. The Agency on Aging subcontracted with the Center for Independent Living to conduct the actual assessments of veterans and provide certain case management services because of the CIL's expertise in this arena under its mandate to offer similar assistance through the Rehabilitation Act.

A licensed social worker with SWCIL serves as the liaison with nursing staff at the VAMC when a veteran is referred through MnRAAA for evaluation for VDHCBS. The SWCIL sends the veteran a packet of materials describing the consumer-directed program and schedules a follow up visit with the veteran if he/she

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[2] U.S. Government Accountability Office, VA Mental Health Report, October, 2011 (*http://www.gao.gov/new.items/d1212.pdf*).

[3] U.S. Government Accountability Office, Homeless Women Veterans December 2011 Report, (*http://www.gao.gov/assets/590/587334.pdf*).

[4] Joining Forces for Women Veterans Summary Report, Business and Professional Women's Foundation, February 2011, (*http://www.bpwfoundation.org/documents/uploads/JFWV_Final_Summit_Report.pdf*).

[5] Executive Order 13342 (*http://www.gpo.gov/fdsys/pkg/WCPD-2004-06-07/pdf/WCPD-2004-06-07-Pg980.pdf*).

[6] U.S. Department of Veterans Affairs Press Release, January 7, 2009 (*http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1639*).

[7] U.S. Department of Veterans Affairs Congressional Budget Justification (*http://www.va.gov/budget/docs/summary/Fy2013_Volume_III-Benefits_Burial_Dept_Admin.pdf*).

is interested in VDHCBS. A VA nurse determines what services the veteran needs that are available through VA and works with the SWCIL social worker to identify additional services that must be engaged to fully implement a home and community-based care plan. For example, SWCIL has used several other community options to obtain services or needed home modifications for veterans. The Center for Independent Living receives a one-time fee for each assessment and bills for case management under its subcontract with MnRAAA. As a result of this project, approximately 18 veterans have been successfully enrolled in VDHCBS.

AbilityOne® Serves Employment Needs of Veterans

The AbilityOne® program is a Federal initiative to help people who are blind or have significant disabilities, including wounded veterans, find employment by working for nonprofit agencies (NPAs) that provide *products* and/or *services* to the U.S. Government. With a national network of 600 NPAs, which work through NISH and the National Industries for the Blind, and AbilityOne® projects in every State of the Nation, the AbilityOne® program is the largest single source of employment for people who are blind or have other significant disabilities in the United States. *The* U.S. AbilityOne® Commission is the Federal agency authorized to administer the AbilityOne® program.

The AbilityOne® program employs over 50,000 people who are blind or have significant disabilities, of which 3,300 are veterans and 1,700 were veterans with disabilities. Through National Industries for the Blind and NISH, the AbilityOne® program's NPAs also support and employ thousands of veterans within their community outside their AbilityOne® workforce. The AbilityOne® program can offer increased community career transition support, exploration, and direct training for veterans in transition to management opportunities.

In 2003, VA's Compensated Work Therapy program (CWT) signed an MOU with the AbilityOne® program as the referral conduit between VA CWT and the AbilityOne® NPAs to collaborate with VA beneficiaries who have a disability. Approximately 2,100 veterans with disabilities have been employed since the partnership's inception. The partnership agreement promotes local relationships between NPAs and VA CWT offices. This allows VA to pre-screen veterans to match AbilityOne® job requirements and to refer qualified veterans with significant disabilities to participate in AbilityOne® job coaching programs.

Easter Seals Serves Veterans and Their Families

Easter Seals has a long-standing record of service to veterans, military servicemembers, and their families. Easter Seals expanded its mission at the end of World War II to include adult services specifically to address the growing number of soldiers returning home with disabilities. Recognizing the new and unmet needs of the hundreds of thousands of men and women returning from the wars in Iraq and Afghanistan, Easter Seals launched its Military and Veterans Initiative in 2005 to address serious gaps in service for veterans and military families by mobilizing its national community-based provider network. Today, Easter Seals touches the lives of America's heroes and their families through its more than 70 affiliates across 48 States and its network of 24,000 professional staff and 40,000 local volunteers.

Since the passage of the Veterans Millennium Healthcare Act in 1999, Easter Seals has worked closely with VA at the national, regional and local level to both raise awareness about access to adult day services for veterans and to contract locally to provide the direct service. In 2010, Congress approved the Caregivers and Veterans Omnibus Health Services Act that authorized a range of new services to support caregivers of eligible post-9/11 veterans, including the establishment of the National Veteran Caregiver Training program. In April of 2011, VA contracted with Easter Seals for its caregiving expertise in working with individuals with serious disabilities to develop and provide the training. Easter Seals operates the VA caregiver contract with Atlas Research, a veteran-owned small business, and three of the country's leading caregiving organizations: the National Alliance on Caregiving, the National Family Caregiver Association, and the Family Caregiver Alliance. Easter Seals and its partners offer in-person, Web-based and self-study caregiver training through the contract to family members of seriously injured, post-9/11 veterans who receive their care at home and are eligible under VA program guidelines. The training includes topics on caregiver self-care, home safety, caregiver skills, veteran personal care, managing difficult behaviors and support resources.

Easter Seals' experience with VA has been very positive throughout the implementation of the caregiver contract. Under the contract management and direction of VA, Easter Seals and its partners have met the targets and exceeded expectations. Feedback has been overwhelmingly positive, including from a mother of a se-

riously injured veteran who wrote: "Thank you for re-inspiring us and for all you continue to do to be a part of healing American heroes."

Recommendations for Expanding Partnership Success

The CCD Veterans and Military Families Task Force believes that these examples of successful partnerships between VA and community-based organizations clearly support our position for increased collaboration. Specifically, we believe that there are opportunities to foster additional collaboration to meet the needs of disabled veterans living in their communities. Consequently, VA should expand community-based, supportive services models (similar to the Supportive Services for Veteran Families program) that leverage the existing social service network to help assist VA in achieving its goals.

As an example, veterans with disabilities often need assistance obtaining appropriate community-based services to allow them to live and work independently in the community. Navigating the many different services for people with disabilities and veterans, such as health benefits, transportation, and vocational rehabilitation services, can be complex. Organizations like the Protection and Advocacy agencies located in every State and territory have expertise and experience navigating these programs and often advocate for veterans with disabilities to receive appropriate services from community-based and faith-based organizations.

For instance, the New York Commission on Quality of Care and Advocacy for People with Disabilities has been working with the New York State Department of Health to create an advisory board of veterans to address the need of veterans to receive community-based health care services, and to help monitor the services that veterans receive. Disability Rights California holds weekly training and information sessions for veterans in the San Diego area to provide them information and assistance obtaining community-based services. Protection and Advocacy agencies are eager to work with VA to ensure veterans with disabilities receive the services and supports necessary to live and work in the community.

The National Disability Rights Network (NDRN), a CCD member organization, is available to assist with coordinating collaboration efforts between VA and the Protection and Advocacy Network. The CCD Veterans and Military Families Task Force encourages VA to work with the Protection and Advocacy agencies, NDRN, and other organizations to provide these unique advocacy services to veterans with disabilities.

We commend VA's NGO Gateway Initiative aimed at helping qualified nonprofits who are interested in assisting VA in a variety of service areas and VA's establishment of a dedicated liaison in the Office of the Secretary to support VA/NGO information sharing and collaboration. However, VA should elevate the profile of this initiative and include readily available guidance on the VA Web site regarding how interested organizations would receive assistance through this initiative. We believe that organizations interested in partnering with VA, must be able to easily relay their interest and abilities to VA.

The ability to augment VA services by linking VA with established community and faith-based organizations represents an opportunity to greatly increase access to a variety of services needed for veterans with disabilities and their families in transitioning to and remaining active members of their communities. The need to expand access to services, particularly for veterans in rural and remote areas, shows the need to increase collaboration to meet the concerns of today's veterans with disabilities. Qualified community and faith-based organizations represent a clear pathway to augmenting VA services for our Nation's veterans.

Thank you for the opportunity to submit testimony regarding the views of the CCD Veterans and Military Families Task Force concerning collaboration between VA and community-based organizations. We encourage the Subcommittee to continue its exploration of this topic and commend your leadership on behalf of our Nation's veterans with disabilities. We are ready to work in partnership to ensure that all veterans are able to reintegrate in to their communities and remain valued, contributing members of society.

Information Required by Clause 2(g) of Rule XI of the House of Representatives

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Receipt of Federal grants or contracts:

The Consortium for Citizens with Disabilities Veterans and Military Families Task Force has not received any Federal grants or contracts during the current or two preceding fiscal years.

MATERIAL SUBMITTED FOR THE RECORD

Post-Hearing Questions and Responses for the Record:

Questions from Hon. Michael H. Michaud, Ranking Democratic Member, Subcommittee on Health, Committee on Veterans' Affairs to Honorable Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs

February 29, 2012

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki:

In reference to our Subcommittee on Health hearing entitled, "Building Bridges Between VA and Community Organizations to Support Veterans and Families," that took place on February 27, 2012, I would appreciate it if you could answer the enclosed hearing questions by the close of business on Wednesday, April 11, 2012.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Jian Zapata at *jian.zapata@mail.house.gov*, and fax your responses to Jian at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

Michael H. Michaud
Ranking Democratic Member
Subcommittee on Health

CW/jz

Questions for the Record from the House Committee on Veterans' Affairs Subcommittee on Health

February 27, 2012

Hearing on *Building Bridges Between VA and Community Organizations to Support Veterans and Families*

Question for Rev. E. Terri LaVelle, Director, VA Center for Faith-based and Neighborhood Partnerships

1. What is being done to specifically address the support needs of servicemembers and veterans that reside in rural or underserved areas?

Questions for Chaplain Michael McCoy, Associate Director, National Chaplain Center

1. Within the 200 training events that the National Chaplain Center has conducted, how many clinics have been included in this outreach?

2. How is the National Chaplain Center measuring success in terms of outreach and training?

Responses from Hon. Eric K. Shinseki, Secretary,
U.S. Department of Veterans Affairs
to Honorable Michael H. Michaud, Ranking Democratic Member,
Subcommittee on Health, Committee on Veterans' Affairs

February 27, 2012

Hearing on *Building Bridges Between VA and Community Organizations to Support Veterans and Families*

Question for Rev. E. Terri LaVelle, Director, VA Center for Faith-based and Neighborhood Partnerships (CFBNP)

Question 1: What is being done to specifically address the support needs of servicemembers and veterans that reside in rural or underserved areas?

Response:

The VA CFBNP hosts quarterly conference calls for members of the Center's listserv. The quarterly conference call provides listserv members with updates on the work of VA's CFBNP especially focusing on sharing the Center's collaborative efforts with internal and external stakeholders working with or on behalf of veterans. The call also provides updates on VA programs and services that will assist listserv members in serving the needs of veterans, their families, survivors, and caregivers.

Some members of the listserv represent and or work with organizations that provide services to veterans in rural communities.

Realizing the need to provide additional information to those serving veterans in rural communities, the Center's final call for FY 2011 provided information on a collaborative community program for veterans and clergy living and working in rural communities.

For the September 15, 2011 quarterly conference call, the speaker was Rev. Steve Sullivan, Chaplain Arkansas VA Medical Center and Director of the VA/Clergy Partnership for Rural Veterans. Chaplain Sullivan shared information about Project South (Serving Our Units at Home). Chaplain Sullivan shared how Project South came into existence, how to effectively engage and work with local clergy and ways to reach the veterans and their families.

Project SOUTH is an inter-denominational cooperative effort between local churches, the National Guard and U.S. Army Reserve local units, and the Arkansas Veterans Affairs to provide basic support and care for local soldiers and National Guardsmen who are preparing to be or are already deployed, and to their families. Project SOUTH works with faith leaders in El Dorado, Arkansas and other surrounding rural communities.

The VA CFBNP co-hosts four regional Veterans Roundtables annually with Veterans Benefits Administration (VBA) Vocational Rehabilitation and Employment (VR&E) Service and the VR&E Regional Office (RO) of the host city.

In previous Veterans Roundtables, it became apparent that information and training programs must be taken to where the needs are; one place is to our rural communities. Rural communities often lack adequate transportation and other resources to get meaningful numbers of participants to such event.

One of the VA Veterans Roundtables for FY 2012 will be held in a rural community.

The VA Veterans Roundtable has two primary goals; the first is to facilitate collaborative working relationships among faith-based and secular organizations working in the host city and with Veterans Benefits Administration, National Cemetery Administration, and Veterans Health Administration so that holistic services can be provided to veterans, their families, survivors, and caregivers.

The second goal is to inform attendees of the number of veterans in their community, what their current needs are, and potential funding available to faith-based and secular organizations who can demonstrate an ability to meet those needs in collaboration with the VA.

To strengthen and expand the CFBNP support to rural veterans, the Director of the CFBNP met with the Director of Veterans Health Administration's (VHA) Office of Rural Health on March 22, 2012. They discussed VHA rural health needs and how VA's CFBNP an assist veterans by working with faith-based and community leaders in rural communities. The next step is for VA's CFBNP to work in collaboration with VA's Community-Based Outpatient Clinics (CBOCs). Together, these "networks" can directly inform and assist rural veterans to secure services they may need.

Questions for Chaplain Michael McCoy, Associate Director, National Chaplain Center

Question 1: Within the 200 training events that the National Chaplain Center has conducted, how many clinics have been included in this outreach?

Response:

The majority of the 233 Veterans Community Outreach Initiative (VCOI) programs have been hosted at or near VA medical centers. Outpatient clinical program personnel are invited to participate in the day-long clergy training events. The Rural Clergy Training program, cosponsored by the VA National Chaplain Center and the VA Office of Rural Health, is an initiative to create Best Practices in training rural clergy in very rural settings. The eight Rural Clergy Training events planned for 2012 (listed below), will be held near VA CBOCs. We anticipate that VA clinic personnel, as well as VA Mobile Vet Center staff personnel will participate.

Elizabeth City, NC—March 6, 2012
Danville, VA—March 8, 2012
Staunton, Virginia;
Beckley, West Virginia;
Carrolton, Kentucky;
Richmond, Kentucky;
Rogersville, Tennessee; and
Cookeville, Tennessee.

The five objectives of these Rural Clergy Training events are for VA Chaplains to:

1. Train rural clergy to recognize the holistic needs of veterans and their families;
2. Train rural clergy to be able to respond sensitively to the needs of returning rural veterans;
3. Train rural clergy to be equipped to make referrals to VA facilities;
4. Encourage rural clergy to establish ministry programs specifically for veterans living in rural communities; and
5. Encourage rural clergy to use their influence in the community to help reduce the stigma attached to mental health issues.

Question 2: How is the National Chaplain Center measuring success in terms of outreach and training?

Response:

We are developing practices and measurement tools for the Rural Health Clergy Training Project that will assist local clergy and Veterans Service Organizations representatives to identify problems of returning veterans. These tools will aid veterans in receiving the appropriate assistance in rural communities. Outcome evaluation is designed in a pre/post framework and is based on three measures: (1) before training, (2) immediately after training, and (3) at yet-to-be-determined periods (potentially 3 months, 6 months, and 12 months) after training. There are seven discrete measures related to outcomes, all related to expanded services in local communities.

We continue to improve the outcome evaluation tools by developing best practices and measurement devices that can be utilized at VCOI events. Some specific questions among the 33-question evaluation forms distributed following each of the training events are: How many referrals have you made to a Veterans Affairs facility in the past 12 months? If you have made a referral to a Veterans Affairs facility, how would you rate your satisfaction with the experience? How many referrals have you made to a community mental health facility in the past 12 months? In your ministry, do you ever interact with: Veterans Affairs Chaplains? Do you ever interact with Veterans Affairs Mental Health Providers? Have you spoken about military/veteran needs from the pulpit?