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OVERSIGHT HEARING: VA OUTREACH TO MEMBERS OF THE NATIONAL GUARD AND RESERVES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

JULY 23, 2008

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OVERSIGHT HEARING: VA OUTREACH TO MEMBERS OF THE NATIONAL GUARD AND RESERVES

WEDNESDAY, JULY 23, 2008

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

The Committee met, pursuant to notice, at 9:32 a.m., in room SR–418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Rockefeller, Murray, Tester, and Sanders.

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

Chairman AKAKA. The Committee on Veterans' Affairs will come to order.

I want to welcome all of you here today, and particularly our witnesses. Today, the Committee will look at the effectiveness of VA's outreach to members of the National Guard and the Reserves who have been mobilized and deployed to Iraq and Afghanistan.

The Committee has held multiple hearings on VA benefits, health care, and services. However, this is the first time we are specifically focusing on the unique challenges confronting members of the Guard and the Reserves.

In my own State of Hawaii, over 5,000 members of the Guard and Reserve have been deployed. The Hawaii National Guard is currently in the midst of its second deployment to Iraq, and over 85 percent of those mobilized are already combat veterans. It is important that these soldiers and all Reservists know that VA will be there for them when they return.

After years of war, we appreciate that there are distinct challenges facing the reintegration of these citizen servicemembers. Unlike their active duty counterparts, Guard and Reserve veterans must transition from their civilian life and employment to active military service and back again.

Despite VA's best efforts to conduct outreach to this population, it seems clear that some are still unaware of all that VA has to offer, and how to access those services and those benefits.

I am concerned about the results from a recent VA IG report that shows that in 2006, VBA failed to send benefits packages to over 36,000 Reservists. VA employees mistakenly thought these Reserv-

ists were ineligible for these benefits. One would have thought that, after years of war, this process would be perfected.

I am also concerned about how VA reaches out to members of the Individual Ready Reserve, and those who are discharged after their deployment. These veterans may have the benefit of a unit support during their reintegration.

I am pleased that, beginning this fall, VA will resume using public service announcements and advertising. These announcements will provide another means to reach an entire veterans' population.

More work needs to be done without question. I hope that both of our panels will shed some light on why we continue to hear from veterans that they just did not know about their eligibility for VA benefits and services. We need to know how VA and Congress can help bridge this information gap. This is particularly important for those who suffer from the invisible wounds of this war and may need more help readjusting to their civilian lives.

I hope today's witnesses will provide us with a real sense of what the next steps are, so that no member of the Guard and Reserves is unaware of their eligibility and the benefits available to them.

Are there further statements? Senator Tester?

Senator TESTER. Thank you, Mr. Chairman.

Chairman AKAKA. Senator Tester.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman. I appreciate you having this hearing. I also want to thank the witnesses for being here today, especially those National Guardsmen who will testify on the second panel. I want to thank you for being here, and thank you for your service. I think it means a lot to have you here today and to have you visit with us about what is going on from a Guard perspective.

I particularly want to welcome Colonel Brad Livingston from the Montana National Guard. I was just doing a little math this morning in my head; I have known Brad for almost 35 years. It is good to have you here; it is good to have you back in Washington.

I look forward to a good discussion this morning with the folks from the DOD and the VA about what Montana and other States represented here have done to take care of their Guardsmen. I hope we can get some agreement from the DOD and the VA that some of these ideas can be standardized and implemented in the Reserves and across State Guard units.

Members of the Guard and Reserve still face some pretty unique challenges when it comes to demobilization. After deployment that can last longer than a year, we give these folks a new mission: getting back to their civilian lives in just 1 week. That is 1 week to trade in a rifle for a civilian job. That is 1 week to try to put aside patrols and convoys for parenthood and car pools.

When the resumption of civilian life happens in a small town hundreds of miles away from anybody else who knows what that soldier is going through, that can make a mission every bit as tough as the missions they have executed in Iraq or Afghanistan.

The good news is that part of what makes our military so strong is it is composed of citizen soldiers who find a way to do anything

that is asked of them, but we need to do a better job of helping those folks accomplish the demobilization mission. To do that, we need to use every tool in the toolbox, and that is why I am so pleased that we have a number of State Guard units represented today to talk about what has worked and, quite frankly, what has not for their Guardsmen.

The Montana National Guard has done some pretty interesting stuff when it comes to making the demobilization process work better for its troops. They have been great leaders on this issue, and there is a real credit given to Adjutant General Randy Mosley and a credit given to Colonel Livingston and his team.

I am proud that my State has been a leader on the issue, but I do think we need to remember something about Montana's experience. It took a tragic suicide in 2007 of a young Guardsmen named Chris Dana for folks to understand the scope of this problem. We must not forget about the death of Specialist Dana, or the fact that we have lost far too many veterans to suicide since the Afghanistan and Iraq wars were begun.

So, let me just say again how important this hearing is, and how important it is that we get this issue right. Our Reservists, our Guardsmen, and their families are counting on us for some results. I want to thank you all.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Tester.

Senator Murray.

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

Senator MURRAY. Thank you very much, Chairman Akaka, for holding today's hearing on how the VA is responding to the needs of our members of the National Guard and Reserve when they return.

Of the more than 800,000 Iraq and Afghani veterans that are eligible for VA care since 2002, fully half of them are members of the National Guard and Reserve. And unlike our active duty troops who come home from battle to a military base and built-in support network, many of our Guard and Reserve members leave the battlefield and return home to family pressures and civilian jobs almost immediately; and unfortunately, many of them do have trouble making that transition.

The skills that helped them deal with the horrific experiences they had on the battlefield often make it harder for them to return to everyday life. And unlike active duty troops, Guard and Reserve soldiers often live in remote rural areas in our States, and it makes it even more difficult for them to get access to the services and the benefits that they have earned.

Now, the VA has targeted outreach programs in place to help these servicemembers, but we still, I think, today, miss far too many of our veterans who need help and really are not aware of the services and benefits they earned.

The VA Inspector General issued a report late last week that reaffirmed that problem. It found that the VA failed to meet its statutory responsibility to inform new veterans of their benefits. In fact, that IG report found that the VA failed to send initial out-

reach letters to more than 65,000 Iraq and Afghanistan veterans—more than half of them Guard and Reserve members.

But really, the challenges go beyond outreach. The Department of Defense has found that members of the National Guard who were deployed to Iraq and Afghanistan are 25 percent more likely to suffer a combat-related psychological wound than our active duty soldiers who have been deployed. And we all know that members of the Guard and Reserve are twice as likely to have their VA claim denied than active duty servicemembers.

This coming fall, I have 2,900 members of the Washington State National Guard who are going to be deployed to Iraq. They are in training right now, and I want to make sure that, as we take care of these men and women while they are serving us overseas it is equally important that we have the services in place when they come home a little over a year from now.

So, this is an issue very important to me, Mr. Chairman, and I really appreciate the work of this Committee as we focus on this today.

Thank you.

Chairman AKAKA. Thank you. Thank you very much, Senator Murray.

Senator Sanders.

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

Senator SANDERS. Thank you very much, Mr. Chairman, for holding this hearing. Let me just begin by saying that I concur with your remarks and those of Senator Tester and Senator Murray.

I am delighted that we are going to be hearing later on from Colonel John Boyd who is the Deputy Chief of Staff for Personnel for the Vermont Army National Guard, who is going to testify about Vermont's veterans and family outreach program.

Let me also welcome Major Randy Gates, who is the State Family Program Director—Family Readiness Program of the Vermont National Guard, who has joined Colonel Boyd here today.

Mr. Chairman, as I think you have heard from other Members, what we all understand is that if we have the best services available, which we want, for those who are returning from Iraq and Afghanistan, it does not mean anything if these people do not know that the services are available. That is the bottom line, and I think it is pretty clear that, up to now, we have not done the kind of job on outreach to our veterans that we should have.

And as I think you have heard from both Senator Tester and Senator Murray, both who come from rural States, when you have members of the National Guard who come from States as we do in Vermont where there are 500 people or 1,000 people in a town, sometimes you can get isolated. And the concern that we have is that somebody goes over and serves in Iraq, serves in Afghanistan, they come back home, they go to a small town, they have a whole lot of problems. The nature of PTSD, the nature of TBI, is not such that you jump up and say, hey, I have got a problem. That is not the nature of that illness.

So how, in a dignified and respectful way, do you reach out to men and women in isolated areas, in rural areas, make them aware of the programs that we are developing, make sure that these programs are effective as they can be? How do you bring those people in?

A couple of years ago, working with the Vermont National Guard and the Veterans Administration, we developed what we think is a pretty good program in the State of Vermont by which we are reaching out now to veterans and their families. We are knocking on doors, we are calling our people all over the State of Vermont. We are trying to make sure that nobody is left behind.

And I think what is good about this hearing—and I will be jumping in and out, Mr. Chairman; I have got another hearing simultaneously, but I will be back—is it is important for us to learn what different States are doing. We can all learn from each other. There is good work going on around the country, I know, in Montana, Minnesota, elsewhere. We are doing good stuff in Vermont. Let's see what works; let's see what does not work.

The current military situation presents some unique problems with TBI, with the number of cases of PTSD. I think everybody here is increasingly aware that we need better cooperation between the VA and National Guard. You cannot have these walls.

The other thing, I think, we are also increasingly aware of is, that if a soldier goes over and leaves a wife or a kid home, you cannot ignore the wife and the kid. This is not just a soldier problem, this is a family problem. We have got hundreds of thousands of kids who have seen their parents go over, and we have got to deal with this as a family unit, and if it means making changes in the rules—things are different today than they were 30 years ago. We have got to deal with the whole family.

So, there is a lot to learn. I think we are making some progress. We have got a long way to go. And I thank you very much, Mr. Chairman, for holding this hearing.

Chairman AKAKA. Thank you very much, Senator Sanders.

I would like to invite the first panel to please come up: General Chapman, Mr. Mayes, and Mr. Nelson.

We have two excellent panels. I would like to thank all of our witnesses again for being here today.

In our first panel, I would like to welcome Major General Marianne Mathewson-Chapman, United States Army, Retired. Major General Chapman is the National Guard and Reserve Coordinator in the Office of Outreach to Guard and Reserve Families for the Veterans Health Administration, Department of Veterans' Affairs.

I would also like to welcome Mr. Brad Mayes, the Director of the Compensation and Pension Services for the Veterans Benefits Administration in the Department of Veterans' Affairs.

Finally, I want to welcome Mr. Donald Nelson, the Deputy Assistant Secretary for Reserve Affairs in the Department of Defense.

We look forward to hearing from each of you, and your full statements will appear in the record.

Major General Mathewson-Chapman, we will begin with you. If you would please give your statement.

STATEMENT OF MARIANNE MATHEWSON-CHAPMAN, Ph.D., ARNP, MAJOR GENERAL, U.S. ARMY (RET.), NATIONAL GUARD AND RESERVE COORDINATOR, OFFICE OF OUTREACH TO GUARD AND RESERVE FAMILIES, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Major General MATHEWSON-CHAPMAN. Good morning, Mr. Chairman and Members of the Committee. Thank you for inviting me to speak about outreach and the cooperation between the Department of Veterans Affairs, Department of Defense, the National Guard, and the Reserves.

I am joined today, as you just mentioned, by Mr. Bradley Mayes, Director of C&P Service for the Veterans' Benefits Administration. My written statement, which I request be submitted for the record, discusses VA's four major outreach efforts throughout the deployment cycle for members of the National Guard and Reserve, from pre-deployment to lifelong contact for health care and benefits.

This statement, along with Mr. Mayes' testimony, are replete with descriptions of proactive VA outreach initiatives executed to meet the complex challenges of the National Guard and Reserves reintegrating home to their communities. War changes us all, and that includes the families; and VA has stepped up to meet this challenge.

The following are four critical outreach initiatives and their stories that demonstrate the immediate impact on the Guard and Reserve as they transition from active duty to veterans. These initiatives demonstrate VA's critical outreach support in four areas: enrollment in health care during the mandatory briefings at the demobilization process; enrollment and referrals during the post-deployment health reassessment for Guard and Reserve members; and then reaching out to Guard and Reserve members through the combat veteran initiative; and finally, our partnership with the National Guard with the use of the transition assistance advisors.

I would first like to illustrate the impact of VA outreach and enrollment at the demobilization sites. Since May 2008, VA has contacted over 4,000 Army soldiers at 12 Army demobilization sites to provide not only enrollment, but health care briefings and benefits briefings. We have been able to enroll 83 percent of them in VHA health care.

At a recent event a female soldier was sitting in the audience otherwise composed entirely of men. VA staff members assisted all demobilizing soldiers in completing the 10–10EZ enrollment form for health care as part of their standard presentation. During the break, the female asked if VA really had a women's clinic. After being assured we do, the woman expressed her excitement that she would now be able to receive all of her health care at VA, particularly sensitive issues that require a female provider. She was also told that VBA has female benefits counselors to help meet her needs.

The second major initiative exemplifies VA's partnership with the DOD in providing support at the post-deployment health reassessment, these PDHRA events are held at military units throughout the country on weekends at 3 and 6 months' post-deployment.

PDHRAs are a DOD program that provides education, screening, and global health assessment to identify deployment-related physical and mental health concerns. VA provides support and appointments for follow-up evaluation of treatment, and also they learn about their benefits at this time.

You might have recently read about the innovative program in The Baltimore Sun. For the last 18 months, Baltimore's VA Medical Center has been hosting PDHRAs in the hospital. VA clinicians saw over 100 members of the Maryland National Guard and screened them onsite at the hospital for everything from common aches and pains to mental health conditions. As a result of this in-hospital innovative program and screening, VA staff were able to provide several soldiers with immediate hospitalization and medical care.

Next, I would like to highlight the impact of the Combat Veteran Initiative, which VA began in May. The call center staff has contacted by phone over 17,000 OEF/OIF combat veterans who have been injured and who may need the care and coordination care of a Care Manager.

Presently, staff are contacting 510,000 National Guard and Reserve members. They are being called and asked if they would like to be enrolled, or for information about VA.

In one case, our call center staff called a National Guard soldier and asked if he needed help or support. He said, I do not need the help, but my brother sure does. He is a combat Guard soldier and he is having trouble with readjustment issues since his deployment. VA contacted both brothers and enrolled them both in VA health care and assigned them to Care Manage to coordinate VA health care services and benefits.

Another more dramatic example is a Guard soldier who was told he was not a veteran, though he even served twice in Iraq. When the program manager called him as a referral from the call center, he said this call could not have come at a better time, as he was having suicidal thoughts because he had no job and no money, and he did not know where to turn. He was happy that VA could coordinate the enrollment and appointments for him the next day.

His mother called a social worker back and thanked the VA for saving her son's life. He was also referred on then, to VBA for C&P claim for his disabilities.

Finally, I would like to highlight the continued partnership between the VA, the National Guard, VHA, and VBA together who trained the first Transition Assistance Advisors, or TAAs, in 2006. They were hired by the National Guard to conduct VA outreach to Guardsmen and Reservists in the 50 States, the District of Columbia, and Guam, Virgin Islands, and Puerto Rico. TAAs are the critical link to facilitate access to VA information services, integrate the delivery of VA and community services throughout the State coalitions, as well as to notify VA staff when troops are returning.

Since February 2008, they have reached out to more than 85,000 Guard and Reserve members and family members in outreach efforts, facilitating over 1,000 referrals to VHA, VBA, and Vet Centers.

I would like to conclude with a story that shows quite clearly the invaluable work of TAAs in performing outreach in hometown America.

In one case, a deployed Guard soldier recently returned home and suffered a stroke. His wife took him to a nearby civilian hospital for care, but bills were mounting and the family needed help. A TAA was called by our outreach staff to assist the family and the Guard soldier with enrollment in health care and assistance in applying for disability benefits. The TAA was able to resolve the veteran's medical bills at the civilian hospital by contacting community resources and members of the State Coalition to assist them.

These few examples of four key initiatives only begin to demonstrate the proactive joint efforts among VHA, VBA, and DOD, as well as proactive efforts throughout the deployment cycle that genuinely are impacting the lives of National Guard and Reserve men and women who have truly borne the battle. I am proud to participate in these efforts to meet the reintegration and homecoming needs of our Guard and Reserve.

Mr. Chairman and Members of the Committee, this concludes my statement. I would be happy to address any questions that you may have on these initiatives.

[The prepared statement of Major General Mathewson-Chapman follows:]

PREPARED STATEMENT OF MARIANNE MATHEWSON-CHAPMAN, PH.D., ARNP, MAJOR GENERAL, U.S. ARMY (RET.), NATIONAL GUARD AND RESERVE COORDINATOR, OFFICE OF OUTREACH TO GUARD AND RESERVE FAMILIES, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Good morning, Mr. Chairman and Members of the Committee. Thank you for inviting me to speak about the cooperation between the Department of Veterans Affairs (VA), Department of Defense (DOD), the National Guard and the military reserves. I am joined today by my colleague, Mr. Bradley Mayes, Director, Compensation and Pension Services, Veterans Benefits Administration.

From the start of Fiscal Year (FY) 2002 through the first quarter of 2008, over 837,000 servicemembers have separated from active duty. Slightly more than half of the returning servicemembers from Operation Enduring Freedom and Operation Iraqi Freedom were members of the National Guard and Reserves. I am pleased to report VA and DOD are coordinating their efforts more closely than ever before to ensure our newest veterans, including members of the National Guard and the Reserves, reintegrating back into their communities are knowledgeable about all of the VA benefits and services for which they are eligible and know how to access the services they need.

VA has a long-standing commitment to serving this important reserve component of our Armed Forces. We are dedicated to providing the highest quality care and services to all who have worn the uniform in any branch of service including our newest veterans who are members of the National Guard and Reserve. We also recognize the importance of timely contact, and that not all separating servicemembers, or members of the National Guard and Reserve, will be interested in immediately enrolling in VA for health care or benefits. As a result, VA has developed a proactive multi-faceted strategy to provide key outreach at critical stages throughout the deployment cycle.

Recently, DOD and VA have agreed to assign a VA Liaison to the DOD Office of Reintegration Program Office (ORP). This position will assist DOD in compliance with Section 582 of the FY 2008 National Defense Authorization Act (NDAA). There will be continual and interdependent collaboration between the ORP, VA and the Services' programs to further develop policies to meet the needs of veterans and servicemembers. VA's presence will bring specific expertise and knowledge to aid ORP in developing best practices based on VA's experience. A crucial component of this position will include supporting the field to better enable consistent implementation of policy and program decisions through coordination with the appropriate VA offices.

My testimony today will provide a detailed description of VA's outreach efforts for non-severely injured National Guard and Reserve members during four phases of this deployment cycle. These four phases include: pre-deployment; during deployment and demobilization prior to separation from active duty; immediately post-deployment; and finally, life-long contact with the Guard or Reserve veteran. In each of these phases, VA works closely with DOD, Guard and Reserve families, communities, counties, state governments and community agencies to ensure we inform them about VA and to facilitate their access to VA services, benefits and health care.

PRE-DEPLOYMENT

Since November 2004, VA has provided benefits brochures to everyone inducted into the five military branches. This pamphlet delivers basic information on VA benefits and services at the start of their military career.

In addition, VA supports efforts for early contact with National Guard and Reserve members and their families. Guard and Reserve members and families learn about VA services and benefits during Soldier Readiness Processing (SRP) events held prior to mobilization. These benefits outreach briefings continue throughout the deployment phase as VA collaborates with each of the services. VA provides outreach through family programs, town hall meetings and family training events. Families are a critical component in reaching veterans and providing information about how to access VA health care and the importance of seeking early assistance for needed health care services.

Our Vet Centers regularly conduct local outreach initiatives and maintain strong working relationships with nearby Guard and Reserve units. In addition to routine visits, Vet Center representatives will sometimes host Open Houses onsite at Reserve units during the weekends where they can answer questions from family members and Reservists. Vet Center staff and GWOT counselors participate in pre-mobilization educational briefings where they are able to establish contacts and distribute information to family members.

DURING DEPLOYMENT AND DEMOBILIZATION

Our latest efforts to expand services during the deployment phase demonstrate further collaboration between VA and DOD as we establish a comprehensive, standardized enrollment process at 12 Army Demobilization sites. Since this pilot began on May 28, VA has contacted more than 2,000 separating Army Guard and Reserve members and offer them the opportunity to enroll in VA health care. VA has enrolled more than 80 percent of these veterans and this month we are expanding this program to the Navy at four sites. We will expand it further in August to the Marines and to the Air Force Reserves later this fall.

DOD provides VA with dates, numbers of servicemembers demobilizing and locations for Reserve Component units when demobilization events occur. At these events, Veterans Health Administration (VHA) staff representatives from the local VA medical center, benefits specialists and Vet Center counselors are given 15 to 30 minutes during mandatory demobilization briefings for a scripted presentation. During this time, veterans receive information about recent changes in enrollment and eligibility, including the extended period in which those who served in combat may enroll for VA health care following their separation from active duty. They are also educated about the period of eligibility for dental benefits, which was recently extended from 90 days to 180 days following separation from service, by the National Defense Authorization Act for Fiscal Year 2008.

This enrollment process has been streamlined and veterans are also shown how to complete the Application for Medical Benefits (the 10–10EZ), which begins the enrollment process for VA health care. VHA staff members also discuss how to make an appointment for an initial examination for service-related conditions and answer questions about the process. These completed forms are collected at the end of each session. VA staff at the supporting facility match the 10–10EZ with a copy of the veteran's DD–214, their discharge papers and separation documents, scan them, and email or mail them to the VA medical center where the veteran chooses to receive care. The receiving facility staff enters this information into VA's electronic medical records; VA's Health Eligibility Center staff will then complete the enrollment process and send a letter to the veteran verifying their enrollment. Guard and Reserve veterans receive a special letter at the demobilization site identifying a toll-free number they can dial if they need to seek medical care before they have received their official enrollment letter in the mail. This is a process improvement strategy to facilitate access for Guard and Reserve members for needed health care prior to notification of official enrollment.

VA staff also makes a straightforward presentation regarding the advantages of enrolling in VA care early, even though the servicemember/veteran may not need health care services at this time. Combat theatre veterans receive health care at no cost for any condition that might be related to their combat service. Essentially, VA reinforces a positive message that enrollment in VA health care, will benefit them both now and in the future.

The Vet Center program is the VHA arm for community outreach to returning combat veterans. The outreach to provide veterans and family members with educational information about readjustment counseling services is one of the legislatively mandated missions of the Vet Center program. In response to the growing numbers of veterans returning from combat in OEF/OIF, the Vet Centers initiated an aggressive outreach campaign to welcome home and educate returning servicemembers at military demobilization and National Guard and Reserve sites. Through its community outreach and brokering efforts, the Vet Center program also provides many veterans the means of access to other VHA and Veterans Benefits Administration (VBA) programs. To augment this effort, the Vet Center program recruited and hired 100 OEF/OIF veterans to provide the bulk of this outreach to their fellow veterans. To improve the quality of its outreach services, in June 2005, the Vet Centers began documenting every OEF/OIF veteran provided with outreach services. The program's focus on aggressive outreach activities has resulted in the provision of timely Vet Center services to significant numbers of OEF/OIF veterans and family members. Since the beginnings of hostilities in Afghanistan and Iraq, the Vet Centers have seen over 288,000 OEF/OIF veterans, of whom over 216,000 were outreach contacts seen primarily at military demobilization and National Guard and Reserve sites and more than 72,000 were provided readjustment counseling at Vet Centers. The Vet Center Program has also provided outreach services to the United States Marine Corp IRR reservists across the Nation.

The approach builds on a prior outreach effort conducted during the first Gulf War, which received the commendation of the President's Advisory Committee on Gulf War Veterans' Illnesses. In its final report of March 1997, the Committee cited the Vet Centers for providing exemplary outreach to contact and inform this veteran cohort about VA services. On October 2004, the U.S. Medicine Institute of Health Studies and Association of Military Surgeons of the United States reported that "VHA's Vet Centers have proven a 'best practice' model in fostering peer-to-peer relationships for those with combat stress disorders."

IMMEDIATELY POST-DEPLOYMENT

Following demobilization, DOD regularly holds post-deployment health reassessments (PDHRA's) for returning combat Guard and Reservists between three and six months after separation from active duty. The PDHRA is a DOD health protection program designed to enhance the deployment-related continuum of care. PDHRA's provide education, screening, and a global health assessment to help facilitate care for deployment-related physical and mental health concerns. Completion of the PDHRA is mandatory for all members of the National Guard or Reserve who complete the post-deployment health assessment at the demobilization sites.

DOD provides VA a list of locations and times where these events will take place—often at the Guard or Reserve unit. VA outreach staff from local medical centers and Vet Centers participates at these events. DOD clinicians conduct screening exams to veterans and VA staff are available to coordinate referrals for any veteran interested in seeking care from a VA facility. Vet Center staff members are also present to assist veterans with enrollment in VA for health care or counseling at a local Vet Center.

PDHRA's are typically held in person with mandatory attendance for units of 30 or more servicemembers, while smaller units conduct their PDHRA's by phone using DOD's call center staff to conduct the screening. Almost 73 percent of all Reserve Component PDHRA referrals were to VA—either a Vet Center or a VA medical facility. VA's PDHRA mission is threefold: enroll eligible reserve component servicemembers, into VA health care; provide information on VA benefits and services, and; provide assistance in scheduling follow-up appointments. VA medical center and Vet Center representatives provide post-event support for all onsite and Call Center PDHRA events.

VA medical centers and Vet Centers accept direct PDHRA referrals from DOD's 24/7 Contract Call Center. Between November 2005 and May 2008, VA staff supported over 1,050 onsite and 380 Call Center PDHRA events. During that same period, DOD conducted 193,559 Reserve Component PDHRA screenings, resulting in more than 41,100 referrals to VA medical centers and 19,200 to Vet Centers.

Another essential element of VA's outreach during the post-deployment stage are the 100 Global War on Terror (GWOT) counselors employed by VA's Readjustment Counseling Service. Vet Center GWOT Veteran Outreach Specialists conduct a focused campaign to inform their fellow GWOT veterans about VA benefits and services. These GWOT Counselors attend demobilization, PDHRA and other activities, including "welcome home" events in their hometown and community. These Counselors are performing a vital service, and their personal connection and dedication to the task at hand have helped countless veterans and their families throughout the reintegration process.

LIFE-LONG CONTACT

While VA's participation at demobilization sites and in PDHRA events represents critical elements of our outreach strategy, we are well aware that not all veterans will enroll during this time and they may return home with limited knowledge of VA services. As a result, through a number of outreach initiatives, VA continues its efforts once members of the National Guard and Reserves have returned to their community. These measures range from nationwide to neighborhood outreach events and leverage VA's relationships with state and local partners, including a wide variety of organizations.

In May 2005, VA and the National Guard entered into a partnership and signed a Memorandum of Understanding to enhance access to VA health care for members of the National Guard in each of the 50 states, District of Columbia, and territories of Puerto Rico, Guam, the U.S. Virgin Islands. In early 2006, the National Guard hired and funded the first 54 Transition Assistance Advisors (TAA's), while VA provided specialized training for them at the VBA Academy in Baltimore about VA benefits and health care services. In 2008, an additional six TAA's were hired to provide further outreach support in states with large pools of mobilizing National Guard members: Texas, Pennsylvania, Georgia, Florida, California, and Minnesota. VA outreach staff continues working closely with TAA's while they are in the field and serving OEF/OIF veterans, through regularly scheduled conference calls, newsletters, and annual training conferences that identify and disseminate best practices in each state. TAA's serve two critical missions: first, they perform local problem-solving for any specific issues facing veterans; second, TAA's bring together key leaders and organizations, such as State Directors of Veterans Affairs, Adjutants General, and VA leadership at the Network and facility level. The VHA OEF/OIF Office of Outreach also has strong ties with the Adjutants General of the National Guard, TAA's, and with State Directors of VA, all of whom can and do keep VA informed of any challenges in accessing VA health care or other issues in the state.

TAA's have been the critical link in facilitating access to VA by National Guard and Reserve members by providing VA with critical information on numbers of returning troops, locations, and home coming and reintegration events. TAA's also facilitate enrollment into VHA care for returning troops.

Moreover, Network, Regional Office, and Medical Center staff have signed a state Memorandum of Understanding with 47 states that define the roles and responsibilities of VA and the state Departments of Veterans Affairs. A few states prefer to operate under the national agreement reached between the National Guard and VA in 2005. These state partnerships are the foundation for the development of state coalitions with participation by VA, State Adjutants General, State Directors of VA, and community and state organizations to address the coming home needs of the Guard and the Reserve members.

VA works with state governments to further our mutual goal of enhanced benefits and access care for Guard and Reserve veterans in multiple ways. Some examples include:

- In Connecticut, the State has signed a Memorandum of Understanding with VA allowing severely injured veterans to volunteer to have their medical information shared with the state, and VA has an active campaign to encourage wounded veterans in the state to contact VA for enrollment and benefits.
- In Delaware, the State signed a Memorandum of Understanding in September 2007 with the Delaware National Guard, the Delaware Department of Labor, VA, and other support agencies to establish clarity of communication and synchronization of efforts between each agency to provide veterans with transition assistance and guidance.
- In Florida, a pilot program was established to allow for ease of transfer of information from VA to the state government for wounded servicemembers who volunteer to have their information shared.

• In Ohio, the National Guard and the regional VA office are negotiating a Memorandum of Understanding to provide comprehensive informational sessions for members of the Guard and their families during different stages of deployment.

• In South Carolina, the State has partnered with VA to offer job and health fairs for returning servicemembers.

• In South Dakota, the State has established a seven step Reunion and Reintegration plan, a portion of which includes providing information on Vet Centers and PDHRAs.

• In Minnesota, during the "Beyond the Yellow Ribbon Reintegration Program", VA participated in briefings to returning troops and families, enrolled members of the National Guard in VA health care, and supported family members in the Family Academy classes, which provided information about VA benefits and health care services for which the spouse or family of a veteran may be eligible.

Further Outreach Initiatives for Guard and Reserve Members:

VA also conducts direct outreach by telephone through several initiatives, including the Secretary's recently announced call center campaign to contact every OEF/OIF veteran and servicemember, including members of the National Guard and Reserve, who have separated from service but who have not yet enrolled in VA health care. On May 2, 2008, VA began contacting almost 510,000 combat OEF/OIF veterans to ensure they know about VA medical services and other benefits. The Department is reaching out to all OEF/OIF veterans to let them know VA is here for them. The first of those calls went to an estimated 17,000 veterans who were sick or injured while serving in Iraq or Afghanistan. If any of these 17,000 veterans did not already have a care manager to work with them, VA offered to appoint one for them. The second phase of the call initiative is to contact those discharged from active duty but who are not yet receiving VA health care. Local VA facilities and network representatives are sent referrals to provide follow-up contact should the veteran want additional information or have unmet health care and benefit needs.

In addition, the Secretary of Veterans Affairs sends a letter to newly separated OEF/OIF veterans. These letters thank veterans for their service, welcome them home, and provide basic information about VA health care and other benefits. Through the first quarter of FY 2008, VA mailed more than 766,000 initial letters and 150,000 follow-up letters to new veterans including members of the Guard and Reserve.

Families are a vital force in ensuring that veterans know how to access care and services they need. They are often the first to notice a change in behavior or any symptoms. VA works with National Guard family programs and provides literature on readjustment counseling and health care services to family program directors at annual training conferences. Many families attend "welcome home" events sponsored by the local VA Medical Center and Vet Centers identify other resources in the community where families and veterans can establish contact to meet their specific needs. VA is continuing its work with the Army's Warrior Transition Units at active duty Army bases and the nine community based health care organizations to ensure the leadership of these units is linked to case managers at VA medical centers and vocational rehabilitation services. VA also supports the Family Assistance Centers at Army bases with VBA counselors and vocational rehabilitation specialists who can support and extend VA's outreach efforts to help servicemembers to enroll in VA health care prior to separation from active duty, apply for a disability, or other VA benefits. Our Vet Centers can also provide outreach services to family members while a veteran is deployed. Many Vet Centers host family outreach events and other activities, such as picnics or fishing expeditions, both while a veteran is deployed and after he or she has returned. Vet Centers also work closely with the Reserve's Family Readiness Units to collaborate with them and support veterans and families through outreach, education and referral services.

Outreach Programs for Severely Injured National Guard and Reservists:

For wounded warriors returning home, forty-three states currently participate in the State Benefits Seamless Transition Program. To date, 350 severely injured veterans have signed the consent form authorizing VA to notify their local State Department of Veterans Affairs of their contact information when they return to their home state. The initiative involves VA health care liaison staff located at the following Department of Defense medical facilities:

- Walter Reed Army Medical Center, Washington D.C.
- National Naval Medical Center, Bethesda
- Brooke Army Medical Center, San Antonio, TX
- Darnall Army Medical Center, Ft. Hood, TX
- Madigan Army Medical Center, Puget Sounds, WA

- Eisenhower Army Medical Center, Augusta, GA
- Evans Army Community Hospital, Ft. Carson, CO
- Naval Medical Center, San Diego, CA
- Womack Army Medical Center, Ft. Bragg, NC
- Naval Hospital, Camp Pendleton, CA
- Naval Hospital, Camp Lejeune, NC

Under the program, wounded veterans returning to their home states can elect to be contacted by their local State Department of Veterans Affairs about state benefits available to them and their families. VHA Liaisons for Health Care identify injured military members who will be transferred to VA facilities, inform them about the program, and obtain a signed consent form from veterans electing to participate. These forms are faxed directly to an identified point of contact in the state's Department of Veterans Affairs. The state offices, in turn, contact the veterans to inform them of available state benefits.

In order to participate in the program, State Departments of Veterans Affairs must provide a point of contact and dedicate a fax machine in a private, locked office to receive the release of information forms. VA asked states to participate in the program in February 2007 when it was expanded beyond the Florida pilot program.

Moreover, the Federal Recovery Coordinator program has been created within VA, with the cooperation of DOD, to assist the most seriously injured servicemembers, whether they be members of the Guard and Reserve or not. These Coordinators act as facilitators to ensure all Federal benefits are made available to help the injured, ill, or wounded servicemember transition out of the military and into civilian life.

Media Campaigns

One important area recently opened to us will improve our outreach efforts during all phases of a servicemember's career. On June 16, less than a month ago, Secretary Peake lifted VA's restriction on advertising. Our mission at the Department of Veterans Affairs is clear: to do all within our authority and ability to help servicemembers readjust successfully into civilian society after their military experience ends and to make sure they know the VA is there to provide health care, benefits and other services they have earned.

Secretary Peake's decision requires the Under Secretaries to coordinate with the Assistant Secretary for Public and Intergovernmental Affairs about outreach, media plans, education, and awareness campaigns and initiatives, and for me to recommend to him further steps to improve our ability to reach veterans and their families. In the few weeks since the change, there have already been a number of meetings with the three Administrations and staff offices working together to move this effort forward. One of the key parts of the rescission allows the Under Secretaries to purchase advertising in media outlets for the purpose of promoting awareness of benefits and services, after coordinating with the Department's public affairs office.

The decision allows us to use proven modern advertising techniques that will appeal to veterans of all ages and their family members. It will give VA, with its variety and diversity of services and benefits, the ability to provide the right message through the right medium to reach veterans. Traditional advertising venues such as broadcast and print are available to us. But we are also looking at social marketing and internet based non-traditional media such as YouTube, MySpace and Facebook, as well as podcasting. All can be considered and evaluated in our outreach effort to veterans and their families.

Our goal is to reach veterans who have just returned from Iraq and Afghanistan as well those who served in World War II, Korea, the cold war, Vietnam, and the Persian Gulf War—we want to reach all veterans of all eras of service with the messages of greatest concern to them through the medium that is most effective.

On November 14, 2006 VA submitted to Congress a 5-year strategic plan (2006–2011) which included an outreach component. At that time we were still precluded from using paid outreach advertising. It is now being revised to include a robust advertising approach. It is our goal to provide the updated outreach strategic plan to you in December 2008 when we submit our scheduled Report of Outreach Activities to the Congress. We also aim to include this fiscal year's accomplishments of our current business plan objectives which will be linked to the strategic plan goals in the report.

As we move forward we will work closely with you, and welcome your suggestions. We believe the opportunities are vast and we will pursue this new approach with vigor.

CONCLUSION

VA's mission is "to care for those who have borne the battle," and it is a mission we take seriously. Every day our clinicians and staff are developing new methods for distributing outreach information to those in need and facilitating access to VA health care and benefits. I thank the Committee for your interest in this matter and, on behalf of VA, I thank DOD for their cooperative efforts in granting VA staff access to demobilizing servicemembers, veterans, and their families.

Chairman AKAKA. Thank you very much, General Chapman.

Mr. Mayes.

STATEMENT OF BRADLEY G. MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS' AFFAIRS

Mr. MAYES. Mr. Chairman, Members of the Committee, I am pleased to be here today to speak on initiatives and outreach efforts undertaken by the Department of Veterans Affairs to National Guard and Reserve members returning from theaters of combat, operations, and demobilizing from active duty.

As was mentioned earlier, I am accompanied by Major General Marianne Mathewson-Chapman.

We are committed in our efforts to see that the Nation's citizen warriors and their families are honored for their service to our country and receive the VA services and benefits they have earned.

As the number of National Guard and Reserve members serving on active duty has increased, VA has aggressively expanded its outreach efforts to inform deactivating members of the many services and benefits available to them.

From the beginning of fiscal year 2003 through the end of June, 2008, we have conducted more than 8,600 briefings for Guard and Reserve soldiers, and we have provided information to approximately 510,000 combat OEF/OIF veterans.

VA initiates outreach to National Guard and Reserve members at the beginning of their military career. Since November 2004, everyone inducted into the five military branches receives a VA benefits pamphlet at the military entrance processing station.

This pamphlet provides inductees with basic information on VA benefits and services at the start of their military active service, because we want servicemembers to know that the VA will be there for them in the future.

Regarding briefings, outreach briefings to demobilizing National Guard and Reserve components are generally one among a series of presentations scheduled for our returning groups. The briefings may be conducted at the military base where administrative demobilization activities occur, or they may be briefed later at the unit's home base, once the members have returned to their local community.

Briefings at the demobe sites are generally abbreviated because National Guard and Reserve units are there for only a few days, with much out-processing to accomplish before returning to their home locations.

Briefings to returning units at their home locations are generally part of a welcome home or a family activities day or job fairs at weekend drill sessions. Those might be TAP briefings, but that is really where we need to reach them, because we have time. The demobilization process—these servicemembers, they are trying to get

home, and we are available for them when they come back to these drills.

At all briefings, the attendees are provided with written informational materials that include the VA handbook, "Federal Benefits for Veterans and Dependents," and VA Pamphlet 20–00–1, "A Summary of VA Benefits," and an insurance information folder. You have examples of those in the folders that we provided to the Committee Members.

There are other outreach efforts. Along with face-to-face outreach efforts, we seek to ensure that a welcome-home package is sent to all returning National Guard and Reserve members. DOD provides us with the names and addresses of these returnees based on active duty separation records. The Veterans Assistance and Discharge System then generates a welcome-home package for recently separated veterans, including Reserve and National Guard soldiers.

The mailing itself contains a letter from VA and a summary and timetable of VA benefits. In addition to the VADS mailings, a separate personal letter from the Secretary, along with benefits information, is sent to each returning OEF/OIF veteran.

VADS also sends separate packages that explain education, loan guaranty and insurance benefits. A six-month follow-up letter with the same general benefits information is also sent to each returning member. And VA is currently working with DOD to update this electronic transfer of information.

Partnerships in the past—outreach to Reserve and National Guard soldiers—was generally accomplished on an on-call or as-requested basis, but with the onset of Operations Enduring Freedom and Iraqi Freedom, and the activation and deployment of large numbers of Reserve and National Guard soldiers, VA's outreach to this group has greatly expanded.

VA has made arrangements with Guard and Reserve officials to schedule briefings for members who are being mobilized as well as being demobilized. In order to facilitate these outreach efforts, we have entered into joint agreements with Department of Defense, and these agreements provide for the sharing of information so that we know when there is going to be an assembly of returning National Guard or Reserve soldiers.

VA and the National Guard Bureau, which represents National Guard units nationwide, have entered into a memorandum of agreement to establish the requirements, the expectations, and obligations of each organization with respect to assisting National Guard soldiers with demobilization issues.

Among its provisions, the agreement calls for the National Guard Bureau to provide VA with timely and appropriate data on when and where groups of demobilizing servicemembers will return to their local communities. It also calls for the National Guard Bureau to establish opportunities for VA personnel to provide information to returning National Guard soldiers and their families in all the States and territories.

And the agreement provides regional or local family activity days, where VA represents or presents health and benefits information to assembled groups within 3 to 6 months of demobilization.

And finally, the handout entitled "VHA/VBA Outreach for Guard and Reserve" depicts these and other initiatives currently underway.

While we have done much, there is more still to do, and we recognize that we must continually seek improvement and innovation in the way we reach out to those we at VA have the privilege of serving.

Mr. Chairman, Members of the Committee, that concludes my testimony, and I would be happy to answer any questions that you may have.

[The prepared statement of Mr. Mayes follows:]

PREPARED STATEMENT OF BRADLEY G. MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to speak on initiatives and outreach efforts undertaken by the Department of Veterans Affairs (VA) to National Guard and Reserve members returning from theaters of combat operations and demobilizing from active duty. We are committed in our efforts to see that the Nation's Citizen Warriors and their families are honored for their service to our country and receive the VA services and benefits they have earned.

As the number of National Guard and Reserve members serving on active duty has increased, VA has aggressively expanded its outreach efforts to inform deactivating members of the many services and benefits available to them. From the beginning of fiscal year 2003, through June 2008, VA has conducted more than 8,650 briefings and provided information to approximately 510,000 combat OEF/OIF veterans.

BENEFITS INFORMATION AT TIME OF INDUCTION INTO SERVICE

VA initiates outreach to National Guard and Reserve members at the beginning of their military career. Since November 2004, everyone inducted into the five military branches receives a VA benefits pamphlet at the military entrance processing station. This pamphlet provides inductees with basic information on VA benefits and services at the start of their military active service. We want servicemembers to know that VA will be there for them in the future.

TRANSITION ASSISTANCE PROGRAM (TAP)

One of the formal pre-discharge outreach programs in which VA participates is the Transition Assistance Program (TAP), which is operated in conjunction with the Department of Labor. TAP is conducted nationwide and in Europe and Asia to prepare retiring or separating military personnel for return to civilian life, and VA provides benefits briefings as a part of the program. At these briefings, servicemembers are informed of the array of VA benefits and services available, instructed on how to complete VA application forms, and advised on what evidence is needed to support their claims. Following the general instruction segment, personal interviews are conducted with those servicemembers who would like assistance in preparing and submitting their applications for compensation and/or vocational rehabilitation and employment benefits.

DISABLED TRANSITION ASSISTANCE PROGRAM (DTAP)

As a part of TAP, servicemembers leaving the military with a service-connected disability, or those who think they may have a service-connected disability, are offered the Disabled Transition Assistance Program (DTAP). DTAP is an integral component of transition assistance for servicemembers who may be released because of disability incurred on active duty. Through VA's DTAP briefings, VA advises transitioning servicemembers about the benefits available through the Vocational Rehabilitation and Employment (VR&E) program. The goal of DTAP is to encourage and assist potentially eligible servicemembers with making informed decisions about the VR&E program and to expedite delivery of these services to those who qualify.

OTHER BENEFITS BRIEFINGS

In addition to TAP and DTAP briefings to separating and retiring servicemembers, VA conducts other benefits briefings at the request of DOD. One example is a presentation conducted at "Commanders' Calls." Military commanders routinely have unit meetings with their assigned personnel. These meetings are referred to as "Commander's Call." During "Commander's Call," the commander usually informs personnel of on-going and future events, hot topics, and personnel issues. Sometimes guest speakers are invited to provide informational briefings. VA is typically asked to cover material on VA's Education and Loan Guaranty Programs.

Outreach briefings to demobilizing National Guard and Reserve components are generally one among a series of presentations scheduled for a returning group. The briefings may be conducted at the military base where administrative demobilization activities occur or later at the unit's home base once the members have returned to their local community. Briefings at the demobilization site are generally abbreviated because National Guard and Reserve units are there for only a few days, with much out-processing to accomplish before returning to their home locations. Briefings to returning units at their home locations are generally part of a "Welcome Home," "Family Activities Day," or "Job Fairs" weekend drill session.

At all briefings, the attendees are provided with written informational materials that include the VA handbook *Federal Benefits for Veterans and Dependents*, VA Pamphlet 20–00–1, *A Summary of VA Benefits*, and an insurance information folder.

OTHER OUTREACH EFFORTS

Along with face-to-face outreach efforts, VA seeks to ensure that a "Welcome Home Package" is sent to all returning National Guard and Reserve members. DOD provides the names and addresses of these returnees based on active duty separation records. The Veterans Assistance at Discharge System (VADS) then generates a "Welcome Home Package" for recently separated veterans, including Reserve and National Guard members. The mailing itself contains a letter from VA and a summary and timetable of VA benefits. In addition to the VADS mailings, a separate personal letter from the Secretary, along with benefits information, is sent to each returning OEF/OIF veteran. VADS also sends separate packages that explain education, loan guaranty, and insurance benefits. A six-month follow-up letter with the same general benefits information is also sent to each returning member. VA is currently working with DOD to update the electronic transfer of this information.

PARTNERSHIPS

In the past, outreach to Reserve and National Guard members is generally accomplished on an "on call" or "as requested" basis. With the onset of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) and the activation and deployment of large numbers of Reserve and National Guard members, VA's outreach to this group has greatly expanded. VA has made arrangements with Guard and Reserve officials to schedule briefings for members who are being mobilized and demobilized.

In order to facilitate these outreach efforts, VA entered into joint agreements with the Department of Defense (DOD). These agreements provide for the sharing of information so VA knows when and where a presentation may be given to an assembly of returning National Guard or Reserve members.

VA and the National Guard Bureau (NGB), which represents National Guard units nationwide, have entered into a memorandum of agreement to establish the requirements, expectations, and obligations of each organization with respect to assisting National Guard members with demobilization issues. Among its provisions, the agreement calls for NGB to provide VA with timely and appropriate data on when and where groups of demobilizing servicemembers will return to their local communities. It also calls for NGB to establish opportunities for VA personnel to provide information to returning National Guard members and their families in all the states and territories. In addition, the agreement promotes regional or local "Family Activity Days," where VA presents health and benefits information to assembled groups within three to six months of demobilization.

VA has also reached agreements with individual National Guard state military departments to facilitate outreach efforts. An initial memorandum of understanding (MOU) was signed by VA and the Washington State Military Department. This served as a model for 47 other state and territorial military departments, which currently have an MOU with VA. Agreements with other states have been initiated and will be finalized in the near future. These agreements include the participation of other organizations within the states, such as state veterans organizations, state employment agencies, and state business associations, which contribute to the tran-

sition of National Guard members back into their local communities. Through the communication place for presentations, and returnees are identified for informational mailings. Communications are enhanced by VA military services coordinators, who remain in contact with the state National Guard headquarters.

As a part of this partnership, the National Guard Bureau employs 60 Transition Assistance Advisors (TAAs) for the 50 states and 4 territories. The TAAs' primary function is to serve as the statewide point of contact and coordinator. They also provide information regarding VA benefits and services to Guard members and their families and assist in resolving any problems with VA healthcare, benefits, and TRICARE. VA and the National Guard Bureau teamed up at the beginning of the program in February 2006 to provide training to the TAAs on VA services and benefits. VA has participated in subsequent annual refresher training, as well as monthly TAA conference calls.

Procedures for outreach presentations to demobilizing Reserve components are less formally established. Communications generally flow between a Reserve unit liaison and the VA regional office military service coordinator. There is currently an agreement pending between VA and the Army Reserve Headquarters which, when completed, will serve as the model for agreements with other military Reserve branches. It is anticipated that the terms of these agreements and the lines of communication established by them will be similar to those between VA and the National Guard.

Another partnership between VA and DOD is designed to assist those National Guard and Reserve members who are seriously wounded while on active duty or develop a condition that causes them to be unfit for the military. VA and DOD are working closely on efforts to evaluate the disabilities of servicemembers still on active duty. Our goal in this process is to smooth their reintegration back into civilian life, with a focus on employment or independent living, should discharge from service become necessary. These efforts include services and outreach programs to regular military personnel, activated guard and reserve personnel, and inactive but drilling reserve component military personnel who may become unfit for duty. These efforts are coordinated through a Senior Oversight Committee (SOC) comprised of both VA and DOD representatives. One of the major projects being implemented is the pilot of a new Disability Evaluation System (DES). This process involves determining the extent of the servicemember's disability from a wound or other condition causing unfitness and determining a course of action based on medical examinations and an in-depth interview conducted by an experienced military services coordinator, who also assists the member in filing any claims. If the member is determined to be unfit by the military, the military services coordinator provides additional information and services to the member during his/her transition. VA has supported the DES process by providing information and assistance to DOD for the creation of a "benefits book" given to servicemembers and their families involved with DES.

OUTREACH IMPROVEMENT INITIATIVES

VADS Process Improvements

In recent years, VA has made great strides in expanding and improving the outreach programs. Because this is a critical component of the VA mission, we continue to seek improvements in the delivery of information on VA services and benefits to those separating from active duty. One major improvement initiative involves the Welcome Home Package sent to recently separated individuals. During fiscal year 2007, VADS generated approximately 188,000 outreach packages. The current VADS method, traditionally used to generate and mail these outreach packages, is scheduled to be replaced by a modern and more efficient system referred to as the VA/DOD Identity Repository (VADIR). One of the drivers for replacement of VADS is that deficiencies in the system caused a number of individuals not to receive their outreach package. When VA learned of this, a help team was immediately sent to the VADS location in Austin, Texas. The system was analyzed and corrective measures were taken. As a result of this, it became clear that the newly developed VADIR system was superior and should replace VADS. VADIR can provide VA with detailed electronic information directly from DOD on separating servicemembers that will replace the current paper-document-based method used by VADS. This interagency data sharing will eliminate error and facilitate a timely mailing of the outreach packages.

Relationship Building

VA also continues to develop a closer relationship with National Guard and Reserve units in order to be available for in-person outreach briefings. Regardless of

whether a briefing is needed at the demobilization site or the units home location, or whether it is a complete TAP presentation or a condensed time sensitive presentation, VA has made it known that we are always on call to help those who have served our country.

CONCLUSION

Mr. Chairman, VA outreach programs provide wide dissemination of information on the array of benefits and services available to National Guard and Reserve members. Our employees are dedicated to ensuring veterans receive the benefits and services they have earned through their service to our Nation, and we work diligently to provide information and assistance in a timely, thorough, accurate, understandable, and respectful manner.

This concludes my summary of the outreach efforts undertaken by VA to provide returning National Guard and Reserve members with information on the VA services and benefits available to them. I would be pleased to answer any questions you may have.

Chairman AKAKA. Thank you very much, Mr. Mayes, for your statement.

Mr. Nelson.

STATEMENT OF DONALD L. NELSON, DEPUTY ASSISTANT SECRETARY FOR RESERVE AFFAIRS, DEPARTMENT OF DEFENSE

Mr. NELSON. Good morning, Chairman Akaka and other distinguished Members of the Committee. Thank you very much for inviting me to appear and speak about the outreach actions being taken by the Department of Defense, and the service components to benefit Reserve and National Guard soldiers ordered to active duty service.

Let me preface my remarks this morning by way of pointing out that by way of personal background I served this great Nation for 34½ years, both active and Reserve, as an officer in the United States Navy. I am acutely aware that the challenge to the freedom of this great Nation is being met freely and wholly by the supreme commitment and unparalleled personal sacrifice of our all-volunteer active, Reserve, and National Guard forces.

There is no question that our soldiers, sailors, airmen, Marines, and Coast Guardsmen deserve only the very best in terms in every conceivable benefit that a grateful Nation can bestow upon them for their service.

For that reason, I am especially appreciative of this opportunity to appear before you and tell you what the Department of Defense has done and is doing to implement the Yellow Ribbon Reintegration Program mandated by Section 582 of the 2008 National Defense Authorization Act.

Section 582 requires the Department of Defense to establish a national combat veteran reintegration program for Reserve and National Guard soldiers and their families. The program must provide deployment support and reintegration activities during all phases of deployment: pre-deployment, deployment, demobilization, and reconstitution.

The Department of Defense established the Yellow Ribbon Reintegration Program to oversee the activities and services provided under this program on March 17, 2008, at 1401 Wilson Boulevard in Rosslyn, Virginia. We now have 11 persons working in that office on a full-time basis, including one Reserve Officer from the Army, Navy, Air Force, and Marines, respectively; a representative from the National Guard Bureau; a liaison officer from the Depart-

ment of Veterans' Affairs; the Center for Excellence and Reintegration Director; and the Deputy Director of the Reintegration Program Office; plus two interns and a receptionist.

The Center for Excellence has been established within the Reintegration Program Office to analyze and collect lessons learned and assess suggestions on program improvements from Reserve components and State National Guard organizations.

There are a variety of additional organizations that provide services to assist Reserve and National Guard soldiers and their families during the entire deployment cycle including, but not limited to: the services and their respective Reserve components; other Federal agencies, most certainly including the Veterans' Administration; the National Guard in each State; State Veterans' Affairs departments; and other local offices and private sector organizations.

Let me offer an executive summary current as of July 17, 2008, of the deployment, support, and reintegration events that the services have held and are planning during the period from January 1, 2008, to September 30, 2008.

Noteworthy is the magnitude of the events that have already been held and scheduled. Six components have conducted 338 reintegration activities since January 2008.

In addition, reintegration activities must be provided in the fourth quarter of fiscal year 2008 for Reserve and National Guard soldiers returning from deployment, with full implementation of support programs for all phases of the deployment cycle to be provided in fiscal year 2009.

Moreover, the six components have also scheduled 141 additional reintegration events for the fourth quarter of fiscal year 2008. The congressional mandate will continue to drive coordinated efforts among the service components and the Department of Veterans' Affairs and other organizations will further improve and standardize existing individualized programs.

As I have previously stated, there are a variety of additional organizations that provide outreach services to assist Reserve and National Guard soldiers and their families throughout the deployment cycle, as described in the legislation. Topping the list are our colleagues from the Veterans Administration.

Additionally, the Joint Family Support Assistance, which falls within the ambit of the Deputy Under Secretary of Defense for military, community, and family policy currently provides services in 15 pilot States, presently experiencing large numbers of mobilizing and demobilizing Reserve and National Guard soldiers, as well as those States with large numbers of personnel alerted for mobilization.

The Department of Defense plans to expand beyond the pilot phase to include all 54 States and territories during fiscal year 2009. Specifically, the services offered by the Joint Family Support Assistance Program include: financial counseling, childcare, counseling on the effects of deployment on children and the effects of reunification, volunteer opportunities for spouses, support and assistance to geographically dispersed youth, separation and grief and loss issues, personal outreach visits by trained psychologists and other professionals, including members of the Chaplain Corps.

In implementing the Yellow Ribbon Reintegration Program, I cannot overemphasize the priority that we in the Department of Defense give to family support programs, as well as to the formation of partnerships among DOD and the Veterans Administration and local mental health programs.

The Department of Defense has been working at flank speed to establish and give shape to Yellow Ribbon Reintegration Program activities all over the Nation, as required by the 2008 National Defense Authorization Act.

After a 6-month monumental effort by the Department of Defense to ensure compliance with all rules, regulations, national security requirements, and following coordination by and through all service components, I am extremely pleased to be able to report that on July 17, 2008, Secretary of Defense Robert M. Gates signed the memorandum establishing the Under Secretary of Defense for Personnel and Readiness as the official executive agent for the Yellow Ribbon Reintegration Program, as required by the legislation.

On the next day, July 18, 2008, just 5 days ago, the Under Secretary signed the directive-type memorandum that requires the services and their components to implement the reintegration programs in the fourth quarter of fiscal year 2008. That memorandum also requires the service secretaries to provide service-specific implementation instructions to fully support robust, high-quality deployment support programs in the first quarter of fiscal year 2009.

Finally, I am very pleased to report that the Department of Defense has received funding for the fourth quarter of fiscal year 2008, and is developing the program's funding requirements for future years.

Let me conclude my remarks by stating that the Yellow Ribbon Reintegration Program is all about our troops. Through the implementation of this program, we must meet our sworn responsibility to best serve our soldiers, sailors, airmen, Marines, and Coast Guardsmen who serve this great Nation.

I am proud of the ongoing efforts of the Department of Defense to fully implement this new program. What our troops deserve is only the very best.

I very much appreciate the fact that you have invited me. On behalf of the Department of Defense, I look forward to working closely with all of you and your respective staffs to ensure that the Yellow Ribbon Reintegration Program is a smashing success. Thank you, again.

[The prepared statement of Mr. Nelson follows:]

PREPARED STATEMENT OF DONALD L. NELSON, DIRECTOR, YELLOW RIBBON REINTEGRATION PROGRAM, DEPARTMENT OF DEFENSE

Chairman Akaka and Members of the Committee: Thank you for your invitation to discuss DOD and VA cooperation on the reintegration of our National Guard and Reserve veterans. As you know, Section 582 of the 2008 National Defense Authorization Act required the Department of Defense to establish a national combat veterans reintegration program to provide National Guard and Reserve members and their families with sufficient information, services, referrals, and proactive outreach opportunities throughout the entire deployment cycle. I'm pleased to tell you that the DOD Yellow Ribbon Reintegration Program Office opened on March 17, 2008, in Suite 401, at 1401 Wilson Boulevard, in Arlington, VA. The office has a toll free number of 866–504–7092.

This office has liaison personnel from the National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve and the Air Force Reserve, serving as sub-

ject matter experts to assist in implementing the program. Veterans Affairs Deputy Secretary Gordon Mansfield has also committed to continuing and strengthening his Department's partnership with the Department of Defense by placing a subject matter expert from the VA on our staff. We are working closely with the VA Veterans Health Administration and the Department of Defense Outreach Office, which focus their efforts on outreach to National Guard and Reserve members and their families. We also work with the National Guard Transition Assistance Advisors, the National Association of State Directors of Veterans Affairs, the Department of Defense Joint Family Resource Center and their Joint Family Support Assistance Program, as well as each of the National Guard and Reserve family program offices. Our purpose in doing so is to ensure that the Department of Defense is doing everything possible to make the best use of available resources in meeting the deployment support requirements of our returning military veterans, especially those that are geographically separated from military installations and dispersed throughout all 54 states and territories.

The Directive-Type Memorandum that implements the program requires the Services and their Reserve components to provide 30-, 60-, and 90-day reintegration programs for their returning members by the 4th quarter of this fiscal year. It also requires them to implement robust deployment support and reintegration programs beginning in the 1st quarter of fiscal year 2009. Our office will monitor and manage these programs at the strategic level and ensure that locally available resources are used to the maximum extent possible, while also making sure that the availability of these programs is shared between the components to allow members and families to access them at the location closest to where they reside.

The Department of Defense recognizes that support for families and employers is vital to success. The Department has devoted substantial resources and efforts toward expanding support for our families. The challenge is particularly acute for widely dispersed reserve families, many of whom do not live close to major military installations. Thus, we have developed and promoted web sites and electronic support for our military families, and the use of nearly 700 military family service centers for all Active, Guard and Reserve members and their families to provide personal reintegration contacts, and we have hosted and attended numerous family support conferences and forums. Reintegration training and efforts to support members and their families following mobilization, particularly for service in the combat zones, are vital. The reintegration program in Minnesota has proven to be an exceptional success and forms the basis for the DOD Yellow Ribbon Reintegration Program with its Yellow Ribbon Reintegration Center of Excellence for all Guard and Reserve members. The Department is fully committed to implementing this program, which will provide Guard and Reserve members, and their families, the support that will help them during the entire deployment cycle—from preparation for active service to successful reintegration upon return to their community, and beyond. We will continue to work with Veterans Affairs, State Governors and their cabinet members, their Adjutants General, the State family program directors as well as with the Military Services and their components to ensure that an integrated support program is delivered to all Guard and Reserve members and their families.

The support for employers over the past six years mirrors the increased support and emphasis upon families. We doubled the budget of the National Committee for Employer Support of the Guard and Reserve (ESGR). We developed an employer database that identifies the employers of Guard/Reserve members, and expanded the ESGR state committees and their support structure (over 4,500 volunteers are now active on these committees) and we are reaching out to thousands of additional employers every year. The Freedom Awards Program and national ceremony to recognize employers selected for this Award has become a capstone event, in which the President, in each of the past two years, recognized the annual Freedom Award winners in the Oval Office (15 recipients per year are selected from more than 2000 nominees from small business, large business, and the public sector). Never in the history of the Guard and Reserve have families and employers been supported to this degree, and they appreciate it, as this effort is critical to sustaining an Operational Reserve.

The Senate Committee on Veterans Affairs has always been very supportive of our National Guard and Reserve Forces. On behalf of those men and women, I want to publicly thank you for all your help in providing for them as they have stepped up to answer the call to duty. Secretary Gates and I are deeply grateful, our military personnel and their families certainly appreciate it, and we know we can count on your continued support. Thank you for this opportunity to discuss the Yellow Ribbon Reintegration Program on behalf of our Guard and Reserve.

Chairman AKAKA. Thank you very much, Mr. Nelson.

Major General Chapman and Mr. Nelson, I am concerned that the efforts of commands to identify and help those who may be suffering from emotional trauma may not be entirely focused. The approach seems to be one of providing information to a large gathering rather than working to identify those in need and so as to reach them in a more appropriate setting.

I would add that sometimes these sweeping approaches can hurt overall morale while still not reaching those in need. The units' temporal and elements of the military culture create a wall that is hard for servicemembers to breach.

My question to you is, what can VA do to create an open and private environment in which servicemembers will be able to ask for help?

Major General MATHEWSON-CHAPMAN. I will begin on that question.

First of all, what we have found very popular and very comfortable to use is our readjustment counseling centers, or Vet Centers, as they are known. Veterans learn about them at the demobilization process, because they do have a 15-minute briefing by a combat veteran. So, that is the first step, the choke point, that we call it, as they are coming through.

If you have read in the newspaper recently, they are getting 232 of those Vet Centers to be built in small communities. They are storefront operations. They are not in the hospital. And you know the stigma of coming into a hospital and asking for mental health care. We are finding that they are coming to the Vet Centers.

VA is getting ready to add another 39 centers in a lot of small communities in America by 2009, then there will be a total of 271 of those centers.

Again, VA is adding additional mental health resources at community-based outpatient clinics that, again, are not in the hospital. They are in small communities providing the outreach, but also, mental health facilities have mental health specialists there.

They are adding another 44 new community clinics, and also in our rural health initiative in small communities—they do not have the base to have a full-time large clinic. They have outreach centers, again, to be able to provide mental health services.

The family members—as we work with family programs, we found the family is the key, the hook; because if we can educate the family, the spouse, the mother, the sister of what to look for when your spouse comes home, and where to go, how to access those services, then we also are reaching out to those with pamphlets and information. Our TAAs are out there working with the family programs.

We are doing the outreach piece. It is more than just the education, but it is how to access the system, and that is the critical component—how to get in when I need it.

Chairman AKAKA. Right.

Major General MATHEWSON-CHAPMAN. And the call center, again, will also call them, as I gave an example of an individual—it was just at the right time that he was called. And all of them will be called to make sure that they are transitioning home successfully.

Chairman AKAKA. Thank you.

Mr. Nelson, would you have any comment?

Mr. NELSON. I would just add, Mr. Chairman, that at the reintegration activities—at the 30-, 60-, and 90-day intervals, beginning with the 30-day reintegration activity—servicemembers are required to fill out a post-deployment health assessment. And at the 90-day level, they are required to fill out a post-deployment health reassessment form.

OSD policy currently vests in unit commanders the discretion to order members to active duty for a day or so—whatever the period is to be required—so they must fill out the post-deployment health reassessment form.

And when the forms are being executed, we have, on station, professionals—fully trained psychologists, doctors, some doctors who are psychiatrists, nurses, and other health care professionals—whose job it is to review the answers and to offer themselves as available to talk to anyone who may have indicated that they do have a problem.

And those who are perceived to have a problem, even though they do not profess on paper to have a problem—we are making our very best efforts to deal with them, because we interview family members.

For example, at the 30-day point, members have been home with their families, the same at 60, the same at 90 days. So, we have an opportunity to talk to family members, coworkers, employers, friends, and other individuals who may have been able to assess the behavior of the individual on an individual basis following release from active duty.

The system certainly is not perfect, but we are making every effort to work out the kinks. I could not agree more that this is exceedingly important, and we are doing our level best to make sure that no one gets through the system who has a problem who is not completely treated by existing facilities that are there to treat people.

Chairman AKAKA. Thank you very much.

Senator Murray.

Senator MURRAY. Thank you, Mr. Chairman.

This past March, in my home State of Washington, a National Guardsman and former Stryker Brigade soldier by the name of Specialist Timothy Juneman tragically took his own life—a story that we are hearing, you know, far too often.

Now, the Spokane VA psychiatrist who was treating that young man wrote in his medical records that imminent redeployment to Iraq with the National Guard was a major stressor contributing to his condition. The week before he took his own life, he received final notification that the National Guard had rescinded a promise not to send him back to Iraq for 2 years.

So, despite the VA's assessment that redeployment was causing him this serious mental hardship, the Spokane VA could not contact the Washington Army National Guard to advise officials of that diagnosis. And I am told that the VA cannot inform the Department of Defense about the medical conditions of active veterans such as Guard and Reserve members without a patient's consent.

Now, I understand and have no doubt that there are good reasons for that policy, but I am wondering if there should not be an exception in extreme cases like this, like suicide; and I wondered if all of you could comment on that for me this morning.

Major General MATHEWSON-CHAPMAN. I can comment on—I know this case is under review, but I think what you are referring to is, again, notifying DOD of high-risk individuals.

Senator MURRAY. That is correct.

Major General MATHEWSON-CHAPMAN. And that is true—because of the policy laws, we cannot tell a commander that someone is high risk. It has to—the individual soldier has to sign out his own medical records to get his records—to be able to give to the commander—when being requested.

I do not have an answer for that.

Senator MURRAY. Is there any way to make an exception in extreme circumstances?

Major General MATHEWSON-CHAPMAN. On the VA side, I do not know. It is something that I can certainly take for the record and see if the VA has some answers for that and get back to you.

Senator MURRAY. Anybody else? Anything we can do?

Mr. NELSON. We make every effort, Senator Murray, to make sure that such tragedies do not occur, by virtue of the professionals that we have to assess these situations, as I indicated just a moment ago.

The privacy statutes to which my colleague referred do place some restraints on the release of information. I would also have to take that issue for the record, because I am not personally familiar with the scope and extent of those privacy regulations, but I do know that they are out there.

That said, I would be happy to take the issue for the record and get together with my colleague on this.

[The response from VHA follows:]

RESPONSE TO QUESTION ARISING DURING THE HEARING BY HON. PATTY MURRAY TO VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Question. Is there any way to VA can share medical records with DOD in an extreme case, such as the risk of suicide?

Response. The Health Insurance Portability and Accountability Act (HIPAA) prohibits the Department of Veterans Affairs (VA) from disclosing protected health information without the patient's express, signed, written authorization or pursuant to legal authority prescribed in Federal laws and regulations. There are, however, exceptions which permit, but do not require, the Department of Veterans Affairs (VA) to disclose personal health information to other entities, including the Department of Defense.

The intent of HIPAA is to protect the patient from unwanted releases of information, thus helping to create an environment of trust for patients and providers when discussing personal health information.

VA cites two relevant authorities under which VA may legally disclose health information to the Department of Defense (DOD) without obtaining the express authorization of the patient:

1. *Serious Threat to Health or Safety:* (HIPAA 45 CFR 164.512(j)(1)(i); 38 U.S.C. 5701(b)(3); and Privacy Act 5 U.S.C. 552a(b)(8)): Protected health information, including mental health information, may be disclosed to DOD when a VA clinical provider determines that such a disclosure would serve to avert a serious threat to health or safety. VA clinicians are aware of and adhere to the duty to warn, which exists if, in a clinical case, a patient presents a clear danger to him or herself or others. Our health care professionals provide immediate care to anyone in need. If the patient is competent, VA requests a patient consent to a disclosure of information as needed. If a patient refuses to accept treatment, VA works under state au-

thorities to provide treatment through involuntary commitment or other means, as warranted.

VA may disclose information to DOD. Once DOD is notified of the serious threat, the patient must be provided a written notification to his or her last known address, indicating that a disclosure was made to DOD.

2. *To a DOD or Other Health Care Provider for Treatment of the Individual:* (HIPAA 45 CFR 164.502(a)(1)(ii); 38 U.S.C. 5701(b)(3); 38 U.S.C. 7332 (2)(A), and (3)(e)(2); and Routine Use #43 under Patient Medical Records-VA (24VA19) Privacy Act system of records): Protected health information may be disclosed to DOD or other health care providers in order for them to provide treatment to the individual. If a patient is being seen or needs to be seen by a DOD health care provider, VA may disclose the patient's health information, including mental health information, to the DOD health care provider in order for DOD to provide care to the patient. VA must have knowledge of a treatment relationship between the patient and the DOD health care provider prior to disclosing the patient's health information to the DOD health care provider.

Senator MURRAY. OK. I would really appreciate you taking a look at that policy, because it seems to me, in those extreme cases, when clearly that is the stressor, there should be communication and work to make sure that situations like that do not occur. So, I would really appreciate an answer back for the record. Thank you.

On another topic, we know that Guard and Reserve veterans, as I said earlier, are twice as likely to have their disability compensation claim rejected by the VA.

Last year, I put an amendment on the Defense Authorization Bill that requires the Secretary of Defense and the Secretary of Veterans Affairs to present a plan to expand the Benefits Delivery at Discharge Program to National Guard and Reserve members in order to reduce that discrepancy.

Mr. Nelson and Mr. Mayes, perhaps you could give me a quick synopsis of where that is and when we are going to see it.

Mr. MAYES. Senator Murray, I will try and take that.

We just—the Compensation and Pension Service within the Veterans Benefits Administration—we just issued policy guidance, I believe it was last month. Essentially, what we have done is expanded the BDD program to any separating servicemember who files a claim 60 to 180 days from separation.

So, before we changed our policy, the BDD program was limited to places where we had formal agreements with the Department of Defense. And if you count the Coast Guard, we had 153 of those agreements in place, actually.

And so, what we have done is said, if we can get that claim within that window, then we will call it a BDD claim. In order for it to be a BDD claim, we need some things, though, because we want to expedite the delivery of the benefits. And what we need is a signed application. So, we need to sit down with the servicemember, find out what disabilities they have that they are claiming.

We have to comply with our statutory requirement to fully notify them of what it takes to successfully prosecute a claim as a result of the Veterans' Claims Assistance Act of 2000. So, we have to provide that notice, and then we get from them what is called a notice response, essentially, which is telling us we have everything that there is for us to review to make a decision.

Senator MURRAY. So, it is a communication issue of going back and forth when they are out in the States and regional areas and you do not have face-to-face contact?

Mr. MAYES. Well, what we want to do and what we are doing is having that face-to-face contact, and we are doing it—and that is BDD.

If I might—we actually have expanded that even further and created what we call Quick Start claims so that if you have a servicemember that maybe is not able to file a claim in that 60- to 180-day window, but is pre-separation, then we will do the same thing.

In order for this to be successful, we need to be able to have those elements of the claim, and primarily, the service treatment records. We are reaching out to Guard and Reserve soldiers at the time we provide benefits briefings.

Now, it may not be TAP because, as I said in my statement, when they are demobilizing, they want to get home.

Senator MURRAY. Right. We know that.

Mr. MAYES. But we are available, and we are there when they come back to these family days or their first drill. And at that time, we give them the briefing.

And we are also setting up claim workshops in instances where the command allows us to be there for enough time to sit down with the demobilized Guard and Reserve soldier, go ahead and take the claim. Hopefully, we can get the notice response, we can get the service treatment records, and then we feed it right into the system. And because they are OEF/OIF claims, we are expediting the processing of those claims.

Senator MURRAY. Should those TAP attendances be mandatory? Would that help?

Mr. MAYES. Well, I get that question a lot.

I would say that TAP, really, in its original—as it was originally created was designed for active duty component, because you—when someone is getting ready to separate, they—typically they are going to have some time.

Retirees, we can give that TAP briefing up to 2 years prior to separation, for others a year prior to separation. We can do it 180 days after separation.

But the Guard and Reserve soldier, I mean, they are coming out of theater, they are going to the demobe site for 3 or 4 days, and then they go home. Whether you call it TAP or a claim workshop or a family day when they come back to that first drill, you know, I do not want to say that it should be mandatory. I think what needs to be mandatory is VA have an opportunity to present the benefits and services that are out there for them.

Senator MURRAY. And today they do not have that?

Mr. MAYES. I think they do in most cases. I really think that they do. And if there is a servicemember that is denied that opportunity, I would suggest that DOD has to provide that opportunity.

But I think they are getting the opportunity, and I would defer to my colleague.

Senator MURRAY. Well, Mr. Nelson, should that be mandatory?

Mr. NELSON. The general program?

Senator MURRAY. Yeah.

Mr. NELSON. I would agree with my colleague that the assistance program started off as a function of the Department of Labor and primarily was, and is—a program directed toward active duty personnel who are separating—thank you—who are separating from the service as opposed to Reservists and Guardsmen who are going back to their civilian jobs; and, more likely than not, may be subject to being recalled—their being—to be reconstituted to somewhere downstream.

They will remain in the Guard and Reserve program. The people to whom the TAP program should be directed are those who are separating, because they are the people who are the potential beneficiaries of all the elements of the TAP program. I would agree with Brad on that.

Senator MURRAY. Well, when we see a VA IG briefing that says the TAP briefings did not meet the VA set goal of 53 percent, I think we still have work to do; and we have got to figure this out.

Mr. Chairman.

Chairman AKAKA. Thank you. We will have another round here.

Senator Tester.

Senator TESTER. Yes, thank you, Mr. Chairman. I want to thank the witnesses for testifying today. I do not really know where to start, but will start here.

As for Mr. Nelson, some of the witnesses' testimony in the next panel talk about requiring servicemembers to complete the 10–10EZ during demobilization. You say that you offer them a chance to enroll in the VA through increasingly standardized demobilization processes. What is wrong with an actual requirement that the member fill out the form? Major General Chapman, you can answer it, too.

Go ahead.

Major General MATHEWSON-CHAPMAN. I am a little confused on your question. This is the first time we have been allowed in to the demobilization process, and we cannot mandate, requiring that everyone fills it out; but we are certainly encouraging them and teaching them how to fill out an abbreviated form rather than the long, cumbersome form.

Senator TESTER. So, why can't you require it?

Major General MATHEWSON-CHAPMAN. Why can't we require them to fill that out?

Senator TESTER. Yes.

Major General MATHEWSON-CHAPMAN. I have just been told that we cannot mandate—VA cannot mandate to DOD because they are still active duty soldiers—they are not veterans yet—that they have to fill it out.

Now, in Montana, the Adjutant General has mandated that all of his Guardsmen complete the forms. We do know about Montana's program, and other States are doing the same thing.

So, whether it is at the demobilization station—we are encouraging them, and we are actually counting the numbers of those that are at the demobe site and how many forms we actually collect. And what we are finding—many of them are already enrolled. Many of them are going to stay on active duty, so they are certainly not veterans.

So, we are getting 100 percent of those that are demobilizing—going through the system, completing the forms, and submitting them. And we have developed a standardized process now so that paperwork goes to where your home of record—where you want to receive your care, back to that field site—and then they register them into the system, and then we complete the final enrollment. It takes about—anywhere—two to 4 weeks.

Senator TESTER. For those that fill it out?

Major General MATHEWSON-CHAPMAN. For those that fill it out.

But right now, we are finding across the board 100 percent of them that are at the demobilization site are filling them out.

Senator TESTER. What——

Major General MATHEWSON-CHAPMAN. At the 12 sites, soon to be 15 sites.

Senator TESTER. And does that include all of the returning folks, the ones that——

Major General MATHEWSON-CHAPMAN. Right. Well, we are asking them to——

Senator TESTER [continuing]. The demobilization, is that everybody that returns from theater.

Major General MATHEWSON-CHAPMAN. Yes, yes.

Senator TESTER. So, everybody who returns fills out the 10–10EZ form?

Major General MATHEWSON-CHAPMAN. Yes. And if they feel they are already enrolled, we encourage them to please fill out the top part so we can verify their enrollment.

Senator TESTER. OK.

Major General MATHEWSON-CHAPMAN. So, we do have forms on everyone.

Senator TESTER. OK. One of the things that the Montana Guard has also done is extend out the post-deployment health assessment to 2 years instead of 90 to 180 days. Obviously, it means tracking a servicemember's mental health status for longer than what is currently done. I think it is a decent idea, because mental health issues do not always manifest themselves right away.

What is your sense about whether this is worth doing in other States?

Major General MATHEWSON-CHAPMAN. Well, this is—again, the PDHRA is a DOD program, and I would probably refer——

Senator TESTER. Mr. Nelson.

Major General MATHEWSON-CHAPMAN [continuing]. To my colleague.

Senator TESTER. Mr. Nelson, I can repeat the question if you want. If you heard it——

Mr. NELSON. I heard the question, which was—the post-deployment health reassessment is a form that servicemembers are required to fill out at the 90-day point.

As a matter of policy, we—let me back up. The Commission on the National Guard and Reserve has met, and we expect to have a final recommendation to Secretary Gates on August 29, 2008; and there are no less than 95 separate recommendations that that Commission dealt with.

And one of them—in fact, several of them—touch upon a concern the post-deployment health assessment and the post-deployment

health reassessment forms. And I believe that the numerical sequence of those forms is, like, from 73 through 80. The services have basically concurred—with the exception of the Army—with all seven of those recommendations.

Senator TESTER. Does one of the recommendations include the reassessment out 2 years?

Mr. NELSON. Not to my knowledge. Not to my knowledge. I cannot answer—not to my knowledge.

Senator TESTER. So, just to get back on question, I mean, the signature injury coming out of multiple deployments in Iraq especially is mental health issues. They often do not crop up immediately. They often crop up even longer than 2 years.

So, what would be wrong with extending that from 90 to 180 days to 24 months.

Mr. NELSON. I am not a health care professional. I do not think I am qualified to answer that question. I am not a health care professional. But I can assure you we will look into that for you sir.

Senator TESTER. Thank you very much. I appreciate that.

I got to have a question for Mr. Mayes, because I do not want him to feel left out here.

The process for arranging VA briefings for a returning Reserve unit is still fairly informal—meaning that it really depends on the individual's commander's willingness and ability to connect with the VA.

Do you anticipate the relationship becoming more formal between the Reserve units and the VA?

Mr. MAYES. Yes, I do. I think you are familiar with the relationship with the National Guard, and it is more formalized. We have a national MOU, and then we have MOUs at the State level. We have put those in place because it does lay out expectations on both sides, and we are exploring a national MOU with the Reserves.

Senator TESTER. OK. When do you anticipate that occurring?

Mr. MAYES. It is well underway, but I cannot give you a date at this time.

Senator TESTER. OK. In your testimony you talked about a lot of outreach you are doing, and it all sounded decent. It sounded good.

One of the things that crossed my mind, your position is compensation benefits for the VA.

Mr. MAYES. Yes, sir.

Senator TESTER. And it deals with Guardsmen and Reservists—probably among others—but Guardsmen and Reservists who are returning from combat that are under special conditions unlike active duty folks. And in rural areas, it becomes an issue. In my opening statement, I talked about folks who go into rural areas, and we are talking frontier areas where they are kind of on their own to get back into society unless VA reaches out.

You have talked about welcome-home packages and briefings. Do you have folks on your staff that have been through the Iraq conflict that can talk about things that will get the attention of Guardsmen and Reservists who are coming back from theater?

What I am talking about is—I get a lot of information everyday being a U.S. Senator, and some of it I look at and some of it I do not. And my guess is that the folks coming back from Iraq and Afghanistan probably are getting a lot of information, whether it is

written or verbal or whatever, and some of it will catch their attention and some of it will not.

So, it would seem to me that the folks coming back would have an idea on what catches people's attention and what does not. So, do you have folks in your shop that have been through the war?

Mr. MAYES. Yes, sir, we do. We have people who have been through this conflict, been through Desert Storm, as well.

Senator TESTER. Working for you?

Mr. MAYES. Working for me, yes, sir.

Senator TESTER. OK. Well, that is good.

All right. Thank you, Mr. Chairman.

Mr. MAYES. You know, if I might——

Senator TESTER. Yes.

Mr. MAYES [continuing]. Expound on that just briefly.

I met with a severely injured Captain—she was severely injured in Iraq— and we sat down and talked about that. And you know, one of the things that she said is you have to look at different ways of reaching these folks, and I think that is where, maybe, you were going with that.

And I anticipated the question from the Committee, you know, is there something you can do better? And I think we have got to—in my oral statement, I said that we have got to be innovative. And I think that is an area that we have got to explore, because there are people out there using text messaging and podcasts, and things out there, frankly, that I do not know about. But we sat down with this individual, we got those ideas, and we are exploring that so that we can sort of communicate in the language of this modern warrior. It is a little bit different than you would communicate with a veteran who served in World War II, possibly, or Korea.

So, I appreciate the question.

Senator TESTER. Yes. Just one more, if I might, Mr. Chairman, because your answer brought some things to mind that Major General Chapman talked about in her testimony.

You are dealing with folks who have been brought out of—they are in the Guard and Reserve, which has been a part-time job, and they are put into a full-time situation, and they leave their normal full-time job, and it can result in financial difficulties. And that, by the way, can translate into mental difficulties. Is there anything that the VA can do to help those folks that are in a situation—are there benefits out there?

Let me give you an example. I was in Great Falls, Montana, about a month ago. A guy walked up to me and said, I was going to college—he was in the Reserves, I believe, maybe the Guard—and I was in Iraq, did my time in Iraq; came back. He's got student loans though, cannot go to college anymore. He has got PTSD, cannot stay focused, and he has got these loans that are available that have to be paid now that he is out of college. Is there anything the VA can do to help folks like that that are in that condition?

Mr. MAYES. Well, the situation that you described, it sounds to me like this veteran—and this is a hypothetical—but this veteran has disabilities that are related to their military service.

And so—I mean, the essence of the Disability Compensation Program is that we provide a monetary benefit, compensation, for

someone who is suffering from a disability or disease that was due to their service.

So, I would say yes. And if it is so severe that it precludes employment, we have a provision in our rating schedule that allows us to pay a total evaluation based on individual unemployability. So, I would say that is available.

If they have a VA home loan, we can work with them to try and prevent that loan going into foreclosure. So, there are some things in our tool bucket, as you mentioned in your opening statement, that we have that we can do.

Senator TESTER. That is good to know. And this is it, but with the caveat that a lot of these folks are not getting through the door, which is a problem.

So, thank you.

Chairman AKAKA. There are many things that we need to do in policy to deal with the problems that are facing us at this time, and we need to do this.

Major General MATHEWSON-CHAPMAN. Thank you, Mr. Chairman.

Mr. MAYES. Thank you.

Chairman AKAKA. I want to thank our first panel for your responses and your presence here, as well.

Again, I repeat, I am so glad that we are holding this hearing on the Guard as well as the Reserve. There are many things that we need to do in policy to deal with the problems that are facing us at this time. We need to do this, so, we need to work together. So, I want to thank the first panel for being here this morning.

Mr. MAYES. Thank you, Mr. Chairman.

Major General MATHEWSON-CHAPMAN. Thank you.

Mr. NELSON. Thank you.

Chairman AKAKA. I call up the second panel.

First, let me welcome Dr. Joseph R. Scotti, who is Professor of Psychology in the Eberly College of Arts and Sciences at West Virginia University—at West Virginia University. You may be seated.

Next, I want to welcome Colonel Bradley E. Livingston, Chief of the Joint Staff of the Montana National Guard.

Next, Lieutenant Colonel John Boyd, who is Deputy Chief of Staff for Personnel from the Vermont National Guard.

Also, welcome to Sergeant Roy Wayne Meredith, an Infantry Team Leader from the Army National Guard.

And finally, welcome to Major Cynthia Rasmussen, a Combat Operational Stress Officer for the 88th Regional Readiness Command, Surgeon General's Office, out of Fort Snelling, Minnesota.

Your full statements will appear in the record, and we look forward to hearing from all of you. We will start with Dr. Scotti, if you will please begin with your statement.

Dr. Scotti.

STATEMENT OF JOSEPH R. SCOTTI, Ph.D., PROFESSOR OF PSYCHOLOGY, EBERLY COLLEGE OF ARTS AND SCIENCES, WEST VIRGINIA UNIVERSITY

Mr. SCOTTI. Mr. Chairman and Members of the Committee, thank you very much for having me today. This is really a great

honor and a super opportunity to present some findings from a survey we did in West Virginia.

I am a licensed psychologist and a professor of clinical psychology in West Virginia. I am not an ivory tower psychologist who just runs out and does research. I want to apply that research, I want to use it. I have many years of experience working with the Morgantown Vet Center and the Clarksburg VA and veterans of many eras. So, this is research that I hope will lead to application.

I am going to summarize some of our results. The full findings are in my report. Basically, we looked at 848 veterans in West Virginia, 57 percent of whom were in the National Guard or Reserve, and 52 percent of whom resided in rural areas of our State. There were earlier comments about the importance of looking at rural veterans. I would like to emphasize that.

It is no surprise to anyone here that being in combat leads to Post Traumatic Stress Disorder, depression, and other mental health problems. The present military conflict is particularly unique, given that it involves the National Guard and many of the issues that have already been stated here in terms of their training and deployment back home.

The information I have here is also important because it is not, as in many studies, just from veterans who seek treatment at the VA. This is from a group of veterans who applied for benefits from the State and that makes them a rather different population.

I want to emphasize several points. One is that the veterans in the National Guard and the Reserve were more likely to be in the Army, were more likely to have combat exposure (as opposed to active duty personnel), if they were from rural areas of the State. In terms of Post Traumatic Stress Disorder and depression, we found that a third of these veterans—more so in rural areas of the State and more so if they were in the National Guard—were experiencing Post Traumatic Stress Disorder, and about 40 percent were experiencing depression. Overall, between these two 47 percent—almost half—were experiencing PTSD and/or depression. Again, more likely in the Guard, more likely in rural areas.

We also looked at access or utilization of services. And in this particular study, the veterans are reporting high awareness of services from all levels, from informal contacts all the way up to VA hospitals and Vet Centers. However, this, again, is also already a group that sought monetary compensation from the State. So, they may be a particularly aware group.

This group, only about 50 percent have had some contact with the VA, and only about 40 percent find that their services are helpful. And I can elaborate on why that might be during the question period.

One of the points that I want to make is that the VA and the Department of Defense—although I think it does a wonderful job, I have had the experience of working with the VA—they need not be the sole source of help for these veterans. There is a great civilian network available, and I think with community mental health professionals, primary care professionals, and private practice that we can go a long way in supplementing VA services.

I wanted to make a couple of recommendations, and I was glad to hear that funding for the post-deployment programs for the Na-

tional Guard is going to be forthcoming. That is sorely needed, and I hope that it is funded at an adequate level. We need to provide support and disseminate effective treatments at many levels, including the VA and down all the way to private care practitioners. I hope that we would have support and funding for linking many of the local State and Federal agencies in doing all this work.

I have many additional comments that I want to make, especially in response to some of the prior testimony; so, I will conclude my formal comments, but I am hoping to answer many questions. Thank you.

[The prepared statement of Mr. Scotti follows:]

PREPARED STATEMENT OF JOSEPH R. SCOTTI, PH.D., PROFESSOR OF PSYCHOLOGY, WEST VIRGINIA UNIVERSITY, MORGANTOWN

Chairman Akaka, Ranking Member Burr, and Members of the Senate Committee on Veterans' Affairs: Thank you for the honor and the opportunity to provide the following testimony.

I am Joseph R. Scotti, Ph.D., a West Virginia licensed clinical psychologist and a professor of psychology at West Virginia University (Morgantown, WV), where I have been employed for the past 18 years. I have conducted service, teaching, and research in the area of Post Traumatic Stress Disorder (PTSD) in a wide-range of populations (e.g., children, college students, adults) that have experienced a variety of traumatic stressors (e.g., combat, motor vehicle accidents, sexual assault, and technological/industrial accidents). I have worked with combat Veterans of various eras (WW II, Korea, Vietnam, Desert Storm, and the current conflicts) since 1989 in various capacities, including over 12 years of consultation services (involving assessment, diagnosis, and treatment) at the Morgantown Vet Center (a Center that has distinguished itself as "Best Vet Center in the Nation" for multiple years) and the Louis A. Johnson VAMC (Clarksburg, WV), and through clinical services offered within the Department of Psychology at West Virginia University. I have multiple publications in journals and books, and dozens of conference presentations on PTSD in general, and combat veterans in particular. Presently, I am conducting research with my colleagues on Veterans of recent conflicts, and am collaborating with the West Virginia National Guard Family Assistance Center to provide services to military service personnel and their families.

This testimony is provided to summarize key findings from a survey research study conducted by my colleagues and myself with Veterans from West Virginia who have been deployed in various areas of the Middle East as part of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and related military operations.

The testimony shall show that for military personnel from the State of West Virginia:

1. Those who served as members of the National Guard and Reserves experienced exposure to combat and related war zone stressors at a level equal to that of Active Duty personnel.

(a) Those Veterans from Rural Counties of West Virginia experienced greater combat exposure than those from Urban West Virginia Counties.

2. Those Veterans who served as members of the National Guard and Reserves are experiencing a greater negative impact on psychological and daily functioning than are Active Duty personnel.

(a) Those Veterans from Rural Counties of West Virginia are experiencing a greater negative impact than those from Urban West Virginia Counties.

(b) The negative impact extends beyond the Veterans themselves and includes significant others and children.

3. Awareness of a wide range of services and supports to address the negative impact on the psychological and daily functioning of Veterans is generally high (80% to 90%).

(a) Utilization of services and supports varies by level, but typically, one-third to one-half or more of veterans in need are not utilizing professional or VA-related services.

(b) Only about one-half of Veterans report that a service they have utilized was "helpful" to them.

BACKGROUND

This survey research study was conducted by the Veterans Work Group at West Virginia University (Project Coordinators: Virginia Majewski, Ph.D., School of Social Work, and Joseph R. Scotti, Ph.D., Department of Psychology; Key Contributing Members: Hilda R. Heady, M.S.W., Associate Vice President for Rural Health, and Roy Tunick, Ph.D., Department of Counseling and Rehabilitation Counseling). The survey was requested and funded by the West Virginia State Legislature Select Interim Committee on Veterans' Issues (Co-Chairs: Delegates Barbara E. Fleischauer and Richard J. Iaquinta, and Senator Jon B. Hunter) in response to that Committee's concerns regarding the need for and access to mental and physical health services among West Virginia's military personnel (particularly the National Guard and Reserve) who were returning from OEF/OIF and related deployments.

The survey study was funded in October 2007, conducted during November 2007 to April 2008, and the resulting data have since been in various stages of analysis. The survey was an intentionally brief 108 questions in order to maximize response rate. The focus was on demographics, deployment experiences, the impact of those deployment experiences (in terms of symptoms of PTSD and depression, and changes in various areas of basic functioning), and awareness and use of a wide range of services. The staff of the WV State Division of Veterans Affairs mailed the survey to 6,400 WV Veterans from their mailing list of Veterans who had applied for the WV State Bonus ($600) for having served overseas. Approximately 1,000 surveys were undeliverable; approximately 1,100 completed surveys have been returned (a 20% response rate: 1,100/5,400). This testimony is based on 848 surveys presently entered into the survey database and which represent those Veterans who have served in the present conflicts of interest.

It is well established that there is an association between exposure to combat and other war zone stressors and the occurrence of mental health problems such as PTSD, depression, and substance abuse. Such research has almost exclusively been conducted with military Veterans who had enlisted or were drafted directly to active duty, and primarily with Veterans who were identified through VA patient roles. The present military conflicts (i.e., beginning with Operations Desert Shield and Desert Storm to OEF and OIF) are unique in the inclusion of members of the National Guard in military conflicts outside the borders of the United States. Given the differences in the intensity, regularity, and type of training between active military and National Guard units, the impact of combat and related war zone stressors on members of the National Guard who have served in the conflicts overseas is a relative unknown. Thus, a portion of this testimony is dedicated to establishing the differential impact of war zone stressors on members of the National Guard, as compared to Active Duty personnel. Further, the Veterans in this survey were not accessed through VA patient roles, but rather through the WV State Division of Veterans Affairs. Thus, the information presented here represents both Veterans who have and have not sought VA services.

SURVEY RESEARCH FINDINGS

General Demographics and Combat Exposure

Overall, the 848 persons (9% Female) in the study averaged 38 years of age (20–64 years) and were primarily white (96%, as reflects the demographics of WV). They came from all 55 counties in WV, with 57% reporting service in the National Guard or Reserves and all currently residing in WV. Of the 43% reporting Active Duty service, 56% were still out-of-state and primarily at a military base. Furthermore, of the 621 personnel residing in WV, 48% resided in the 13 urban counties of the State; 52% in the other 42 rural counties. All respondents indicated at least a high school degree and 30% reported some college. Active Duty personnel were younger, on average, than members of the Guard/Reserves (35 vs. 40 years), and were somewhat more ethnically/racially diverse (93% vs. 97% white). (We note an overwhelmingly positive response to this survey, with 87% or respondents reporting that the survey was "Worth the Time to Do.")

All respondents had been deployed at least once to the Persian Gulf Region since 1990 (97% since the year 2000) in—or in support of—various operations: Iraq (71%), Afghanistan (16%), the Persian Gulf Region (32%; e.g., Kuwait, Oman, Qatar, Saudi Arabia, Turkey), KFOR/SFOR (the Kosovo Force/Stabilization Force in the Balkans region; 14%), and Operations Desert Shield/Desert Storm (10%). Prior duty in Operation Restore Hope (Somalia, 1%) and Vietnam (2%), among other conflicts and operations, was additionally reported. Multiple duty stations and or deployments were reported by 43% of the respondents.

All branches of military service were represented; however, members of the Guard/Reserves were more likely to be in the Army (78%) than were Active Duty

personnel (48%), and were more likely to report Combat Support Duty (70% vs. 60%) and less likely to report direct Combat Duty (43% vs. 52%).

The Combat Exposure Scale (CES) was utilized to quantify the level of exposure to combat and war zone stressors, including engagement in patrols and dangerous duties; firing rounds at enemy forces; seeing someone hit by rounds or explosive devices; and the percentage of unit personnel who were wounded, killed, or missing. The CES score can be quantified as indicating Light, Light-Moderate, Moderate, Moderate-Heavy, and Heavy levels of combat exposure. The average score for both Guard/Reserve and Active Duty personnel was in the Moderate range; however, over 20% of Guard/Reserve and Active Duty personnel experienced Moderate-Heavy to Heavy levels of combat exposure.

Urban-Rural Differences. Veterans from Rural Counties of WV differed from those residing in Urban Counties in several ways. Rural Veterans were: (a) more likely than Urban Veterans to have been in the Army (83% vs. 60%), (b) to report Combat Duty (71% vs. 39%), and, (c) to report more exposure to a Moderate Level of combat (based on the Combat Exposure Scale; 33% vs. 23%) and less exposure to a Light Level of combat (16% vs. 28%).

Impact on Mental Health

Commonly used and well-validated self-report measures of PTSD and depression symptoms were utilized (PTSD Checklist, Center for Epidemiological Studies—Depression Scale) to evaluate the possible impact of combat exposure on the respondents.

[Symptoms of PTSD include reexperiencing the traumatic event, such as nightmares and intrusive thoughts; avoiding reminders of the event, including people, places, and activities; and hyperarousal, which includes exaggerated startle response, irritability, sleep disturbance, and concentration problems. Symptoms of depression include prolonged sadness, low self-worth, sleep and appetite disturbances, self-blame, and suicidal ideation.]

Using the recommended cutoff scores for these two measures (greater than 43 on the PTSD Checklist and greater than 15 on the CES-Depression Scale), 35% of the Veterans had scores suggesting clinical levels of PTSD, and 43% had scores suggesting clinical levels of Depression. Given the high concordance of depression with PTSD (a correlation of .85 in this study), Veterans were classified as having PTSD and/or Depression (PTSD/Depression Group: 47% of the respondents) or as not meeting criteria for either (Other Veterans Group: 53%).

[NOTE: It should not be assumed that the Other Veterans Group was free of mental health problems. The Other Veterans did not meet criteria for PTSD or Depression, but may well exhibit other anxiety disorders, substance use/abuse problems, sleep disturbances, and a range of sub-clinical symptoms. Further, we did not directly evaluate Traumatic Brain Injury in this study.]

By point of comparison, the 35% rate of PTSD in the present study is similar to the 31% lifetime rate for PTSD reported in the *National Vietnam Veterans Recovery Study* (NVVRS). Further, the recent Rand Corporation Report (*The Invisible Wounds of War*, 2008) summarizes some 22 prior studies of OEF/OIF Veterans, giving a typical range of 5–15% for the occurrence of PTSD, but with some studies reporting rates as high as 30%. As if often seen in the trauma literature, rates vary by assessment measure and criteria, sample characteristics, and time since event, among other factors.

In this case, we note that members of the Guard/Reserves were more likely than Active Duty personnel to meet the criteria for PTSD/Depression (51% vs. 40%), despite having similar demographic backgrounds and combat experiences. This result may reflect the impact of pre-deployment preparation and training, support of families during deployment, and post-deployment debriefing and support resources.

Urban-Rural Differences. One characteristic that is related to mental health outcome in this study is whether the Veteran lived in an Urban or Rural County (a factor not investigated in the research summarized in the Rand Report). Veterans residing in West Virginia (primarily Guard and Reserves) were more likely to meet criteria for PTSD/Depression if they lived in a Rural County (58%) versus an Urban County (44%). Note, however, that county of origin may be a proxy for multiple other variables, including that persons in rural counties may have a lower income, lower employment levels, lower quality of education, dispersed support systems, greater transportation problems (roads, gas prices, reliable vehicles, and public services), and general availability and access to mental and physical health agencies and other support services.

Suicide Risk

Due to growing concerns about the increased rates of suicide among OEF/OIF Veterans, we reviewed the data for three factors that have been shown to be associated with increased suicide risk: high levels of symptoms of depression and PTSD, and high levels of combat exposure (Rand Corporation, 2008). In this sample, 8% of the Veterans had scores consistent with this "risk profile," suggesting high risk for suicide.

Impact on Daily Functioning and Family

We asked participating Veterans to report both how they currently were functioning in daily life, and how their level of functioning had changed from prior to their most recent deployment. Overall, veterans did not differ in their reported level of functioning by their type of service (Guard/Reserves vs. Active Duty), and time since last deployment was not related to impact (i.e., functioning did not improve over time).

As would be expected, Veterans with PTSD/Depression reported greater declines in pre- to post-deployment functioning on a 10-point scale (1 = extremely poor, 10 = extremely good), averaging less than a 1-point decline in rated functioning for Other Veterans, and averaging over a 3-point decline for those with PTSD Depression in the areas of: (a) Physical Health (–1.4 vs. –3.7), (b) Mental Health (–0.8 vs. –4.1), (c) Family Relationships (–0.6 vs. –3.8), (d) Social Support (–0.2 vs. –2.5), and (e) the Behavior and Academic Progress of Children (–0.2 vs. –1.5). Further, when rating overall current functioning, 60% of Veterans with PTSD/Depression rated at least one area of functioning (Work/School, Military Duties, Home/Family, Social/Friends) as Poor or Extremely Poor, as compared to only 7% of Other Veterans. It is critical to note here that the impact of PTSD/Depression goes beyond the mental and physical health of the Veteran; it also negatively impacts significant others, children, friends, and work.

Urban-Rural Differences. Those Veterans residing in Rural Counties were differentially impacted as compared to the Urban cohort. First, Rural versus Urban Veterans reported a more negative impact on Mental Health (–3.0 vs. –2.1) and Family Relationships (–2.7 vs. –1.8). Second, 43% of Rural Veterans rated at least one area of functioning (Work/School, Military Duties, Home/Family, Social/Friends) as Poor or Extremely Poor, as compared to 25% of Urban Veterans. Finally, and most telling, only 7% of both Urban and Rural Veterans without PTSD/Depression rated at least one area of functioning as Poor or Extremely Poor, as compared to 48% of Urban Veterans with PTSD/Depression. Over two-thirds (69%) of Rural Veterans with PTSD/Depression rated at least one area of functioning as Poor or Extremely Poor.

Service Awareness and Utilization

The above statistics establish that, as a group, members of the West Virginia National Guard and Reserves who served in the recent conflicts are experiencing a differentially greater mental health impact than Active Duty Veterans from West Virginia. Furthermore, Veterans residing in the Rural Counties of West Virginia are experiencing both a greater mental health impact and greater declines in functioning. It is then important to know if either Guard/Reserve Veterans or Veterans from Rural Counties are differentially aware of and seeking services.

To address this issue, the survey included a series of questions asking whether the Veterans were aware of a wide range of support and service options, whether they had used those services and support, and whether the services and supports had been helpful or not. The intentional brevity of the survey only allowed the respondents to indicate use of a service, such as a VAMC. They were not able to indicate the specific services accessed, such as the medical, psychiatric, or benefits services at a VAMC. Further, use of a service could have been by phone, mail, or in person. Thus, these results only indicate some contact with a service, not the method of contact, specific aspect of the service utilized, nor the duration of service utilization. With these caveats, the general findings are next presented.

Awareness of Services. Overall, West Virginia Veterans reported being aware of the availability of a wide-range of services and supports at each of five levels: (a) 92% reported the availability of Informal Supports (e.g., family, friends, other veterans), (b) 87% reported the availability of Formal Supports (e.g., Veterans organizations and other support groups), (c) 84% reported the availability of Emergency Medical Services (e.g., crisis line, emergency room), (d) 91% indicated being aware that services from Mental Health Professionals were available (e.g., clergy, counselors, psychologists, social workers, etc.), and, (e) 88% were aware that they could receive services from Center-Based Facilities (e.g., VAMC, Vet Center, community mental health center). These rates of awareness of availability did not differ by type

of duty (Guard/Reserves versus Active Duty). Urban Veterans without PTSD/Depression were somewhat more aware of the availability of Emergency Medical Services than were Rural Veterans with PTSD/Depression (89% vs. 79%).

Use of Services. It would appear that awareness of services is quite high, although there is some room for improvement. Whether those services have been utilized or not is the next question. Regardless of status, 72% of Veterans in the survey reported use of Informal Supports. Use of Formal Supports (53% overall) was more likely to be reported by Veterans with PTSD/Depression (62%) than Other Veterans (44%), as was the use of Emergency Medical Services (29% vs. 43%; 36% overall). Mental Health Professionals (62% overall) were used by 54% of Other Veterans and 70% of those with PTSD/Depression. Within the variety of Mental Health Professionals, Veterans with PTSD/Depression who lived in Rural Counties were the most likely group to use physician services (67%). Services at Center-Based Facilities (54% utilization, overall; including Vet Centers and VAMCs) were used more by Veterans with PTSD/Depression (65%) than Other Veterans (43%); within this set of services, hardly any use of community mental health centers was reported (5%).

Overall, the utilization of a wide range of supports and services is rather high, although clearly one-third or more of Veterans who are potentially in need of services are not accessing them. Further, the focus here is on a limited set of mental health issues, and not physical health and other areas of concern (including TBI and substance use/abuse). Nationally, about 39% of Veterans have at least one contact with the VA system. The overall 37% utilization rate for Vet Centers and 58% for VAMCs by West Virginia Veterans is apparently higher than the national figures, and is likely due to the density of services in West Virginia, with coverage by four different VISNs (4, 5, 6, 9) and including four VAMCs, eight Vet Centers, and multiple CBOCs and contract clinics in the most rural counties. The utilization rate reported here may also be higher due to the very broad definition of "service use" in this survey.

Helpfulness of Supports and Services. Overall, 65% of the respondents indicated that use of Informal Supports was helpful to them; 53% indicated that services of Mental Health Professionals were helpful. Formal Supports were helpful to 45% overall, but more so to Veterans with PTSD/Depression (50%) than Other Veterans (39%). Emergency Medical Services were helpful to 32% of the respondents who used them (36% of Veterans with PTSD/Depression, 26% of Other Veterans). Finally, while 45% found the Center-Based Facilities to be helpful, again Veterans with PTSD/Depression (52%) found the services more helpful than did Other Veterans (36%). Although we cannot determine from this survey if Veterans were seeking or receiving those services most appropriate to their individual situations, it is disheartening to see that less than half of Veterans (including those with mental health issues and declines in functioning) are reporting the receipt of helpful services.

CONCLUSIONS AND CONCERNS

The prior sections support the initial statements concerning the: (a) high level of combat exposure experienced by members of the West Virginia National Guard and Reserves, with higher exposure by Rural than Urban Veterans; (b) greater negative impact on the psychological and daily functioning (of Veterans and their significant others and children) experienced by members of the National Guard and Reserves, with greater negative impact on Rural as compared to Urban Veterans; and, (c) apparent under-utilization of various levels of support and services, and the much less than complete satisfaction with the "helpfulness" of those services, despite generally high rates of awareness of service availability among Veterans.

These findings point to significant concerns regarding the provision of adequate services to all Veterans, but especially members of the National Guard and Reserves, and those from rural areas of Our Nation. These findings, coupled with the fact that the respondents in WV seek out individuals in their informal helping systems first, and given that there are multiple levels of services and supports that Veterans utilize, we need not depend solely on the VA and DOD for the provision of those services and supports. Further, as the need for services goes well beyond Veteran themselves, but includes their children and immediate and extended families, the need for a wide range of family support services is evident—this being an area well beyond typical VA services. In West Virginia, for example, the Council of Churches has developed CARE-Net, a grassroots network of houses of worship and their local communities to provide support, services, and referrals to Veterans and their families. Further, the West Virginia National Guard Family Assistance Center is consulting with other States (such as Minnesota) about the development of a full circle of programs and supports that run from pre-deployment, during deployment,

and following deployment. Although the Guard is now mandated to provide homecoming and follow-up programs, States are left to develop and fund those programs.

In West Virginia, we are also collaborating with the VA, AHEC (Area Health Education Centers), and the Citizen-Soldier Program to bring to our State a model program for disseminating information, providing continuing education to community providers, and linking agencies. These sorts of efforts are arising at all levels due to the overwhelming need to support and serve Veterans and their families, and to reintegrate Veterans back into their families and communities. It is recognized that the VA and DOD need not—and perhaps should not be expected to—do it all, even if such were possible. We recognize that it takes a community—not an agency—to welcome a Veteran home.

In our work, we have thus formulated a number of questions that will need to be addressed, including:

1. How will we network the multiple levels of service, from informal/grassroots groups to state programs and facilities to Federal programs and facilities?
2. How will we identify and follow Veterans over years to decades, from initial return from deployment to resolution of identified problems?
3. How will we identify and follow those Veterans in most immediate need and those at greatest risk for suicide?
4. How will we ensure that all Veterans have equal access to services, including rural and minority Veterans, those who have been other than honorably discharged, and those who commonly do not seek treatment or experience significant barriers to service access?
5. How will we ensure that Veterans are able to return—as soon as possible—to a productive life?
6. How will we ensure that the Families of Veterans receive the support and services that they need at all stages of their Veteran's deployment?
7. How will we ensure adequate funding for services and related research?
8. How can we do our best, as a Nation, to fully honor the commitments and sacrifices of Veterans and their Families?

RECOMMENDATIONS

In response to these data, the above questions and concerns, and our personal experiences working with Veterans, families, communities, agencies, and committed professionals, we have formulated three key recommendations:

I. Fully fund and support homecoming programs to enable the National Guard to adequately prepare their personnel and families for upcoming deployment; provide support and services during deployment; and offer support, services and referrals post-deployment (such as at the required 30-, 60-, 90-, and 180-day reunions).

II. Support and fund the dissemination and evaluation of best practices in a broad array of areas, including: (a) group and individual treatment of combat-related PTSD (and comorbid depression, substance abuse, family violence, etc.); (b) identification of suicide risk and provision of related risk reduction services; (c) reintegration to community, work, and educational settings; and (d) child and family support and therapy services. Such dissemination should occur with a range of professionals (e.g., clergy, social workers, psychologists, vocational counselors, physicians and other primary care professionals, psychiatrists, teachers), and in a range of settings (e.g., from private mental and physical health practitioners; to local grade schools, technical schools, and colleges; houses of worship; community mental health centers; community health centers, hospitals, and rural health clinics; to state agencies, military units, and AHECs; to Federal agencies, such as Vet Centers, CBOCs, and VAMCs).

III. Support and fund the linking of local, state, and Federal agencies in a coordinated effort of overlapping lay, volunteer, paraprofessional, and professional services and resources in order to meet the tremendous mental health, physical health, and quality-of-life needs of our Military Personnel.

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

Colonel Livingston.

STATEMENT OF COLONEL BRADLEY A. LIVINGSTON, CHIEF, JOINT STAFF, MONTANA NATIONAL GUARD

Colonel LIVINGSTON. Mr. Chairman and Members of the Committee, thank you for the opportunity to provide testimony on the

Montana National Guard's efforts to strengthen our post-deployment and reintegration process.

My testimony today reflects my personal views, and does not necessarily reflect the views of the Air Force, the Department of Defense, or the Administration.

Again, I am Colonel Brad Livingston, the Director of the Joint Staff for the Montana National Guard. As previously identified, in March 2007, the Montana National Guard lost a soldier to a suicide linked to PTSD. That action prompted Montana's Governor Brian Schweitzer and the Adjutant General Randy Mosley to form a post-deployment health reassessment program task force to evaluate the post-deployment process used by the Montana National Guard.

We asked the task force, comprised of non-DOD subject matter representatives from a variety of areas—for example, mental health experts, Veterans Administration, local ministers, and State government officials to evaluate our current process, and to recommend actions for program improvements.

After nearly 3 months of meeting, the PDHRA task force reported—confirmed that the Montana National Guard was following and, in many cases, exceeding established Department of Defense and National Guard Bureau program guidelines, yet the task force made fourteen recommendations in an effort to improve our program. Due to the time, I will not go through all 14 of them, as they are in my written testimony.

As previously identified, all returning soldiers and airmen now complete the VA form 10–10EZ to enroll for VA benefits. This expedites follow-on care through the VA in the event that it becomes necessary.

The assistance we have received from the Fort Harrison Veterans Administration team has been key in our improved program. The current PDHRA program conducted within 90 and 180 days after redeployment has been extended to 2 years. Redeploying soldiers and airmen receive a behavioral health review either through a post-deployment health reassessment or a periodic health assessment conducted every 6 months for 2 years.

Montana implemented the periodic health assessment in June 2007. This new program replaced the formal annual medical certificate and the 5-year physical program with an annual medical review. The new review is required every year, and includes a self-assessment by medical examination and a face-to-face meeting with a physician or a physician assistant.

Montana Senators Max Baucus and John Tester met with Dr. Chu, Under Secretary for Defense for Personnel and Readiness, DOD, and secured an additional PDHRA cycle for Montana. This, again, allowed us to expand our current review out to the 2-year mark.

The Montana National Guard formed a pilot program with TriWest Health care Alliance to place behavioral health care specialists at both the Joint Force Headquarters in Helena, Montana, and the 120th Fighter Wing Headquarters in Great Falls. This program incorporates a face-to-face with a behavioral health specialist into our annual periodic health assessment program. The pilot began in June 2008, and will continue through December 2008. At

that time, we will evaluate the effectiveness, along with the options for future participation.

The Montana National Guard Public Affairs office developed a comprehensive marketing plan for our outreach efforts. A large part of the plan included development of a PTSD outreach video and brochures that have been used as an educational tool to help Montana build a stronger community partnership with medical behavioral health providers, churches, Veterans service organizations, and both the State and Federal—and employees throughout the State of Montana.

Additionally, we conducted community presentations and a presentation of *Picking up the Pieces*, a DVD that we produced, along with a short presentation on PTSD in 20 Montana communities that host a National Guard Armory. Our goal was to provide education on the Guard's progress in addressing PTSD, elevate the public's awareness, and involve Montana communities' efforts to address the issues of PTSD within the Montana National Guard and other service components.

The Montana National Guard continues to move forward in its implementation of the task force recommendations and our new development cycle support beyond the Yellow Ribbon Program. We appreciate the assistance received from our congressional team, the Governor, the National Guard Bureau, the Department of Defense, and our many community partners who have contributed their assistance and support in our efforts. We believe it takes a community to return a veteran from combat.

On behalf of Governor Schweitzer, Major General Mosley, and more than 3,700 men and women of the Montana National Guard, thank you for your continued support and commitment to Montana's veterans and their family. Thank you.

[The prepared statement of Colonel Livingston follows:]

PREPARED STATEMENT OF COLONEL BRADLEY A. LIVINGSTON, DIRECTOR OF THE JOINT STAFF, MONTANA NATIONAL GUARD

Mr. Chairman and Members of the Committee: Thank you for the opportunity to provide testimony on the Montana National Guard's efforts to strengthen our post-deployment and reintegration processes.

"My testimony today reflects my personal views and does not necessarily reflect the views of the Air Force, the Department of Defense, or the Administration."

I am Col. Brad Livingston, the Director of the Joint Staff for the Montana National Guard. In March 2007, the Montana National Guard lost an Army Soldier to a suicide linked to Post Traumatic Stress Disorder (PTSD). That action prompted Montana's Governor, Brian Schweitzer, and Adjutant General, Randy Mosley, to form a Post-Deployment Health Reassessment Program (PDHRA) Task Force to evaluate the post-deployment processes used by the Montana National Guard.

We asked the PDHRA Task Force, comprised of ten community subject-matter representatives from a variety of areas—for example: mental health experts; Veterans Administration employees; local ministers; and state government officials—to evaluate our current processes and to recommend actions for program improvements.

Although the PDHRA Task Force report confirmed the Montana National Guard was following and, in many cases, exceeding established Department of Defense and National Guard Bureau program guidelines, the Task Force made 14 recommendations in an effort to help improve our program.

The recommendations are as follows:

1. Evaluate medical status before discharge
2. Allow Guardsmen to request honorable discharge
3. Thoroughly review all Guard PDHRA personnel files for completeness
4. Expand the PDHRA Process

5. Mandate Enrollment in the VA Healthcare System
6. Guardsmen receive awards and medals within 90 days of return
7. Send badge information to DOD within 90 days
8. Include mental health focus in training
9. Increase awareness of available resources
10. Create Crisis Response Team (CRT)
11. Allow drill attendance upon return home
12. Increase informal support systems—Vet2Vet
13. Enhance Family Readiness Program
14. Form partnerships with State Veteran's Groups

PDHRA CAMPAIGN PLAN SUMMARY OF ACCOMPLISHMENTS

Modified Discharge Process

Montana modified the discharge process to incorporate an additional series of reviews prior to approval of a discharge. In addition to the current command assessment, reviews were added for medical, legal, and senior leadership. This serves the purpose of confirming that a discharge request for an OEF/OIF/ONE member is not related to a PTSD or other combat issue.

Developed Crisis Response Teams

In response to the recommendation, we created two Crisis Response Teams, with one team located in Helena, Montana and the other in Great Falls, Montana. The purpose of the Crisis Response Team is to evaluate, analyze, and advise unit representatives, Guardsmen, and/or their families on situations that involve National Guard members affected by Post Traumatic Stress Disorder (PTSD), Mild Traumatic Brain Injury (mTBI), or other traumatic life events.

Mandated Enrollment into VA System

All returning Soldiers and Airmen now complete the VA Form 10–10EZ to enroll for VA benefits. This expedites follow-on care through the VA in the event it becomes necessary.

Modified PDHRA Process

The current PDHRA process, conducted within 90–180 days after redeployment, has been extended to two years. Redeploying Soldiers and Airmen receive a behavioral health review through either a Post Deployment Health Reassessment or a Periodic Health Assessment, conducted every six months for two years.

Suicide Prevention and PTSD/mTBI Training

Increased training on suicide prevention, PTSD, and mTBI was conducted. All units have received suicide training and this is now an annual requirement. Trained Montana counselors conducted PTSD/mTBI Outreach Training in all units. We distributed focused resource/benefit information (to include a copy of the book, *Down Range to Iraq and Back*) and conducted outreach to increase awareness of the National Guard Transition Assistance Advisor (TAA). We continue our efforts through Web site modifications, ongoing unit training, and partnerships with community organizations.

Reaffirmed Drill Attendance Policy

The Adjutant General published a policy letter to reaffirm a Soldier's (ARNG only) ability to drill immediately upon redeployment for the first 90 days previously identified as a "no drill" period).

Hired a PDHRA Program Manager

A full-time PDHRA Program Manager was hired. This position manages the PDHRA process and our ongoing efforts in implementing the actions of the PDHRA Campaign Plan.

Redesigned MTNG Website—Yellow Ribbon

The Montana National Guard Web site, located at www.montanaguard.com, is updated to include information on the Beyond the Yellow Ribbon program. The Web site consolidates related information to help minimize confusion when benefits are needed. As we move forward, we will develop a separate PDHRA Web site to continue enhancing this effort.

Implemented Periodic Health Assessment

Montana implemented The Periodic Health Assessment (PHA) in June 2007. This new program replaced the former Annual Medical Certificate and the five-year physical program with an annual medical review. The new review is required every

year. It includes a self-assessment complimented by a medical examination and face-to-face meeting with a physician or physician's assistant.

Redesigned Individual Mobilization Process

Soldiers and Airmen who volunteer to mobilize as individual augmentees now receive the same redeployment information as units who redeploy. A comprehensive checklist ensures all necessary stations are completed before a Soldier or Airman is released.

Honorable Discharge Policy Request

We published a policy memorandum to allow Guardsmen to request an honorable discharge based on deployment-related PTSD or mTBI difficulties.

Expanded Family Resource Centers

Through additional funding resources, the Montana National Guard Family Program was able to hire two contracted part-time Family Assistant Coordinators, located in Billings and Kalispell, Montana.

Increased Family Communications

The Family Program has expanded its efforts to provide information and additional focus on PTSD/mTBI signs and symptoms, along with providing resource information for families. The family program is also developing a consolidated resource guide to further enhance information access and availability.

State Veteran's Affairs—MT Mental Health Association

The State Department of Veteran's Affairs partnered with the Montana Mental Health Association to air a variety of statewide Public Service Announcement radio spots from 9 Jan 2008 through 19 March 2008.

Received Additional PDHRA Cycle from OSD

Montana Senators Max Baucus and Jon Tester met with Dr. Chu, Undersecretary of Defense for Personnel and Readiness, DOD, and secured an additional PDHRA cycle for Montana. This allows us to expand our current review out to the two-year mark.

Invitational Travel Authorizations for Family Members

National Guard Bureau extended funding to the Montana National Guard to place family members on invitational orders to attend Deployment Cycle Support (DCS) events. This helps us in involving all families in the redeployment training.

TRIWEST Healthcare Pilot Program

The Montana National Guard formed a pilot program with TRIWEST Healthcare Alliance to place a behavioral healthcare specialist at both the Joint Force Headquarters in Helena and at the 120th Fighter Wing Headquarters in Great Falls. This program incorporates a face-to-face with a behavioral health specialist into the annual Periodic Health Assessment program. The pilot began in June 2008 and will continue through December 2008. At that time, we will evaluate the effectiveness, along with options for future participation.

Joint Family Support Assistance Program (JFSAP)

National Guard Bureau selected Montana to participate in the Joint Family Support Assistance Program. This program extends three new positions to our Family Programs to assist with family and youth outreach. These positions include a Child and Youth Specialist and two Military Family Benefits Specialists. Program contractors have already begun the recruitment process.

Community Partnership Program—Picking up the Pieces DVD

The Montana National Guard Public Affairs Office developed a comprehensive marketing plan for our outreach efforts. A large part of the plan included the development of a PTSD Outreach Video and brochures that have been used as educational tools to help the MTNG build stronger community partnerships with Medical (behavioral health care providers), Ministerial (area churches), Veteran Services Organizations (American Legion, VFW, and DAV), State (DPHHS), Federal (OSD, NGB), and Employers located throughout the state. Montana sent a direct mailing that included a copy of the DVD and informational brochures, along with a letter of partnership request, to all behavioral health care providers, ministerial groups, and Veteran Services Organizations in early May 2008. Additionally, we conducted community presentations of our *Picking up the Pieces* DVD, along with a short presentation on Post Traumatic Stress Disorder (PTSD), in 20 communities that host a National Guard Armory. Our goal was to provide education on the Guard's

progress in addressing PTSD, elevate public awareness, and involve Montana communities with our efforts to address the issues of PTSD within the Montana National Guard and other service components. This was a community event conducted during the weeks of 19 May and 26 May 2008. Nearly 400 Montana residents attended one of these meetings.

Radio Public Service Announcements

Montana Veteran's Affairs Division and the Montana Mental Health Association teamed up to produce and air 30 second awareness radio spots across Montana in the months of January, February, and March 2008. These spots focused on PTSD and the VA resources available to assist those in need.

Television Public Service Announcements

The Montana Veteran's Affairs Division and Montana Mental Health Association produced 30-second television public service announcements to again highlight and raise awareness of PTSD. The spots use footage from the recently completed *Picking up the Pieces* DVD, produced by the MTNG Public Affairs Office.

Published National Guard Resource Guide

The Montana National Guard developed a Resource Guide that consolidates many of the most commonly used resources to treat PTSD and mTBI into one convenient booklet. We mailed the booklet to all members of the Montana National Guard and their families in July 2008.

Closing Remarks

The Montana National Guard continues to move forward in its implementation of the Task Force recommendations and our new Deployment Cycle Support, Beyond the Yellow Ribbon program. We appreciate the assistance received from our Congressional TEAM, the Governor, National Guard Bureau, Department of Defense, and our many community partners who have contributed their assistance and support in our efforts.

On behalf of Governor Schweitzer, MG Mosley, and the more than 3,700 men and women of the Montana National Guard, thank you for your continued support and commitment to our Montana veterans and their families.

Thank You.

Chairman AKAKA. Thank you very much, Colonel Livingston from Montana National Guard.

And now we will hear from Colonel Boyd from Vermont Army National Guard.

Colonel Boyd.

STATEMENT OF LIEUTENANT COLONEL JOHN C. BOYD, DEPUTY CHIEF OF STAFF FOR PERSONNEL, VERMONT ARMY NATIONAL GUARD

Lieutenant Colonel BOYD. Good morning, Chairman Akaka and Members of the Committee. Thank you for the invitation to discuss the Vermont National Guard Veterans and Family Outreach Program.

My name is Lieutenant Colonel John Boyd, and I serve as the Deputy Chief of Staff for Personnel for the Vermont Army National Guard, and I have direct oversight over our outreach program for returning servicemembers and their families.

My testimony today reflects my personal views and does not necessarily reflect the views of the Army, the Department of Defense, or the Administration.

Since September 11, 2001, 2,581 Vermont National Guardsmen and 268 Reservists who reside in Vermont have deployed in support of OIF and OEF.

Early in the mobilization process, the Vermont National Guard recognized that soldiers and airmen deserve the very best post-deployment support available. It became increasingly apparent that

Post Traumatic Stress Disorder was developing into a significant issue. While the many degrees of this affliction were diagnosed in some soldiers, the instate infrastructure to match this emerging need had yet to be created.

As the Committee knows, National Guard and Reserve servicemembers, particularly in States such as Vermont, which are rural and do not have any active duty military installations, can experience challenges with awareness of and access to mental health and other benefits when they return from deployment.

In 2005, the State of Vermont recognized the need for greater assistance for the National Guard soldiers and their families, which led our Legislature to allocating $250,000. These funds were used to establish the first ever sharing agreement between the Veterans Administration and the Vermont National Guard.

Seeing a continued and growing need for mental health services for veterans and their families, the Vermont National Guard, in partnership with others, designed an innovative outreach readjustment and reintegration program targeted at our returning OIF and OEF veterans and their families throughout the State.

This program, which was started in 2007 with $1 million in Federal funding, employs trained outreach specialists, a majority of which are combat veterans, to reach out directly to our returning OIF and OEF veterans and their families to ensure that they are receiving the medical mental health and other assistance that they need. One of the main goals of this program is to personally contact each and every one of these veterans to check in on them and connect them to relevant services.

In order to develop the goals for the outreach program, the Vermont National Guard and VA officials from the White River Junction Medical Facility met to discuss existing services in the State on the Federal and local level, and how congressional resources could be used most effectively to provide servicemembers and their families with the best possible care.

Up to this time, Vermont had lost 11 Guardsmen: nine in Iraq, one in Kuwait, and one in Afghanistan. In addition, another 16 soldiers and Marines with Vermont-related connections were killed in action. This number continued to elevate Vermont into the unfortunate circumstance of having one of the highest per capita casualty rates in the war. This cumulative loss and the effect it has had on several deployments, became a driving force to develop a robust program focused on helping returning soldiers with PTSD, other medical conditions, TBI, and other needs.

The Vermont Veterans and Family Outreach Program goal was to construct a Vermont National Guard managed outreach program developed and sustained to help identify and refer servicemembers and their families to the appropriate clinical care to serve their readjustment needs.

This program was designed so that each of the five outreach specialists worked out of five existing Vermont National Guard family assistance centers. These centers are located in different areas of the State, and it was linking our work with the Guard's family programs that allowed us to have a full wraparound with the family and the soldier.

At the same time that this outreach team was working across the State, Federal resources were used to fulfill the Adjutant General's outreach program's goal to help all soldiers suffering from mental health difficulties. The resources were used to enter into a sharing agreement with the Veterans Administration, allowing them to hire two additional qualified and certified clinicians, serving under the supervision of the Mental Health Services Director at the White River VA. And in addition, $259,000 was shared with the VA to support clinical mental health outreach throughout Vermont. These services included basic and advanced mental health service for our servicemembers and their families.

Initially, a simple survey was developed to capture basic soldier data such as name and gender. In addition, among other questions, each respondent was asked to answer which deployment they were on, which component they deployed with, the length of tour, et cetera. This initial survey has since been revised twice with the assistance of the Veterans' Affairs hospital, and we subsequently have begun using a TBI survey, which is providing some significant results.

The program has set its goal in contacting all of our OIF and OEF Reserve members, airmen, sailors, and Marines in the State. To do this, we use a number of different strategies reaching out, such as public service announcements, mailings, posters, just to name a few.

I would like to highlight the importance of using combat veterans on an outreach team. I believe these members are able to focus down on a direct, person-to-person peer outreach approach. Our program has observed that using fellow veterans help allay anxiety some soldiers felt when they were first contacted.

All of our outreach specialists focused on ensuring veterans were receiving their benefits, including early diagnosis and treatment of PTSD and TBI, ensuring that mental health counseling could be extended to family members and that, as much as possible, could take place in the communities where the veteran lived.

In doing this detail-oriented work, our staff observed that making personal contact with the veterans is a time-intensive process. When we list a servicemember as being contacted, that means we have actually opened a case with the individual, made a serious attempt to complete the survey with them. For many cases, this is just the first phase of our work. Often, establishing a relationship with a contacted veteran—the next step is a referral to VA.

In order to make sure that our outreach staff is of the highest quality, we spend a significant amount of time in training so as to ensure professionalism on the job. That included training with the VA as well as private parties.

Towards the end of 2007, Senator Sanders convened a meeting of the Vermont veteran and military community stakeholders (including the Vermont Guard, Federal and State Veterans Affair leadership) to discuss the lessons learned from our first year of the program, and to establish how new resources could best be used to strengthen and expand the program.

We believe that Vermont's outreach program strength is its use of mostly veteran outreach specialists to focus on personally meeting soldiers on their own turf, where anecdotal evidence suggests

they are much more prone to reveal the challenges they are experiencing in their lives than if they are being interviewed at a military facility or in a group setting.

Our program also does a strong job of leveraging the resources of entities in the State that already provide important services for our servicemembers, especially Vermont Department of Veterans Affairs. We have formed strong partnerships with all of these agencies with the State, and we also have strong partnerships in the public, private, and nonprofit stakeholders through our military family and community network.

As our program continues to mature, it serves as an example of an effective and cost-efficient rural delivery model for other States. As earlier testimony today has discussed, the Department of Defense is now in the process of implementing the new Yellow Ribbon Reintegration Program, created in Fiscal Year 2008 Defense Authorization Act.

We are pleased that through Senator Sanders' efforts, the Yellow Ribbon Program included a provision based on our Vermont model, which allows Yellow Ribbon to fund outreach initiatives in the various States.

We are proud of the role that Vermont took in developing an effective response to the invisible wounds suffered by our soldiers which also impacts their families and communities. We believe this commitment to our veterans is our obligation, and an important way to ensure that they are able to remain a part of the Guard and Reserve, while also living a productive and normal life.

As you can see from my PowerPoint slides in your packet, as of 18 July 2008, we have contacted nearly 1,000 of our soldiers, sailors, airmen, and Marines. Of them, 85 percent are enrolled in the VA for some level of care or assistance. Our hope is to continue this work until every servicemember and their family that needs help gets help.

Thank you for this opportunity to discuss Vermont's outreach program, and I look forward to answering any questions that you may have.

[The prepared statement of Lieutenant Colonel Boyd follows:]

PREPARED STATEMENT OF LIEUTENANT COLONEL JOHN C. BOYD, DEPUTY CHIEF OF STAFF FOR PERSONNEL, VERMONT ARMY NATIONAL GUARD

Chairman Akaka and Members of the Committee, Thank you for your invitation to discuss the Vermont National Guard Veterans and Family Outreach Program. My name is Lieutenant Colonel John Boyd and I serve as the Deputy Chief of Staff for Personnel of the Vermont Army National Guard and have direct oversight over the outreach program for returning servicemembers and their families.

"My testimony today reflects my personal views and does not necessarily reflect the views of the Army, the Department of Defense, or the Administration."

Since September 11, 2001, 2581 Vermont National Guardsmen (1968 Army Guard and 613 Air Guard) and 268 Reservists (159 Army Reserve, 22 Air Force Reserve, 59 Marine Corps Reserve and 28 Naval Reserve) have deployed in support of Operation Iraqi Freedom and Operation Enduring Freedom. I believe it is worthwhile to note that Vermont is a Guard and Reserve state with no active duty installation in the state. The closest active duty installations are over five hours travel from anywhere in the state. As we all know, the reserve component's role since 9/11 has transformed from a strategic reserve force to an operational reserve force. This transformation has led to greater frequency in mobilizations and deployments since 2001.

Early in the mobilization process of our very first deployments after September 11th, the Vermont National Guard recognized that Soldiers and Airmen deserved

the very best post-deployment support available. As Operation Enduring Freedom and Operation Iraqi Freedom continued, it became increasingly apparent that Post Traumatic Stress Disorder was developing into a significant issue. While the many degrees of this affliction were diagnosed in some soldiers, the in-state infrastructure to match this emerging need had yet to be created. As the Committee knows, National Guard and Reserve servicemembers, particularly in states such as Vermont which are rural and do not have any active duty military installations, can experience challenges with awareness of and access to mental health and other benefits when they return from deployment. In 2005, the State of Vermont recognized the need for greater assistance for National Guard Soldiers and their families, which led to the legislature allocating $250,000. These funds were used to establish the first ever, sharing agreement between the VA and the Vermont National Guard. This agreement allowed the VA to screen and treat veterans outside their eligibility window and more importantly provide mental health counseling for the family members of our OIF and OEF veterans. This paradigm shift has produced amazing results for the veteran and his or her family and strengthened the ties between the Vermont National Guard and the VA.

Seeing a continued and growing need for mental health services for veterans and their families, the Vermont National Guard, in partnership with the Department of Veterans Affairs Medical Center in White River Junction, Vermont, our Congressional delegation, and other state stakeholders designed an innovative outreach, readjustment, and reintegration program targeted at returning Iraq and Afghanistan veterans and their families throughout the State of Vermont.

This program, which was started in 2007 with $1 million in Federal funding, employs trained outreach specialists, a majority of which are combat veterans, to reach out directly to returning OEF/OIF servicemembers and their families to ensure that they are receiving the medical, mental health, and other assistance that they may need. That may mean assistance with general health problems; TBI screening and treatment; mental health, marriage, and/or financial counseling; employment issues; services for children; and substance abuse awareness and treatment or other areas. One of the main goals of the program is to personally contact each and every one of these veterans to check in on them and connect them to relevant services.

In order to develop the goals for the outreach program the Vermont National Guard stakeholders (Family Readiness Leadership, Chaplains, State Medical Command representatives, and the United States Property and Fiscal Office in Vermont) and VA officials from the White River Junction Medical Facility met to discuss existing services in the state on the Federal and local level and how Congressional resources could be used most effectively to provide servicemembers and their families with the best care possible.

Up to this time, Vermont has lost eleven Guardsmen; nine in Iraq, one in Kuwait and one in Afghanistan. In addition, another sixteen Soldiers and Marines with Vermont-related connections were killed in action. This number continued to elevate Vermont into the unfortunate circumstance of having the highest per capita casualty rate in the Iraq war. This cumulative loss and the effect it had on several deployments, especially Task Force Saber (Ar Ramadi, Iraq, June 2005–June 2006), became a driving force to develop a robust program focused on helping returning soldiers with PTSD, other mental health conditions, TBI and other needs.

The Vermont Veterans and Family Outreach Program first launched in January 2007. Its goal was to "construct a Vermont National Guard managed outreach program, developed and sustained to help identify and refer Service Members and their families to appropriate clinical care to serve their readjustment needs."

More specifically the first phase of the program included:

- Interviewing, hiring, and training five Outreach Specialists and one supervisor in skills to contact post-deployed Reservists and their families, ascertain their individual health situation, and then refer them to qualified clinical and pastoral help as needed;
- Entering into a sharing agreement with the VA to use DOD dollars to pay for VA care for servicemembers and their families; and
- Resources were also used to reimburse outreach specialists who drove servicemembers to VA facilities to get clinical help.

The program was designed so that each of the five outreach specialists worked out of five existing Vermont National Guard Family Assistance Centers (FACs) in five different areas of the state where there was significant in-state Guard membership. Linking our work with the Guard's Family Assistance Centers made sense for a number of reasons:

• The new outreach staff was able to capitalize on the existing networks used by the FAC Specialists which gave them immediate access to servicemembers and their families that had strong and trusted relationships with the FAC staff;

• We leveraged the resources of the Family Assistance Centers allowing us to use Federal dollars more efficiently by reducing the need for new office space; and

• Referrals to the Outreach Program came through the FACs by concerned family members, employers, and commanders. Conversely, family related issues identified during Outreach Specialist/Soldier discussions were given to the FACs for immediate attention.

This full "wrap-around" method continues to work extremely well. The program began in earnest in the late spring of 2007 with Outreach Team members traveling around the state to conduct direct outreach to veterans.

At the same time that this Outreach Team was working across the state, Federal resources were also used to fulfill the Adjutant General's and the Outreach Program's goal to help all soldiers suffering from mental health difficulties. The resources were used to enter into a sharing agreement with the VA, allowing them to hire two additional qualified and certified clinicians serving under the supervision of the Mental Health Services Director at the White River Junction VA Medical Center. In addition, $259,000 was shared with the VA to support the clinical mental health outreach throughout Vermont. These services included basic and advanced mental health services for our servicemembers and their families.

We also realized early on, the strong need to track our work so that we could follow the trends in the health or other challenges our returning servicemembers and their families were experiencing, and to evaluate and improve our efforts. Initially a simple survey was developed to capture basic solder data such as name, age, and gender. In addition, among other questions, each respondent was asked to answer which deployment they were on, which Component they deployed with, length of tour, and whether or not they were receiving any disability benefits. This initial survey has been revised twice with the assistance of the Mental Health Services Director of the VA Medical Center and a copy is included as an attachment to this testimony. Subsequently, in concert with the VA we also introduced a TBI survey that has greatly improved our efficiency at determining those veterans who require a more formal TBI screening.

The program has set as its goal contacting all OEF/OIF Reserve Soldiers, Airmen, Sailors, and Marines in the state. To do this we used a number of different strategies for reaching out to these servicemembers. Each Reserve Center in Vermont was contacted with information about the Outreach program and its features were explained to unit commanders. Additional help came from the State of Vermont's Office of Veterans' Affairs, which had Reserve soldier contact information not available to the National Guard. Information from the Department of Defense Form 214 was shared with the Guard and that proved immensely useful in figuring out how to contact these servicemembers. In addition, the Outreach Team placed information about the program at each rest stop on Interstate Highways 89 and 91. These highly visible posters resulted in some of the first referrals to the program.

I also want to highlight the importance of using combat veterans as Outreach Team members and focusing on direct person-to-person or peer outreach. Our program has observed that using fellow veterans helped allay anxiety some soldiers felt when first contacted. Two of the team members are OIF Task Force Saber veterans, further strengthening ties to servicemembers from this deployment. All of our Outreach specialists focused on ensuring veterans were receiving benefits including early diagnosis and treatment of PTSD and TBI, and also assuring that mental health counseling could be extended to family members, and that as much as possible treatment could take place in the communities where the veterans lived.

In doing this detailed oriented work our staff have observed that making personal contact with veterans is a time intensive process. When we list a servicemember as being "contacted," that means that we have actually opened a case with the individual and made a serious attempt at completing a survey with them. For many cases, this is just the first phase of work. Often, after establishing a relationship with a contacted Veteran, referral to the VA takes place. In many cases the Outreach Specialist drives the servicemember to the White River Junction VA Medical Center, or the CBOC clinic in Colchester, Vermont, for their first couple of visits. While this "windshield time" reduced the time available to contact other veterans, Outreach Team members have noted that this drive time is, in reality, a short decompression period for the servicemember. This time helps many soldiers prior to their arrival at either of the two VA facilities. Faced with the decision between helping a soldier right in front of them and those yet to be contacted, the Outreach Specialist always tends to the more immediate need. The person-to-person time spent

by our Outreach Specialists with each individual servicemember and/or their family is a very important component of the program.

In order to make sure that our Outreach staff was of the highest quality we also spent a significant amount of time in training so as to ensure professionalism on the job. Training opportunities were explored, designed, and scheduled using existing VA and State Department of Human Services expertise. Each team member went through a series of VA benefit classes so as to best understand the system they were bringing referrals to. In addition, each Outreach Specialist graduated from a Critical Incident Stress Management (CISM) course taught by the International Critical Incident Stress Foundation. This coursework included "what-if" scenario training and dovetailed well with additional training on anger management, sexual assault, active listening skill development, suicide prevention, and reintegration coping skills.

Towards the end of 2007 the Vermont Congressional delegation secured follow-on year resources of $3 million to continue the program. In order to make sure the resources were used most effectively, Senator Sanders convened a meeting of the Vermont veteran and military community stakeholders (including the Vermont National Guard and Federal and state VA leadership) to discuss the lessons learned from the first year of the program and establish how the new resources could best be used to strengthen and expand the program.

Beyond continuing the existing program the stakeholders agreed to:

- Deliver a joint letter from the Adjutant General and the Director of the White River Junction VA Medical Center to all returning Vermont veterans letting them and their families know about the program;
- Craft a series of public service announcements about the program;
- Create a 24-hour 1–800 number staffed by Vermont National Guard Veterans and Family Outreach personnel that servicemembers and families could access for immediate information;
- Enhance VA services for servicemembers and families;
- Hire more outreach workers to extend the reach and coverage area of our program;
- Provide expanded mental health services to treat Post Traumatic Stress Disorder and other health issues;
- Screen servicemembers for possible Traumatic Brain Injuries that have gone undetected or untreated; and
- Produce more publications for posting, mailing and delivery to increase awareness of the program.

We are currently implementing all of these initiatives.

In the last number of years, many states including Minnesota, Maryland, Missouri, Montana, Maine, New Hampshire, and California have developed a wide range of innovative programs to help servicemembers transition back home. Each of these programs has important lessons to offer that other states can learn from and use as appropriate to their state and military population. We believe that Vermont's outreach program's strength is its use of mostly veteran outreach specialists to focus on personally meeting soldiers on their "own turf" where anecdotal evidence suggests they are much more prone to reveal the challenges they are experiencing in their lives than if they were being interviewed at a military facility or in a group setting. Our program also does a strong job of leveraging the resources of entities in the state that already provide important services for our servicemembers, especially the Vermont Department of Veterans Affairs. We have formed a strong partnership with the Federal VA in Vermont and have used DOD resources to enhance the VA's ability to provide care to our servicemembers and their families. We also have strong partnerships with public, private, and non-profit stakeholders in our state through our Military, Family, and Community Network.

Since 2007, there has been a great deal of attention on the national level regarding reintegration programs for the Guard and Reserves, their proper structure, and the amount and source of funding needed to support them. The Vermont National Guard program, as it continues to mature, serves as an example of an effective and cost efficient rural delivery model for other states. As earlier testimony today has discussed, the Department of Defense is now in the process of implementing the new Yellow Ribbon Reintegration Program created in the FY08 Defense Authorization bill. We are pleased that through Senator Sanders' efforts that the Yellow Ribbon program includes a provision based on our Vermont model, which allows Yellow Ribbon to fund outreach initiatives in the various states.

We are proud of the role Vermont took in developing an effective response to the "invisible wounds" suffered by our soldiers, which also impacts their families and communities. We believe this commitment to our veterans is our obligation and an

important way to ensure that they are able to remain a part of the Guard and Reserve while also living a productive and normal life. As you can see from the Power Point slide presentation attached at the end of my testimony, as of 18 July 2008 a total of 977 Vermont Veterans out of approximately 3700 had been contacted and had a case opened for them by our Outreach Specialist. Our goal is to contact each and every OEF/OIF veteran in our state. Of those contacted to date, 93% are male, 7% female and 85% enrolled in the VA for some level of care and assistance. 27% have been referred to the VA after a TBI screening tool was administered; 21% are currently on disability; and 19% are experiencing significant personal issues. Our hope is to continue this work until every servicemember and their family that needs help gets help. Thank you for this opportunity to discuss Vermont's outreach program and I look forward to answering any questions you may have.

Chairman AKAKA. Thank you very much, Colonel Boyd, for your statement.

Now we will hear from Sergeant Meredith.

STATEMENT OF SERGEANT ROY WAYNE MEREDITH, TEAM LEADER, 1/158 CALVARY, MARYLAND ARMY NATIONAL GUARD

Sergeant MEREDITH. Chairman Akaka and distinguished Members of the Committee, thank you for the opportunity to speak with you today regarding my experience with the VA's post-deployment outreach program.

Having served two tours of duty in Iraq over the last 3 years, my testimony will reflect my personal experience, and does not necessarily reflect the views of the Army, the Department of Defense, or the Administration. However, I am grateful for this opportunity to speak.

Mr. Chairman, I would qualify my testimony by first stating that, when I returned from Iraq in 2005, a formal reintegration such as the program we have now did not exist.

When I returned to Fort Stewart, Georgia, I underwent some briefs from military personnel. The experienced counselors we have from the VA today were not at my reintegration training then. I was given some pamphlets and told to report to my local VA clinic if anything was wrong with me. I was told I could follow up for treatment for my wounds, but military staff thought everything that could be done for me was already done.

I still was given an in-the-line-of-duty entry in my medical records. This means I can walk in and should not have to worry about processing a claim or restarting treatment. The doctors in any VA hospital or military hospital should be able to access my records and do a continuation of treatment for me at no cost because my injury was in the line of duty.

However, when I reported to the VA clinic at Perry Point, Maryland, to receive follow-up care from battle injuries caused by an improvised explosive device while patrolling Samarra, Iraq, the VA tried to say my treatment would not be covered and I would have to pay for my medical expenses.

I was billed, and when I went back for more treatment, I took copies of my medical records from the treatment I received after I was hit on July 30, 2005, on Camp Taji, Iraq. Even when I showed them my medical records, the VA still billed me.

Finally, after several months of late notices and collection letters, the VA backed off and paid for the treatment and apologized for the way my case was handled. I had to file a claim in order not to be charged for treatment. This was a very stressful time upon

my family, myself; and was rectified only because a social worker heard what I was going through and immediately started to help me. This was the first time any VA representative tried to explain my benefits associated with my 2005 tour.

Comparatively, Mr. Chairman, after returning from Operation Iraqi Freedom in 2008, I was pleasantly surprised at the maturity of the post-deployment process being implemented by the State of Maryland. Sir, there are a number of areas in which my second experience was much better.

First, there was a program outlining three phases of reintegration training—30 days, 60 days, and 90 days after returning home from my deployment. My family could participate in every phase, and to make it easier on us, the State of Maryland paid for hotel rooms for us over the course of the training. Having our wives or significant others interact was a huge success, and helped make the homecoming much easier.

The VA had experienced counselors and claims workers at our disposal. They actually had two supervisors who gave a very informative class on how to file for claims, apply for benefits, guidance on seeking medical care; and not only did they give out many forms of literature about the VA, but also gave me their cards with all their contact information on it. I received email addresses, clinics, and hospital addresses countrywide; office faxes, office phone numbers, and even personal cell phone numbers of theirs, in case I needed to talk to them. I have also had these supervisors call me to see how I was coming along.

There was also a fourth phase which consisted of a follow-up at the VA hospital in Baltimore, Maryland. This has helped me a great deal, for I had a head injury from this tour, and the doctors have already set up appointments for me to be reevaluated for this recent injury, but also to recheck my previous injuries from my last tour, as well.

Mr. Chairman, I would like to say as a Gulf War vet, and a two-time Iraqi Freedom vet, and the father of a Marine—my son, Mike, who has a combat tour in Iraq, as well—that I am not only concerned for myself and my troops, but am concerned for my children, as they one day will need the VA. And as a father, I want the best treatment for my children, and will help the VA to improve the care of our warriors.

That being said, the difference in where we are today compared to where we were during my first two deployments is a 180-degree difference in the quality of care given to those of us who have answered the call to defend our Nation.

No longer do I wonder if I will be taken care of by my nation for wounds both seen and unseen, but rather I feel confident that I may be treated with respect and dignity that befits a proud warrior who is grateful to serve and will so again stand up and put my heart, body, and soul to the test.

I humbly thank you once again for the opportunity to speak here today, and I look forward to answering any questions that you may have.

[The prepared statement of Sergeant Meredith follows:]

PREPARED STATEMENT OF SERGEANT ROY W. MEREDITH, TEAM LEADER, MARYLAND ARMY NATIONAL GUARD

Chairman Akaka, Senator Burr and distinguished Members of the Committee, thank you for the opportunity to speak with you today. I am grateful for the chance to testify regarding my experience with post-deployment outreach to members of the National Guard and Reserve.

My testimony today reflects my personal views and does not necessarily reflect the views of the Army, the Department of Defense, or the Administration.

I come before this Committee as a proud soldier; proud of the support we have received from our elected and military leaders. I also come before you as a soldier concerned about the welfare and post-deployment services of members of my team and others throughout this country. There is no country better or more capable of matching our country's ability to efficiently and effectively mass a large number of soldiers, sailors, airman, and equipment and deploy anywhere in world to protect, defend and secure peace. Equally so, is our ability to bring everyone home.

As a member of the Reserve Component, my access to medical services is not the same as that of a member of the active duty. As some individuals are now completing their second, in some cases third tours of duty, it is extremely important that the level of emphasis given toward deployment of forces; also be placed on providing post-deployment support. The goal should include a well defined process which facilitates the transition from a military service to civilian life with the intent of identifying medical and emotional conditions to support follow-on medical requirements. I must say, there has been a significant improvement between the procedures and services received after returning from my second in 2007 and my most recent return from Iraq in March of this year.

POST-DEPLOYMENT HEALTH ASSESSMENT

The first opportunity to address the medical needs of returning soldiers is during the Post-Deployment Health Assessment (PDHA). From January 2005 through January 2006, I was deployed in support of Operation Iraqi Freedom (OIF) and deployed again in June 2007 through March 2008. After each deployment, I had to undergo a PDHA. The timing of the PDHA during the demobilization process is perfect; where the soldiers remain in a formal and controlled status. The PDHA provides an early opportunity to assess the physical condition of soldiers. This is great because the goal should be to identify and capture any condition as soon as possible. However, unlike the pre-mobilization physical assessment, the PDHA is not a complete physical but based on self identification of ailments. I think it would be proper and re-assuring to soldiers if members received a similar level of assessment as the pre-mobilization. Second, based on my experience, the information captured in the PDHA should somehow be connected to the claims process. During my second deployment I received several injuries to include shrapnel which is still embedded in my right arm. This information was well documented and identified during the PDHA. However, my Post-Deployment Health Reassessment (PDHRA) stage, after receiving medical care from the local veterans hospital, I received a bill and was told I had to file a claim. The PDHA should be a seamlessly connected to post mobilization medical services.

POST-DEPLOYMENT HEALTH REASSESSMENT

Along with being seamless connection to medical care, the Post-Deployment Heath Reassessment (PDHRA) lacks one of the key strengths that support an effective PDHA; control and access to the soldiers. From what I have seen, as soldiers return to their homes, it is difficult to communicate and require them to attend PDHRA events. I think the primary reason for this breakdown relates to the fact that members are not provided military orders requiring them to report. As individuals began to assimilate into their normal lives and return and/or to work, competing requirements will overshadow the PDHRA without proper directives requiring member to report to duty. In my opinion, providing members with military orders prior to finalizing demobilization could improve the effectiveness of PDHRA.

Since my first deployment to Iraq in 2006, the reintegration program has made strides but there are a number of areas in which the program can be improved. As Team Leader, it is my additional duty to manage and insure soldiers participate in the reintegration process. To be effective there needs to be a formal and defined program with proper oversight at the state level. A formal program will ensure soldiers, regardless of which state they may live, receives services and medical treatment. Additionally, soldiers should be allowed to receive treatment and services at the local level without requiring them to travel unnecessary distances.

Mr. Chairman, thanks for this opportunity to come before your Committee. I look forward to your questions.

Chairman AKAKA. Thank you very much, Sergeant Meredith.

Our final witness, Major Rasmussen, will be testifying on the unique challenges confronting Reservists.

Will you please begin.

STATEMENT OF MAJOR CYNTHIA RASMUSSEN, RN, MSN, CANP, COMBAT OPERATIONAL STRESS CONTROL OFFICER, 88th REGIONAL READINESS COMMAND, SURGEON'S OFFICE, FT. SNELLING, MN

Major RASMUSSEN. Thank you, Chairman Akaka, distinguished Members of this Committee, and all others attending. Thank you for the opportunity to talk today on behalf of servicemembers, veterans, and their families who are experiencing reintegration or coming home from deployment.

My testimony today reflects my personal views, and does not necessarily reflect the views of the Army, Department of Defense, or the Administration. I have submitted testimony for the record.

I would like to specifically thank James Monroe, Vietnam veteran Chaplain of the Boston VA for some of the materials and information that you are going to hear today.

I am a mobilized Reserve soldier, and I feel a little bit like the only one here. I am a psychiatric nurse and an adult nurse practitioner; and I am on military leave from the VA.

I have had the honor of working with hundreds of servicemembers, families, and community members, including from the Canadian Army during my 3½ years as a combat stress officer mobilized for the 88th Regional Readiness Command, which is an Army Reserve Command of six States. When we started this program 5 years ago, we served 26,000 servicemembers and their families in six States.

So, needless to say, it is a little bit different. We work with the Guard in every State, because we could not do it without them. But, our challenges, even for the Reserves, are a little bit different than for the Guard.

I am honored to have the opportunity to share with you their stories of what it is like for a warrior, especially Guard and Reserve soldiers, to come home.

Warrior skills, what we learn in the uniform, are not the skills that work when we take the uniform off. The military is a culture of its own. As you can see, we dress differently, we talk differently, we eat differently, sometimes we eat dirt differently, and may I introduce you to some of these skills.

We are mission-oriented. Once a mission is assigned, unrelated tasks are unimportant. And if I may share, as we talked earlier before we came up here, he mentioned, "ma'am, that is like the most important thing. Everywhere I go, people do not understand, we need to get it done right now. We need to—you know. It is very frustrating," which is what we talk about.

Decisions need to be quick, clear, and accurate or someone could get hurt; the mission would not be completed and somebody could get hurt.

Multiple competing tasks, when the servicemember gets home, cause confusion. We do not know how to think that way. We know how to be mission-oriented. We receive an op order, it tells us who, what, when, where, why, and how, basically. We do not get op orders when we get home 5 days after when we take the uniform off.

Owen Rice, who is a Hennepin County Sheriff Deputy in Hennepin County Jail, has been to Iraq, got a Traumatic Brain Injury in Iraq. He says, "Ma'am, it is like this. One person talks in the military and everyone else listens. When you get home, everyone talks, everyone listens, and nobody hears."

What I hear from soldiers across the country, servicemembers across the country is, "Ma'am, it is too chaotic here. Please send me back where I know how to survive, I know how to function. I know how to do that."

Safety and trust. When you are in a combat zone or in a uniform for a long time, vigilance pays off. You learn to never relax. You assume everyone is the enemy. You learn to be suspicious of everyone and everything, including children, family members, animals on the side of the road, boxes, bridges, et cetera.

So, what does that look like when you get home and try to take the uniform off? You avoid getting involved, because you are still suspicious. You still do not trust anyone, including your family and friends. They need to earn your trust, but they do not understand this. So, what happens? You test people to earn their trust. You are always on guard. You become isolative. You become suspicious of others.

My Command Sergeant Major lost his son in Iraq after he spent a year there. We went out to dinner one evening with him and his wife, my husband, who is a Vietnam-era Navy vet, and some other vets. We could not find a wall big enough in a restaurant for all of the vets to sit against the wall so that they could monitor everyone that came in and out.

The NCO who works with me is on mobilization with me right now. He does Operation Purple Camp in the six States. A few weeks ago, he spent a long time with the kids at Operation Purple Camp, and the comments—he sent me many comments. One he sent to me that was really poignant came from an 8-year-old boy who said to him, "You know, my dad, he used to do everything with me. He used to take me golfing, he used to take me fishing. Now, my dad does not do anything with me." I thought that was amazing.

Emotions and anger. In war, we control our emotions. Obviously, you would not want your warriors having their emotions out in the open anywhere, plus, we cannot accomplish a mission if we have different emotions going on. We numb out.

Anger is useful. Anger is not only useful, anger is an awesome emotion. We want anger. We like anger. We encourage it because it is the fight-or-flight response. It makes your body, your mind, and everything about you be the best you can be and accomplish the mission that you need to accomplish. We encourage it. We live that way. We like to live that way.

But guess what? When the uniform comes off, the anger that you have learned in practice and felt good about does not go away.

It looks like this: Not talking about your emotions and being angry in war is a strength. It only leads to—you cannot talk about your emotions at home, which is considered a weakness.

We look insensitive to others when we get home. It is not that we are insensitive; it is that we have not practiced those emotions for a long time. Emotions take practice.

We have a decreased ability to read other people's emotions, not because we do not care, not because we are cold-hearted warriors, but because we have not practiced that for a long time. This can lead to increased irritability and defensiveness, because if your spouse, your mom, dad, or someone else in your family accuses you of not caring anymore or not showing emotion, we are not going to say, oh, yes, you are right. Thank you. I am sorry I was unable to articulate that. Instead, we are going to say, what are you talking about? That is not true. We are going to get defensive, as all of us would if someone said that to us.

It leads to increased alcohol and drug use to cover up our emotions. You know why? Not because we are warriors and we learn to do that. It is more socially acceptable in our society to go to the bar and have a few drinks or sit home and slam down a case of beer with your friends or buddies than it is to raise your hand and say, I need help. I need medication. I need to talk to someone. Not just in the military, but across the board.

In our program, we work with all branches of the service and many VA and civilian organizations across the country. Despite this amazing comprehensive program, servicemembers and families are still falling through the cracks.

I had the honor and opportunity to speak to 150 Purple Heart National Service Officers at their training in Phoenix a few months ago. I received this note, handwritten, put it in my pocket, and went back to the hotel room, and it read:

"Ma'am, for the last 3 years I have been treated for PTSD by doctors, nurses, and others that have no clue over what it is being a soldier and have this feeling inside"—this is a quote, by the way—"I cannot thank you enough for coming today. In the last 2 hours, you have done what nobody could have done. You make me feel normal again. That is a feeling that I thought I would never feel again since I was discharged from the Army. Thank you and God bless."

This was an Operation Iraqi Freedom vet from Puerto Rico, approximately 24 years old.

One final point I want to make: Not all issues with servicemembers are about PTSD. We need to deal with the combat stress, the operational stress, the things I just talked about that are normal habits for all servicemembers.

When I spoke to the purple heart recipients, a World War II vet raised his hand and started sobbing and said, "Where were you when I came home?"

I had a Korean war wife say to me last week at the Battle Creek VA, "If you would have been around 40 years ago, I would not be divorced from my husband who is a Korean vet, because now I understand why we had all the problems we had."

This is not PTSD, this is a warrior taking his uniform off and trying to come home. We have operational stress. We have grief

issues. We have lost a year or more in whatever life it was we thought we were going to have. We have depression. We have anger issues. We have PTSD. We have all kinds of issues. Please, please, please stop just calling it PTSD, because I do not want to be called PTSD. I want to be called a combat vet with some issues coming home. Thank you.

And may I end with this quote from General Colin Powell:

"The day soldiers stop bringing you their problems is the day you have stopped leading them. They have either lost confidence that you cannot help them, or concluded that you do not care. Either case is a failure of leadership."

Thank you for the attention to this very important topic. Thank you for giving the opportunity to me to answer the call to bring their stories to you, and I welcome any questions from the Committee.

[The prepared statement of Major Rasmussen follows:]

PREPARED STATEMENT OF MAJOR CYNTHIA M. RASMUSSEN, RN, MSN, CANP, COMBAT STRESS OFFICER, SEXUAL ASSAULT RESPONSE COORDINATOR, 88TH REGIONAL READINESS COMMAND

My Testimony today reflects my personal views and does not necessarily reflect the views of the Army, the Department of the Army, the Department of Defense or the Administration.

Chairman Akaka, Senator Burr, and Distinguished Members of this Committee, and all others attending, thank you for the opportunity to talk today on behalf of Servicemembers, Veterans and their families who are experiencing Reintegration, or, coming home from Deployment. I welcome any questions from this panel to fully detail what we offer.

I have been mobilized for 3 years as a member of the Combat Stress Control Team at the 88th Regional Readiness Command (RRC). Following the end of my tour, I will return to my civilian position at the Minneapolis Veterans' Administration facility. The 88th is the Army Reserve Command for Servicemembers in six Midwestern states (Minnesota, Wisconsin, Michigan, Ohio, Indiana, and Illinois).

Shortly after 9/11, the RRC mobilized LTC Susan Whiteaker, a Licensed Clinical Social Worker (LICSW) and LTC Mary Erickson, Occupational Therapist (OT). They organized this team to care for the mental health needs of the Servicemembers and Families in the region during the entire deployment cycle to include Reintegration. Our comprehensive program has served thousands of Servicemembers, Commanders, Family members, Employers and Communities through education, support, crisis intervention, and referrals.

The 88th RRC Surgeon's Office Combat Operational Stress Control (COSC) Team provides a comprehensive program of education, assessment, brief intervention and referral to meet the behavioral health needs of Soldiers, Families, and the community.

Mild Traumatic Brain Injury (mTBI)/Post Traumatic Stress Disorder (PTSD) are the signature injuries of the campaigns in Iraq and Afghanistan. Most programs, while well constructed and resourced, are passive in nature. This requires the injured Servicemember, or his/her Family, to not only recognize the problem, but also to figure out where to seek help, and to gain the knowledge to fight through the red tape to get the help they need. Since 2003, the 88th RRC has a very effective program in place that helps its units, Soldiers, and Families, removing a good portion of the administrative, medical, and financial burden these injuries can cause.

Education begins before a Soldier is deployed, with a variety of briefings that establish rapport between the command and the Soldiers' families. It is critical they know there is a place they can go to for assistance, answers, and counseling. The education and support network continue throughout the mobilization processing, the actual deployment, and following deployment.

The period following deployment is critical. The majority of Reserve Component (RC) Soldiers just want to go home. They are not thinking too much about what occurred in the previous twelve to fifteen months, they think they can "forget it." That is what makes the Post Deployment Health Assessment (within six months of their return) invaluable.

Our various programs have made leaps and strides in terms of delivery of care and resources. In 2005 alone, grief seminars for families were initiated and conducted. We received a $10,000 Health Promotions Programs Incorporated (HPPI) grant from the U.S. Army Center for Health Promotion and Preventive Medicine (CHPPM) for Soldier/Family Wellness Programs throughout the Command. We reached out to our National Guard partners to assist in Anger Management classes and other training for redeploying units, to name just a few accomplishments.

Our successes continued into 2008 including providing numerous Mental Health First Responder courses, our continuing to provide reintegration education and support for Veterans' Affairs staff throughout the country, and received numerous awards for our various programs and efforts.

There are several recommendations resulting from our work. Customer care must be a number one priority. Success depends on inter-service, joint programming across all government and civilian organizations that have a stake in the health of the Servicemembers and Families. All of us need to enhance the whole Family system, ensuring the entire Soldier Family is taken care of and heard. Staffs across the medical spectrum who work with Servicemembers and Veterans must be culturally competent. They need to understand the Warrior mindset and how that translates into Warriors as civilians and consumers and be able to design care based on their unique needs. From this, it should be understood that the same personnel in the spectrum must be held accountable for abuse and/or inappropriate behavior toward a Servicemember or Veteran.

We recognize the need to work hand-in-hand with the Department of Defense to provide "seamless transition" care for all Servicemembers/Veterans and Families, not just those who are seriously wounded. Medical providers must be able to recognize, articulate and care for the Servicemember with Combat Operational Stress Reaction before the sequences of events results in serious life-altering consequences. Veterans have multiple and complex issues. Our legacy systems of "stovepipe care" are out-dated and ineffective. If the Servicemembers are Reserve Soldiers or Guard Members, include their commands and battle buddies, wingmen, shipmates, and so on, in their care. All of us need to recognize that reintegration issues are a part of the challenge of caring for Veterans and Families.

Again, I thank this Committee for the opportunity to explain, in part, what we're doing at the "Blue Devils" Command, the 88th RRC, and our efforts at reaching across component and service lines to ensure no one is "lost" because of negligence or inattention.

Chairman AKAKA. Thank you very much, Major Rasmussen.

Your dedication to the needs of returning servicemembers from your statements, also, is amazing. Your tremendous enthusiasm for your work—I have got to say, it shows.

Major RASMUSSEN. Thank you.

Chairman AKAKA. Without giving us a name, can you tell us about one of your most challenging cases? You have mentioned some, but your most challenging case, and what was specifically done to make a veteran as whole as possibility.

Major RASMUSSEN. Absolutely, sir. I could tell hundreds of them, but—and I can also tell you a name.

Chairman AKAKA. Just one.

[Laughter.]

Major RASMUSSEN. OK. You can tell I like to talk. Sorry.

OK. This is an Army Reservist—I received a call from a VA social worker. The VA social worker stated to me, ma'am, you need to help this servicemember. It turns out this servicemember, still an Army Reserves soldier, also a vet, with DD–213, 30 percent blind from a fuel IED, could not work.

At the time that I received the call, I immediately called this servicemember and found out that they were at the door to repossess his vehicle. A week later his house was going to be taken away from him. He was self-medicating with alcohol and because of that, his wife and four children had moved out of the house.

What happened then—he owed $16,000 on his vehicle, as well as his house and other bills through the VA, because he did not realize that he did not have to pay his bills at the VA. It turned out, after requesting a meeting with the VA team and working very closely with the servicemember and his unit—his military unit and Reserve unit—they were awesome. I mean, they were right on it every time we ever needed anything. This soldier had TBI, PTSD, serious blindness, pain, grief, and significant family issues.

What we did was we pulled together VA staff, Vet Center staff, luckily we called a Congressperson's aide, and within a few days—as well as the family assistance center from the National Guard and some other funds that are available that, luckily, after you do this a while, you will learn what is available—we pulled together $16,000 in less than a week to be able to pay off all his bills so that at least that was one stress off of his life.

Let's see. The main issues that still continue after quite a while are that his family—him and his family—are back together and they are doing better, but they have had no counseling; or his wife has not been taught yet at all about working with Traumatic Brain Injury or PTSD because he was in an alcohol and drug track. So they were not—there was not a concerted effort to make sure that all of the issues that he had were being focused on at the same time.

Chairman AKAKA. Thank you very much for that.

As you notice, we have all of you here from West Virginia, Vermont, Maryland, and Minnesota. We were looking at the issue from across the country.

I have one question to ask all of you. You can make it brief. This question is for the entire panel. It is clear that, if we cannot reach veterans, their needs will go unmet, without question. What can VA do to improve the effectiveness of its outreach efforts, especially for Guard and Reserve, whose experience is so different from those in active duty? Nothing is off the table, and what we are trying to do here is we are looking for creative solutions.

So, I am asking you, what can VA do to improve the effectiveness of its outreach efforts?

Let me start with Dr. Scotti.

Mr. SCOTTI. I have a number of ideas, and I have already heard former panelists mention doing more through the media to advertise these services, and I am interested in the video that the Colonel has in terms of demonstrating that these are the types of problems.

So, I think it is very important to have actual veterans with actual difficulties to talk about their actual lives and the help that is available to them. That has been shown in many other fields to be very effective in getting people in for treatment.

I am glad that the post-deployment health measures are being used. The question was raised earlier about how long that should continue. I will conservatively say 10 years. Mental health problems wax and wane. People come back and are overwhelmed. It is not just PTSD. Major Rasmussen is right, we should not just focus on that issue. There are a whole range of problems, and we need to evaluate, and reevaluate, and reevaluate. I would like to do it for the rest of their lives.

The problem with these post-deployment forms, the information goes into a computer. Some program somewhere pulls that name, it may not get back to where they are stationed, and there may not be resources to pull that veteran aside and address their issues.

So, assessment and screening is one thing, getting that to the point of actively getting treatments for the veteran is a whole different issue. It needs to trickle down and it needs to do so immediately.

Also, the Vet Centers are an excellent place for outreach, and I am very proud to have worked at the Morgantown Vet Center in West Virginia that has been awarded the best Vet Center in the Nation three times. And they do a tremendous job, but they are incredibly overwhelmed. They will not tell you this, but when I go there and there is a room full of fifty veterans and one counselor and they are calling that group therapy. It is not. They need more help, they need more outreach. They are still overwhelmed with Vietnam veterans, Desert Storm veterans are coming in now at a greater rate, and we still have Korea and World War II veterans coming out of the woodwork.

The focus at the Vet Center and the VA is not on OEF/OIF and other conflicts, as they are still dealing with many other prior conflicts, and new cases all the time. So, we need all this outreach and we need greater resources, and we need to get those measures back to the hands of the people who are going to do something to help the veteran.

Chairman AKAKA. Thank you, Dr. Scotti.

Colonel Livingston.

Colonel LIVINGSTON. Mr. Chairman. I guess for the VA, and using the Fort Harrison VA as a model, is that, do not be "active duty-centric" in the standpoint that Montana, too, only has one active duty facility, that is Malmstrom Air Force Base, 90 miles from the VA hospital.

Partner with your National Guard and with your Reserve. But specifically, the National Guard; you can leverage the State relationship also. What Governor Schweitzer and the State officials did for the Montana National Guard was phenomenal. And the VA, partnering with the National Guard, ran public service announcements that we were able to put out there, that leveraged money of the State, leveraged money from the feds. It was—it is, today, a great partnership. I think we have a great team with the VA Administration that is on the same fort that we are located. The Director was part of our task force, and I think it is just very active. So, that would be my encouragement—again, it sounds National Guard-centric—that is not what I am saying here. But take a look at your National Guard, because that Adjutant General connects to a Governor, and a Governor is more than willing to leverage, I believe, State resources also to help solve this issue.

Chairman AKAKA. Thank you, Colonel Livingston.

Colonel Boyd.

Lieutenant Colonel BOYD. Mr. Chairman, I would concur with Colonel Livingston's comments and add the other piece that, in this modern day, we seem enamored with doing everything electronically. There is something to be said about burning up a little shoe leather and going to find these people.

It is not an excuse to say, well, I sent somebody an email. It really—our experience has been, when you go and knock on a door, 99 times out of 100 that veteran is going to talk to you, and then you are going to find out what is going on. They may not answer the phone call. They may not answer the email. So, there has got be a component of that "shoe leather" patrol, if you will. Thank you.

Chairman AKAKA. Thank you, Colonel Boyd.

Sergeant Meredith.

Sergeant MEREDITH. Yes, sir. One thing that I noticed that I have had trouble as a team leader is getting some of my men to come to some of these reintegration training meetings.

We were not very familiar with the new regulations that have come out April 2nd. We demobed May 20th, I believe it was—or March 20th of this year. So, part of our problem was that we had thought that there was a 90-day window of no training. The majority of us did go to this reintegration training, but there are still a handful that did not go; and we thought that we could not do anything to get them in until after the 90-day window.

In the last several days, I have been given a regulation for the Yellow Ribbon, but we were—we had demobed before and we did not fall underneath of that, from what our reintegration officer and our command knew.

The one way that we could fix people not coming in is to give us orders of the 30 days to 60 days, and then 90 days before we demobe. That way, we know when, where, and what time to report for this reintegration training. And team leaders and the command would be able to say, every one of my men have been accounted for, because each one of them has orders. And if they do not show up, we can actually go to their homes, instead of going through a lengthy process before we are allowed to do that under the authority that we have now. If we all had orders, we could go right down and say, you must come to this training.

So, that would simplify and hold to account my men underneath my command, and that is the single biggest thing, sir. Because as a three-time vet, I know what it is, especially being wounded—of how hard it is to want to come to these kinds of things. When you come home, you just want to get done and let it go, but having orders could make us accountable to come in.

Thank you.

Chairman AKAKA. Thank you, Sergeant.

Major Rasmussen.

Major RASMUSSEN. Thank you. I know this about Guard and Reserve soldiers, but I want to just keep in mind that, when an active duty servicemember ends his tour and gets a DD–214, they may come home to your rural areas alone, also. And some of the—in the past, the suicides that we have seen have been related to that and not to Guard and Reservists.

Anyway, really quickly, success depends on inter-service joint programming across all government and civilian organizations that have a stake in the health of servicemembers and families.

Treat the whole family system. All staff that work with servicemembers and veterans must be culturally competent. You do not have to wear the uniform, but you have to be able to understand

why we do what we do, why we think the way we do, and to not judge that or not avoid it or anything because of it.

Appointments must be made for the convenience of the consumer and not the facility. You need to work hand-in-hand with DOD to provide seamless transition care for all servicemembers, veterans, and families.

VAs need to have good representatives in all Guard and Reserve units. We do have—in most of our Reserve units, we have arranged for Vet Center staff and VA staff to come on our drill weekends to become—to get to know—just to hang out and get to know folks so that when we are done—because we are not going to be in this role much longer—that there will be somebody there they know besides us to call and talk to.

If the servicemembers, our Reservists or Guard soldiers, include their commands and battle buddies, wingmen, shipmates, et cetera, in their care, especially since many of them will be deployed again and need to prepare for this while getting care and support for the current issues.

Thank you very much.

Chairman AKAKA. Thank you very much.

Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

My first question would appear to be hostile but is not. Why is it that everybody but Dr. Scotti had to say, I am speaking personally, not on behalf of the Reserve, the Guard, or the Department of Defense?

I really want to know that. Does that mean that they are afraid that you might tell the truth? Does that mean that they are embarrassed by what you might say, because their culture is that everything always works and always works right? I would like to know why you have to say that.

Colonel LIVINGSTON. Sir, I might be able to address that because my testimony had not been vetted——

Senator ROCKEFELLER. You cannot correct it because you said it.

Colonel LIVINGSTON. Correct.

Senator ROCKEFELLER. You can explain it.

Colonel LIVINGSTON. OK, I can explain it then.

My testimony had not been vetted through DOD.

Senator ROCKEFELLER. Isn't that a very good thing?

Colonel LIVINGSTON. So I was instructed that my testimony had to have——

[Laughter.]

Colonel LIVINGSTON [continuing]. That statement put on it, sir.

Senator ROCKEFELLER. See, I can understand that. I have so many questions I do not even know where to begin.

But I can understand that, if you are from the Department of Transportation, if you have come back from the types of experiences that you have all come back from, your testimony, Major Rasmussen, is probably one of the best I have ever heard here, and I have been on this Committee for 24 years.

But it just breeds a sense of suspicion, not in you, but in them. They have to be right. You did not vet it with them; therefore, you are dangerous. You are telling the truth. You are telling the truth like few people ever do before this Committee.

One of the problems is the fact that when the VA and other people come before the Committee, we know that everything they have said has been vetted, so, there is no real reason for us to listen particularly carefully to them because we know that it is not necessarily what they think.

You are telling us what you think, and therefore you are real. You really help us. This is superb help to us, just at the time that the whole care of veterans has become, along with global warming, one of the two top issues for the entire Congress, because it is like we have suddenly rediscovered you—our own guilt, our own mistake, regardless of who—you know, political party or anything else going back over many years. And there are reasons for that and I will not go into them.

But it annoys me that you have to say that, because it implies that if you did not that you would get in trouble, and that makes me angry. OK. I have got that off my chest. You see, I have got my little thing done.

Dr. Scotti, I got—you know, you say that, in your testimony, that about a third of the addresses are wrong for all veterans. Now, the Veterans Administration is considered the best health care system in the country, which maybe speaks not so well about the rest of our health care system, or maybe it speaks very well about the VA. I will not comment on that. But it is all based upon data, the very thing which some of you question, the very thing which some of you question. Boots on the ground—just do not give me emails.

I would like you to take me through what happens when a veteran comes back. I meet with veterans. And I will take a Sunday afternoon, and I walk in. I do not take off my tie, because I am who I am, and we will meet for 4 hours. They will be mostly from the recent two ongoing wars, but they will be from other wars also. And I am, I think, pretty well thought of by veterans, so they open up more quickly. And the things they tell me are some of the things that you were talking about, Major Rasmussen. That is what educates me. That is what motivates me. That is what makes me want to do more and better. That is why we put $5 billion more into the VA.

Now, we are having to put $5 billion more into the VA—that does not tell you a thing because it is a very large battleship. It has more people working in it than the Pentagon, and it takes a little while to turn things around.

But you know, I do not really know where to begin. Because you have got to get the help. I love this concept of, do not say PTSD.

What is it that you want us to call you? What phrase do you want us to use?

Major RASMUSSEN. Are you asking me that question?

Senator ROCKEFELLER. I am asking.

Major RASMUSSEN. I actually do not have PTSD from combat, sir, but I think it is something that would be appropriate to dialog with those of us that work on a regular basis.

"Combat operational stress responses," or "operational stress responses," for those of us that were not in combat but still had to wear the uniform.

Senator ROCKEFELLER. OK.

Dr. Scotti, you talk about when people come home to their families. And you talk about 43 percent having suggested clinical levels of depression (the dread word), 35 percent have PTSD, and 8 percent of veterans have a high-risk profile suggesting a real possibility of suicide. All that is profoundly complex—if you push the wrong button—stuff.

Some of the veterans I talk with talk with me after an hour or so about going down into their basements and digging a room under their basement, so if it came to the point where they could not handle it, they could go handle it in their own way. People fleeing away.

One of the questions that I think you were hoping I would ask you is about the difference between rural and urban in West Virginia. And I have never been able to figure that out, because we do not have any city over 50,000 people, and they average—I would guess, like in Vermont, except maybe for Burlington—around 8,000.

Mr. SCOTTI. Big cities.

Senator ROCKEFELLER. Yes. [Laughter.]

But how do you dump this on families?

I mean, we have got VA centers scattered all over West Virginia. You know that. And the reason was so—because they did not want to go to the VA centers, because the VA centers of a number of years ago were pretty bad, and they had not very good people running them, and that makes all the difference in the world, and their counselors were not trained—by definition, they could not be trained for what you all have been through; could not be trained. It is a whole new way of fighting a war, and accepting stress and pain and all the dangers that come from that.

But how can you take—how can families, other than being there everyday—how can they really help? I mean, again, like you said, Major, the soldiers I talked to frequently talked about when a 6- or 7-year-old jumped in their lap wanting to be hugged.

And I would say, "So, what did you do?"

"I very gently pushed the child off of me so that I would not hurt that child."

This is not something that families can do. This is not something that even outreach—I mean, outreach to do what? Outreach to get them to go to the VA centers? Well—gas, all the rest of it—I mean, it makes it very, very hard to do. So, what is the pattern? What is the pattern that should be gone through in a State like West Virginia, which has 6,800 Guard and Reserve, many of whom greatly resent the regular military, if I may say that—and that is an issue which I wish we could talk about, because I heard endless amounts of—you know, we are being treated like second-class citizens, et cetera.

But how can you train—how do you train family members?

Mr. SCOTTI. I think you asked and answered all your questions.

Senator ROCKEFELLER. Well, I apologize.

Mr. SCOTTI. You cannot——

Senator ROCKEFELLER. I apologize.

Mr. SCOTTI [continuing]. You cannot train them; and I might say that perhaps you should not train them.

You need to make them aware. You need to work with the families while the veteran is deployed, for two reasons. One, so the veteran knows that their family is being taken care of while they are in a danger zone.

And two, so the family can continue along without someone important, a mother or a father or an aunt or an uncle, grandmother, grandfather, et cetera, someone who they have depended on. You need to provide support services for them.

And while the active duty personnel is gone, we need to educate them on what is likely to be the case—operational stress response sounds like a great term—when they come back.

And be aware, when you gently push the child off of the lap so you do not hurt them, they need to know that that is why that is happening, not to be afraid of daddy, but that is why that is happening. And then, we are going to move on and help get treatment for everybody. It may not be what it is for PTSD, for depression, for substance abuse—there are just general stress issues, et cetera, but it is a whole program of education.

I have been recently talking with the West Virginia National Guard and we had a Governor's conference in West Virginia on returning veterans. We had a Colonel from the Minnesota National Guard come and talk with us about their program, and I am hearing similar things going on with Vermont and Montana. I am going to pick their brains before they leave today. We need to do many things for the service personnel and the family before they leave. We need a comprehensive program while they are gone. We need to make sure that these 30-, 60-, 90-, 180-day, 5-year, 10-year programs are kept up and that everybody—we are on top of what is happening in those families, not just mental health, but physical health, financial health.

I have heard a number of stories where the veteran—the personnel is over in the combat zone. The combat pay is coming home. It is twice the money the family ever had. And by the time they get home, it is not only gone but they are in debt because they are not used to spending that much money. We need financial counseling for the families while they are gone.

Getting people to the centers. West Virginia is just rich with VAs: four VAs, six Vet Centers, multiple CBOCs, and lots of other outreach centers—and it is still hard to get people to show up there. There is a great stigma associated with mental health. People are worried about whether they are going to be able to continue in their jobs or continue in the military if they are diagnosed with Post Traumatic Stress or depression. People also just do not recognize when they have problems, which is why we need this great deal of education.

Again, I would like to reinforce that having these post-deployment assessments is critical. But even more important is that we attend to those data and, you know, the trigger gets back down to the personnel on the ground that something is going on for this particular veteran and they need assistance.

Education is incredibly important at all these levels. We have got to take care of everyone, veterans and families.

Senator ROCKEFELLER. I went way over my time. I apologize to my esteemed colleagues.

Chairman AKAKA. Senator Sanders.

Senator SANDERS. Thank you, Mr. Chairman.

This has been an excellent panel. I think we all recognize that and we appreciate all of the members, all of the panelists, for being here.

Let me start off by asking Colonel Boyd a question. He and I and the Vermont National Guard and the VA have worked together to try to develop what we think is a very good outreach program. One of the beauties of what is going on right now is we are seeing different States doing different things.

So, let me start off by asking Colonel Boyd, what are we doing in Vermont that you think other States can learn from? What are other States doing that you think that we can learn from?

Lieutenant Colonel BOYD. Senator, I think what we are doing very well in Vermont—as you look at the Yellow Ribbon timeline that is laid out in NDAA 2008, the bottom line is—from day 91 on, whether that is 180 days or 10 years, we are doing it everyday with outreach counselors, correction specialists, working with veterans, getting them what they need and following up with them.

What the other States are doing that I think we will improve on here shortly—Minnesota, for example, the 30, 60, 90 is very, very formalized, and they are doing it very, very well. And so, I think that we can learn from them in that aspect.

The other piece that I think we bring to the table is our sharing agreements with the Veterans Administration. The VA, under very limited circumstances, can assist family members. With our sharing agreement, we can bring those kids who are having a hard time with dad or mom's deployment, or the spouse that is having a bout with depression can come into the VA. Because when all the troops are gone from the State, the VA might not be so busy.

In a place like Vermont, you take, 1,500, 1,600, 1,800, 2,000 troops out, you do not have a lot of business. And we thought it was also good, because it wraps around our families, something we did not have.

Senator SANDERS. Let me pick up on Colonel Boyd's question and ask it to Dr. Scotti or anybody else, Major Rasmussen.

I think we all understand that we are talking about family problems, not just the individual. And I think the point that Colonel Boyd has made out in Vermont—we are trying to reach out to wives and kids, as well. And we are trying to develop a new type of relationship between the VA and the National Guard.

Dr. Scotti, is that important?

Mr. SCOTTI. I think that is extremely important.

As has already been commented, the VA traditionally has not dealt with families unless the veteran has requested it, and even then I do not think effectively in my experience. They are just not trained for that.

We need to have that outreach. We need to have more people at the VA who are family specialists. But as I said earlier, I do not think we need the VA to do it all. We have very good mental health systems that are out there that are already extremely well-trained in dealing with child behavior problems, family problems, depression, and substance abuse, and other issues in the spouse that is left behind. I think we should take advantage of that, rather than

just keep growing the VA and keep adding these personnel. The people are out there, and they are very, very, very willing to help.

Senator SANDERS. Major Rasmussen.

Major RASMUSSEN. Is it OK for me to ask a question?

Senator SANDERS. Sure.

Major RASMUSSEN. When you say the Vermont National Guard and the Montana National Guard and the Minnesota National Guard, are you really meaning that all there is—all the soldiers in the State: the Reserve soldiers and active soldiers or veterans that come home? Because I am kind of—that is making me a little nervous, because I know that, as a Reservist—I mean, I work really well with Guards all over the country. I have no problems. You know, we work very well together.

But my concern is that I very often hear from Marines, Navy, active duty, Army——

Senator SANDERS. That is a good question.

Major RASMUSSEN. That I will—I am sorry.

Senator SANDERS. No, that is a very good question, and we try to break down those barriers, as well. And we are reaching out to—Colonel, we are reaching out to active duty people and Marines and people who are not in the National Guard.

Lieutenant Colonel BOYD. That is correct, sir. Those who have come off of active duty, those who have gotten a DD–214 and returned to civilian life, those from the Marine Corps Reserve, Army Reserve, any component—we are not turning anybody away, Senator.

Senator SANDERS. Right.

Lieutenant Colonel BOYD. Regardless of who is funding it.

Senator SANDERS. The bottom line is we are all in this together and we are not trying to distinguish.

Any other comment about the need to reach out to the entire family, above and beyond?

Colonel Livingston.

Colonel LIVINGSTON. Thank you, Senator.

I guess if you would take this and think about what we just talked about. Sometimes we mask it with alcohol or drugs. It was not created by government, but Alcoholics Anonymous, which initially was designed to treat the individual, and in the process they realized they needed an Al-Anon program to heal the family.

I think initially we have been trying to treat the veteran, and now I think we have come to the realization that the family also needs to be treated.

So, whether it is an Al-Anon approach—and that is why, again, in Montana, we felt that it was not just DOD's responsibility, or the VA's responsibility; it was the Montana National Guard's responsibility to take care of our soldiers and airmen and their family and leverage State government, local government, civilian organizations who have stepped forward, including, again, TriWest, who has done a marvelous partnership with us providing behavioral health experts for not only our members but also our families also.

Senator SANDERS. OK. Well, thank you, very, very much.

I am sorry. Sergeant Meredith, did you want to jump in?

Sergeant MEREDITH. Yes, sir. I can speak on this personally.

I am currently going through counseling with my family. We did not choose to go through the VA system because of some of the past problems that we have and the magnitude of soldiers that are going through the VA system. We chose to go another route through the military. It is called Military OneSource. It is a very good program.

It actually—instead of having you travel to a VA center, which sometimes can take several hours, they have found counselors right down the road or within the same city or just a few minutes away, and that has been very, very helpful. And it allows your spouse or significant other to go with you, and your children, and instead of just talking about problems, problems, problems, it is, OK, how is this soldier different? How is your husband different? How is your boyfriend or fiancé different? What is going on? What do you think that you are seeing where he is different, or she is different?

This has been a very good program, and I also encourage my troops to go through this system as well. It is not just for counseling; it is also with jobs and other areas, you know, that we have trouble dealing with once we get back home. Because, from being active duty—you know, when we are getting ready to come out of the system, when I was in the Marine Corps, we had time to go through the system and get ready to come back home, as a rule.

With the Guard, within a matter of a few days, you are done, and you are expected to assimilate right back into the civilian style of life, and it is just not there, sir.

Senator SANDERS. Thank you very much.

Chairman AKAKA. Thank you, Senator Sanders.

I do have other questions for you, but I would like to ask Senator Rockefeller whether you have any further questions.

Senator ROCKEFELLER. About a hundred.

Dr. Scotti, you say—and you are right, because we both come from the same State—that, in West Virginia, on a family assistance program that the Guard has, we have four people taking care of five thousand. That does not work.

Mr. SCOTTI. No, sir.

Senator ROCKEFELLER. So, somewhere there has to be a difference between the soft touch that you indicated, Sergeant, when you can go into, you know, a member of the clergy or somebody downtown who is sympathetic, and the fact that you go with your family allows you to say what is on your mind to another individual who is not a member of your family, but the members of your family are hearing you say it in very real terms so they come to understand you at least a little bit more after you take the uniform off, as the Major said.

Sixty-five percent of veterans turned first to informal supports, and that is terrific and that is natural, because that is who is around you: your family, your friends, your neighbors, this or that. But you are dealing here with some of the most complex physical and mental, psychological, perceived, real, unreal, dreaming, so that you go to sleep next to your wife—and you do go to sleep and you wake up in the middle of the night convinced that this is an Iraqi terrorist with a knife who is about to slash your throat. That is not trivial stuff, and it is not stuff that families can handle. So,

there has to be really professional training, other than if you are just going to say, well, let them talk it out, and it will help.

I mean, when I meet with those veterans, and I do it all the time, I always leave with the feeling that I have—you know, maybe encouraged them a little bit. But then they are immediately let down because I am gone and the professionals are not there.

You said, at one point in your testimony, that 50 percent of veterans in West Virginia never even go to a VA hospital—never even go. So, we can sort of count that one aside.

On your CBOCs and outreach centers and other kinds of things which you and I have both worked on—you know, I am thinking of the one up in Wheeling, with John Looney, a Vietnam vet. It worked like a charm. He is just there—it is something on the street. It is not a big building. It does not have a long driveway. It does not have executive parking places; you have got to find a place on the street; and you just walk in, and you are with friends. That, however, is not the kind of training, it seems to me, that is needed to deal with some of these really severe problems and to individuals who may not have the problems that I just talked about, but the problems that they do have are as real to them as if they were those problems.

So, what do we do about that? Now, we have got a whole bunch of money so we can begin training. But the last I heard, you are a psychologist, right? Well, to become a psychologist, you have to take 7 years after you have finished college. Am I correct about that?

Mr. SCOTTI. I did it in five, but, yes.

Senator ROCKEFELLER. Well, you are smart. [Laughter.]

But I mean, I am just talking about, what are we going to do, because this is here and now? And this is going to go on for a long, long time, this War on Terror.

Mr. SCOTTI. And even if it does not go on for a long, long time, the problems are.

Senator ROCKEFELLER. The problem is——

Mr. SCOTTI. The problems are.

Senator ROCKEFELLER. I agree with you, it is for life. It is all for life.

Mr. SCOTTI. The Vet Centers do a tremendous job in supportive therapy. My experience with people who work in Vet Centers—tremendous care providers—but they are not trained in some of the most empirically supported treatments that are incredibly intensive and individualized.

Group therapy has its purposes and points. It is very important for veterans to be talking about their experiences, but it has to be done in a controlled and safe environment where they feel that they can do that, and where somebody is listening and understanding and is not going to run out of the room screaming when they hear the horror stories. And they are horror stories.

We need to get more people fully trained at many, many levels. In our State, the Council on Churches has developed a program called CARENET: Caring Beyond the Yellow Ribbon. They are trying to train their clergy in how to recognize when members of our congregation are having difficulties—and this is of all sorts—but particularly our returning veterans. And what are the limitations

of what they can do? They know they should not be doing therapy, but they want to know how much they should listen without it going too far and opening up a can of worms that cannot be easily shut.

And the same thing is the problem with large-group therapies or intensive programs that are just about group therapy. I have done many, many years of individual therapy for trauma of all sorts. It is incredibly effective, but it is incredibly intensive and long term. But there is hope. There are people I have treated that I would say have been cured.

Senator ROCKEFELLER. So, what you are basically saying is that, at some point in this process there needs to be a professional who is available; a trained professional in these areas who is available.

Mr. SCOTTI. Yes.

Senator ROCKEFELLER. And you cannot just rely on families. They help——

Mr. SCOTTI. You certainly cannot rely on families.

Senator ROCKEFELLER. But you cannot escape——

Mr. SCOTTI. You do not want the veteran telling the stories that they need to tell to their family. They cannot and they should not.

Senator ROCKEFELLER. Yes.

Mr. SCOTTI. It is not fair to either party.

And we need training at the VA level. We need training in the community. There are not enough community care providers who know how to deal with trauma. And we need training at the level of physicians to recognize when somebody is having mental health problems.

It is fine to go to your local CBOC and get some medical care, but physicians should be able to ask a couple of questions or recognize a couple of signs and say, I think you should see Dr. So-and-so down the hall who is a mental health counselor, to get some initial screening and a contact going there.

You mentioned our family program in West Virginia. We have four staff, two are psychologists. They are not allowed to treat more than three sessions. So, even if that——

Senator ROCKEFELLER. You mean you have three sessions and then that is it?

Mr. SCOTTI. That is it.

Senator ROCKEFELLER. Well——

Mr. SCOTTI. And then vets have to get on elsewhere, if they will go to the VA.

I would also—on a personal soapbox, if I can take a moment to do that—I think in terms of compensation and pension, most of the veterans that I have dealt with over the last 20 years do not apply for compensation for the money. They apply to get the treatment. The money is useful and helpful. They want the treatment, because money does not solve the problems.

And I personally feel that the VA sets the bar too high as to what qualifies for Post Traumatic Stress Disorder. In the civilian world, any veteran who walked in with the problems that most of the men and women I have talked with have would get a diagnosis of PTSD in an instant.

In the military world, in the VA world, it is like, oh, you are only having nightmares once a week? Yes, you and everyone else. That

is enough. You do not have to have them every night, four times a night. Once a week, once a month is enough.

You think about it everyday? Well, so does everyone else. That is way beyond the criteria needed to get PTSD. You are avoiding people and bunkering down in your basement, as you said? That is enough to meet criteria.

The bar is way to high. If it were up to me, if you served in a war zone, you would get the money, and you would get the treatment automatically. You do not have to jump through hoops. That is my soapbox.

Senator ROCKEFELLER. Well I have, again, gone way over my time.

I just really mean it when I say that you are sort of an ideal panel. You are the kind of panel that every Congressman and Senator dreams about.

Major RASMUSSEN. Is that a nightmare, sir?

Senator ROCKEFELLER. Huh?

Mr. SCOTTI. Is that a nightmare, sir?

[Laughter.]

Senator ROCKEFELLER. No, no, no, no, no. Because you are saying what you think, what you know, what you believe, what hurts, what could help, and you are saying it free of any vetting. The very though of vetting you is offensive to me, but that is a matter I will leave for another day.

Mr. Chairman, I thank you, and I apologize for my length.

Chairman AKAKA. Thank you very much, Senator Rockefeller.

Without question, he is a valued Member of this Committee, and former Chairman of this Committee, as well. And you can tell that Senator Rockefeller has a passion for trying to get things right. So, we value him as a member of the U.S. Senate, and I am so glad that he was here today. And I want to thank you folks again.

As Senator Rockefeller pointed out, this is an ideal panel, because you represent different parts of the country, the Reservists as well as the National Guard, and the academic sector as well.

So, once again, allow me to thank all of our witnesses for the testimony that you have provided. This information will undoubtedly be of great value to this Committee as we proceed to consider the problems we have explored today, and ideas that have been offered to address them.

We also can utilize the lessons learned from things that are being done right, and find ways to incorporate those methods in achieving our common goals.

We all work tirelessly to ensure that veterans receive the best possible care and the greatest possible benefits in recognition of their honorable service to our country, and our country in time of need.

Historically, the members of the Guard and Reserves have been somewhat under-served by our efforts. And we are endeavoring to change that.

The National Guard and Reserve servicemembers face unique challenges as they selflessly set aside their education, their careers, to serve in harm's way. We have all learned more about those obstacles today, and I look forward to working with my friends and colleagues on the Committee, in this Senate, and our friends in VA

and DOD to remove as many of these obstacles as we can. And these are the steps that we are looking forward to taking.

Again, I want to thank all of you, and this hearing is now adjourned——

Senator ROCKEFELLER. Mr. Chairman, can I just add one more little thing? This is, I promise, less than a minute.

It strikes me as an ultimate irony that we ask people, 18, 19, 20, 21, who are willing to take risks and are eager to do so, and then, when they have been through their first deployment, second deployment, they want to get back with their buddies, and I really resonate—I think it was you who said that, get me back—or maybe it was you, Sergeant—get me back to the rules: how, when, where, why, what time.

That is a comfort zone developed over a period of time, but then we take these very young people and we put them through a type of hell that nobody else in the country can come anywhere close to understanding and—which is one of the reasons, frankly, that I have—maybe you do not agree with me, but I have agreed with embedded journalism because it is what has brought this thing home.

And now, it is—you know, the television is just full of it. But then, when a youngster comes back—you are 22, which I consider somebody a youngster—they come back and they are in the very worst position to take the risk of what they then have to go through in the immediate future and, really, for the rest of their life.

So, we pick them for their youth, and then we, to this point at least, have been too much dropping them at their most vulnerable age.

Chairman AKAKA. Thank you very much, Senator Rockefeller.

This hearing is now adjourned.

[Whereupon, at 12:03 p.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF KEVIN AND JOYCE LUCEY,
PARENTS OF CPL. JEFFREY MICHAEL LUCEY—USMC RESERVIST

We first want to thank you for allowing us to present our son's story today.

We are the proud parents of Cpl. Jeffrey Michael Lucey—an USMC reservist who signed in 1999; was activated in January, 2003; sent over in Kuwait in February, 2003, participated in the invasion and then returned physically unscathed in July, 2003. Initially, there were minor adjustment problems. Then, on December 24, 2003, Jeffrey tossed the dog tags to his youngest sister while standing in the kitchen, intoxicated and with tears in his eyes, declaring himself to be no more than a murderer. We encouraged him to get help but he refused due to stigma. We finally brought him to the Veteran Administration Medical Center on Friday, May 28, 2004—the Friday of the Memorial Day weekend. After refusing to enter voluntarily, Jeffrey was involuntarily committed due to being both homicidal and suicidal only to be discharged three and a half days later—despite making very serious statements while in their custody. During his stay there, staff had advised us that we might want to consider 'kicking him out of the house and letting him hit rock bottom or call the police and if necessary, lie' to get Jeff to remain sober for a period of time so they could assess him for PTSD. Thus, Jeffrey was never assessed for Post Traumatic Stress Disorder—in fact, he only saw a psychiatrist on the evening of the admission and the morning of discharge on June 1, 2004. We, his family, were never informed that he had admitted to not only having a plan to harm himself, but also a method. He would carry out his plan using the hose he had told the admitting psychiatrist about when he ended his life on June 22, 2004.

On June 3, 2004, Jeffrey was involved in a single car accident and then resumed drinking heavily while being on medication. Becoming further despondent, we contacted the VAMC and informed them of the developments. They stated that he sounded to be worse and encouraged us to return him. He reluctantly returned to the VAMC but refused to go in voluntarily due to his first experience of being with so many older veterans who were suffering from assorted mental health issues. They never called anyone authorized to do an involuntary. Jeffrey came back home despite his support system stating that we were being overwhelmed by the issues. We called the civilian Emergency Crisis Services only to be turned away again. All abandoned both Jeffrey and our family. We were left totally alone.

Despite Jeffrey's halt in drinking for 5 days—Joyce calling the VA and telling them that we were watching our son die slowly in front of us (how prophetic!) and her emphasizing that we only have this small window of time, we were put off for another 3 days and referred to the Vet Center. Jeff's intake was done and a plan developed to get a bed for Jeffrey for PTSD—in the meanwhile, the Vet Center therapist would come to the house 3 days per week . . . except time ran out. (Further details of Jeffrey's struggles and death can be found under his name on the internet).

On June 21, 2004, late into the night, Jeffrey asked if he could sit in my lap which he did—and we rocked for about forty-five minutes. Then, the next time I held him in my lap was the next night as I took the hose from around his neck and lowered him to the ground.

Jeffrey and our family are not alone. Regretfully, this travesty has been repeated over and over again throughout this Nation.

While all talk and argue about this issue, there is probably another putting a noose around their neck or loading a bullet into the chamber.

In this country, to have this situation is completely unacceptable, immoral, illegal, inexcusable and unconscionable—it is simply wrong.

We are here today on behalf of so many of our veterans who are bearing wounds both seen and hidden who proudly wore the uniform for their country and their fam-

ilies/loved ones—not only asking why but also when . . . when will this Nation and her government give to those who have sacrificed so much the Best of care and develop the healthcare system second to none for our wounded warriors?

We stand totally bewildered as to how the veterans serving within Congress, with the exception of so few voices, could abandon their less fortunate brothers and sisters in uniform to suffer so horribly and allow many of them to die from their negligence . . . such as our son and so many more.

It is because of this negligence by both this administration and the past Congresses that we suffered so many needless deaths off of the battlefields.

Let not the Legacy of this Congress be of those of the recent past Congresses and the present administration;

Let not this be another Congress which will just talk the talk and allow the necessary funding for the treatment of our warriors inflicted with the hidden wounds of Post Traumatic Stress Disorder to disappear not only once, twice, but Three times in the darkness of conference committee—at those times immersing our government and Nation into the depths of shame, disgrace and dishonor;

Let this not be another Congress who abandons, turns its' back and leaves the troops behind once they return home to a broken, dysfunctional VA healthcare system which has shown that it will deceive and minimize to Congress itself;

Rather, Let this Congress truly be the Congress which will support the troops and veterans—supporting them in both word and deed;

Let this Congress be the Congress which will embrace those who served and will keep this Nation's promises to our heroic men and women;

Let us as a Nation be all that we can be to those who now are in need of our help.

ADDENDUM

RECOMMENDATIONS BASED ON OUR EXPERIENCES:

Health Proxy for those deployed;

Community education of resources for troops, veterans and military families as well as reciprocal education for the community based services as to PTSD and other related mental health issues from combat related experiences—this would include the medical field as well as first responders, bartenders, package store employees, etc.

Developed in concert with communities, community based intervention centers i.e. weekly Veterans Court in Buffalo; specialized correctional centers for veterans afflicted with PTSD as well as developing alternative innovative sentencing options for those who work the program.

Development of SAVE teams as modeled on the SAVE team in Massachusetts who not only assist but can also advocate for veterans / families but for selected veterans—can also provide employment opportunities to those who wish to help and work with their brothers and sisters in arms.

To do follow-up on the Joshua Omvig law—to provide adequate resources to house and treat those found to be in need.

If the VA system is to continue, then give it a rebirth—make it responsive to the needs of the veterans; not forcing the veterans to meet the needs of the system. Let the system not remain to be the slow, lumbering, dispassionate bureaucracy—change it to be the active outreach which it should have always been. The VA must develop programs reaching beyond their walls.

If the VA is truly serious about self examination and challenging itself to be the best that it can be, then it must appoint those who will challenge it. Don't appoint the old traditional members—some or all who may have a vested interest in maintaining the status quo—to those committees charged with examining various issues; appoint members such as veterans who know of its' lackings and failings so that they can be addressed as well as some of their loved ones who will be able to give different perspectives.

These are but a few of suggestions which we have. It may be the time to call together various components of the systems including veterans, military families, etc. to a multi-day conference to assist in the creation of that which should have always been—the most effective, efficient, responsive and comprehensive veteran healthcare system on this planet.

We thank you for your time and patience.

Respectfully submitted,

KEVIN AND JOYCE LUCEY,
The proud parents of Cpl. Jeffrey Michael Lucey,
a 23-year-old USMC reservist forever
succumbed to the hidden wounds of PTSD.
03/18/1981–06/22/2004.

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

Thank you for an opportunity to offer testimony outlining the extensive and aggressive efforts the State of Missouri's Veterans Commission has made since March 2003 to create programs to support Guard, Reserve and injured Active Duty.

The program directed by the State Veterans Ombudsman, *Operation Outreach*, has become a nationwide model for Best Business Practice.

Five States, one country (Canada) and the Department of the Army (through their Army Community Covenant Program) are using this program as an example of Best Business Practices in creation of their support and outreach.

Missouri has 540–560,000 Veterans, with 51,100 deployments since OEF, affecting over 225,000 family members. The Missouri National Guard currently has 1100 members deployed in support of the KFOR 10 mission, under the leadership of the Commanding General, Larry D. Kay, who also is the Deputy Director of the Missouri Veterans Commission when not on leave to support his military obligations.

The State agency is a Title III agency, which does not report to a DOD agency and is a sister agency to the Missouri National Guard. Representatives from the Missouri Veterans Commission work laterally as well as drilling down in to the local communities and governments and up through the State, to the Department of Defense and the Veterans Administration.

The following outlines the extensive outreach created thus far.

Referrals between agencies occur daily, and over $2 million dollars have been coordinated to support Guard, Reserve and injured Active Duty.

To mention a few successes, 45 families have been kept from homelessness, medical board cases have a 100% success rating in achieving a minimum of a 30% DOD medical discharge, so as to minimize the negative impact on receipt of VA benefits.

The VA and the State of Missouri Veterans Commission has been working together on at least a bi-monthly basis to benefit Veterans and families from the Global War on Terror since 2004 on several individual issues facing America's newest Veterans. Weekly referrals are made via agency relationships.

In 2003 a citizen in Missouri began a very recognized outreach program to support the Guard and Reserve military and their families as her Reservist daughter was deployed at a time when her husband was very injured. The daughter left a 13-month-old and a husband and the family recognized they were living what would be facing the injured returning from war.

Missouri's Governor, Matt Blunt, and the legislature worked with the Executive Director of the Missouri Veterans Commission and the Missouri Association of Veterans Organizations to expand her efforts and brought her to the Missouri Veterans Commission as the first State Veterans Ombudsman in the United States.

At this point, the program they developed has a strong relationship with all of the VA facilities in Missouri to support all components of the military, focused on the Veterans, military and families serving in the Global War on Terror. We are providing you a matrix defining the outreach to all branches and components as well as community and benevolent organizations.

Most recently, at the suggestion of the Office of the Secretary of Defense, the Department of the Army has used this program as its nationwide Best Business Practices example to create its newly developed Army Community Covenant Program. Missouri's program is also being mirrored by five States and one country, Canada.

In addition to the State Veterans Ombudsman working directly with the injured at time of initial injury at the medical facilities where she has had 100% success in advocating on behalf of the injured for at least a minimum of a 30 percent Medical Board rating and identifying gaps, the staff working in the *Operation Outreach* Program have now coordinated over $2 million in private grants as well as kept 45 families from homelessness. The State Veterans Ombudsman and the Missouri Veterans Commission has been integral in the development of legislation and policy both nationally and statewide.

This aggressive program is the oldest in the Nation and staff have assisted Troops, Veterans and families from over 30 States while continually identifying gaps and proposing potential solutions.

VA OEF/OIF managers, social workers and PTSD clinics and polytrauma staff work regularly to coordinate resources through Missouri's program to benefit those at our facilities. Social Worker, Polytrauma Network Site, St. Louis, Erin Hullinger wrote to State Veterans Ombudsman Pat Rowe Kerr and said:

"I just wanted to write you to say thank you for all that you have done for the veterans in our polytrauma program here in St. Louis. The resources and financial assistance that you have connected my patients with have been invaluable. We often see amazing differences in our patients after severe financial stress is relieved—it improves their stress/anxiety and allows them to redirect their focus from dealing with financial problems to dealing with their complex medical and psychological issues. Many are even more compliant with treatments and recommendations after this burden is lifted. I love to get the relieved and excited phone calls from patients and spouses when the assistance comes in. These injured young men and women have so much to deal with after they come home, and finances often rise right to the top of the list. The type of assistance you give also helps some of these patients to be able to leave jobs that are grossly inappropriate for them (physically and mentally), and pursue more appropriate, gainful careers.

You are invaluable to me and to my veterans. I think I have told you before that I would have to completely change the way I assist with resource referral (finances, SSD, housing, utilities, etc.) if you were not doing what you do. I feel so fortunate (especially when compared to my counterparts in other regions) to have your commitment and support to helping our veterans. Thank you so much for all you do, and I look forward to continuing to work with you in the future!"

STATE MISSOURI VETERANS COMMISSION (MVC)

Missouri State Veterans Ombudsman Program

COMPREHENSIVE REINTEGRATION SERVICES

*Created a specific outreach through the Missouri Veterans Commission called "The State Veterans Ombudsman Program."

The initial goals were to reach as many Guard, Reserve and their families who deployed since 9/11 to (a) provide financial support in crises situations, (b) to develop relationships that would ultimately bring the injured in to the VA health, disability and pension system, with assisted access to state and local benefits and resources, which also provides an economic benefit to the communities of Missouri; (c) to identify gaps and propose solutions with the systems supporting Missouri's newest veterans; and (d) to raise awareness that the State of Missouri Veterans Commission is the only neutral point of contact for all branches and components.

**Five States and one Country (Canada) are mirroring this program in some manner and the Department of the Army is using the Missouri Veterans Commission "State Veterans Ombudsman Program *Operation Outreach*" as the nationwide Best Business Practices in the creation of its new Army Community Covenant Program.

Have developed outreach for over 3100 individual cases in 3 years, coordinating over $2 million in grant resources as well as keeping 45 families from homelessness.

The State Veterans Ombudsman Program *Operation Outreach* advocates, educates, coordinates resources and individually assists in navigating the complex DOD, Federal, state and local systems.

To date, it has a 100% success rate in working DOD medical board cases to increase ratings to a minimum of at least 30% at discharge from the Department of Defense through the MEB/PEB system based upon review of medical records.

TO ACCOMPLISH THESE OUTCOMES, THE PROGRAM

Develops and utilizes resources and assists in navigating Service Members, Veterans and Families toward optimal life solutions in transitioning to civilian environment

Increased outreach to deploying and returning servicemembers and their families through Reserve, NG and Family Readiness Programs/Briefings (have briefed thousands of NG, Reserve, injured Active Duty and families)

Developed outline explaining DOD/VA/TSGLI/MED/PEB/Social Security Disability for educating injured.

Increased support and connectivity with Ft. Leonard Wood to support Missouri's injured by:

• Educating Medical Hold Commanders
• Provide liaison support for injured/sick troops transferred from Ft. Leonard Wood to civilian medical facilities
• Provide transitioning assistance to Guard, Reserve and injured Active Duty demobilizing through this facility and through the WTU
• At the request of Ft. Leonard Wood WTU the Ombudsman meets almost monthly with the injured at the facility assessing needs, assisting with life care plans and decisionmaking, reviewing MED/PEB ratings, getting injured servicemembers in to additional Federal and systems that can benefit their families.
• The Ombudsman has developed a relationship between Ft. Leonard Wood Medical Holdover and Rusk Rehabilitation Center to provide specialized care for Missouri's traumatic brain injured.

Increased support and connectivity with Ft. Riley by:

• Educating Medical Hold Commanders
• Provide liaison support for injured/sick troops transferred from Ft. Riley to civilian environment
• Provide transitioning assistance to Guard, Reserve and injured Active Duty demobilizing through this facility WTU

Increased support and connectivity with Whiteman Air Force Base by:

• Educating Commanders, returned Airmen/women and Family Readiness Groups
• Provide liaison support for injured/sick/financially strapped Airmen/women
• Provide transitioning assistance to Guard and Reserve demobilizing through this facility

Increased support and connectivity with Fayetteville CBHCO-AR to support Missouri's injured.

Welcome Home letters are sent individually from the Executive Director of the Missouri Veterans Commission as well as the Missouri National Guard Adjutant General with specific points of contacts listed as the respective agencies to National Guard servicemembers.

Additionally, the Missouri Veterans Commission sends Welcome Home letters to all branches and components with POC information listed.

BRIEFINGS

Weekend briefings

Briefings are provided to Guard and Reserve of all components that can be scheduled relative to time, access and staff availability as well as to family readiness groups

Demobilization Briefings

Presented to Reserve components prior to release from Active Duty Status as available

Medical Hold Briefings

Given at regular intervals at WTU facilities, working specifically with the Reserve Component injured initially. Now Active Duty injured are referred to the State Veterans Ombudsman for advocacy, education and assistance as well relative to transition to civilian life.

Financial Assistance

*Working with the Lt. Gov., created the *Missouri Military Family Relief Fund* (MMFRF) where Guard and Reserve can receive up to a $3000.00 grant as a result of financial difficulties relating to their deployment. Over $286,000 has been raised, with 100% of private donations or tax check-off contributions going to the Fund.

With the leadership and support of the Lt. Gov. the State Veterans Ombudsman created and coordinates *The Power of 11 Cents* which is an academic outreach in the schools to educate children on patriotism. The program has been recognized in an article that appears in the National Honor Society's Leadership Magazine. To date over 7,800,000 pennies have been raised by children for the MMFRF through the school presentations.

Created *Trekking For Troops*, along with a billboard campaign on the tax check-off, all of which raise dollars for the Missouri Military Family Relief Fund.

• See (Comprehensive Reintegration Services) (Legislation) (other State Programs) relative to additional financial assistance.

Community Outreach, Education and Advocacy

Developing support mechanisms within communities through events, Supermarkets of Veterans Benefits, and Support Your Troops Events.

Working on coordinating a community and faith based conference as a follow-up to the first Intra-Agency State Veterans Conference.

Freedom Walks

Will host the second Freedom Walk for the Capitol city of Jefferson this September.

Benevolent and community/Veteran Service Organization partnerships

Appointed to the Boards of Operation Military Kid, the Brain Injury Association of Missouri. Serves as the ex officio member on behalf of the Missouri Veterans Commission to the Missouri Military Preparedness Enhancement Commission and on the advisory committee for the Missouri Military Family Relief Fund.

Created an informal coalition of military donors that spans the United States and includes such 501(c)(3) organizations as USA Cares (www.usacares.us) out of Kentucky, Operation First Response (www.operationfirstresponse.org) out of Washington, DC, Wounded Soldier (www.woundedsoldier.org) out of Chicago, Operation Undergarment (www.operationundergarment.com) St. Louis, and the Coalition to Salute America's Heroes (www.saluteheroes.org) New York, OIF Family Fund (www.oiffamilyfund.org), California, to name a few. Works regularly with the VFW Unmet Needs Program (www.unmetneeds.org) located in Kansas City, Mark Cuban's Fallen Patriot Fund (www.fallenpatriot.org) in Dallas, Snowball Express (www.snowballexpress.org), California, Semper Fi Fund (www.semperfifund.org) as well as the American Legion's National Temporary Financial Assistance Program (TFA) grant, to name a few.

As an example, The Ombudsman created Operation Save the Home, Operation On Spirit's Wings, Operation Children's Hearts, to assist with extreme extraordinary situations, raising over $30,000 in resources for each outreach.

State Intra-Agency Veterans Summit

Coordinated to acquaint all state agencies with the Missouri Veterans Commission as well as to facilitate collaborations amongst agencies

Traumatic Brain Injury

Assisted with creating a State Action Plan for Traumatic Brain Injury in Missouri at the direction of the Governor working with the Missouri Head Injury Advisory Council, Governor's Council on Disabilities, Missouri Department of Health and Senior Services, Brain Injury Association of Missouri, Missouri Veterans Commission, Missouri Planning Council for Developmental Disabilities, Rehabilitation Institute of St. Louis, Missouri Protection and Advocacy Services, University of Missouri-Columbia, the Center for Head Injury Services, Missouri Association of Rehabilitation

National presentations/testimonies

- 89th RRC Battle Focus Conference, Kansas
- Vietnam Veterans of America Winter Conference, Arizona
- Brain Injury Association of Missouri Annual Conference, Missouri Veterans Commission
- Coalition to Salute America's Heroes Road to Recovery Conferences, Texas, Florida—4 years—*Life After War—It's About Making A Plan*
- Coalition to Salute America's Heroes Troop Recognition, Missouri
- Wounded Soldiers Conference, Illinois
- Congressional Subcommittee of the House of Representatives on Small Business, Washington, DC
- The Joint Committee of the Missouri House and Senate on Veterans Affairs
- Missouri State Veterans Commission's Accredited Veteran Service Officer Training
- The Missouri Department of Economic Development's Annual training for Disabled Veterans Outreach Program (DVOPS) and Local Veterans Employment Representatives (LVERS)
- The National Head Injury Association Annual Conference, Missouri
- Naval Ombudsmen Family Programs, Missouri
- Missouri Association for Social Welfare Conference, Missouri
- Various community, civic and veteran service organizations statewide
- Participated in the AMVET's National Symposium on the Needs of Returning Veterans, Chicago, Illinois
- Attended the 15th Annual International Conference on Combat Stress at Camp Pendleton, California
- Attended Department of Defense *America Supports You* Annual Conference in Washington, DC

• Keynote Speaker at Tri-State Veterans Conference in Dubuque, IA
• Keynote Speaker at Marine Parents Annual Conference in Washington DC and Missouri
• Presented to the Head Injury Associations of Idaho, Oregon and Alaska by video conference
• Presented at the Missouri Department of Mental Health CLAIM Training
• Keynote Speaker at Fort Leonard Medical Hold and Dental Winter Ball
• Presenter at Missouri Department of Mental Health Annual Conference
• Presenter and Coordinator of Fisher House Donator Luncheon in St. Louis, MO
• Presented at International Center for Psychosocial Trauma "Multiple Faces of Trauma: An Integrative Approach to Preparing communities—2008 14th Annual Conference, Missouri
• NGB Family Readiness Summit (Washington, DC)—assist in developing new policy formation
• Special Forces (Florida)—profiled Missouri's Operation Outreach Program and State Veterans Ombudsman position
• National Guard Bureau—provided subject matter expert advice at Family Readiness Symposium, Washington, DC
• National Association of State Departments of Veterans Affairs—presented Power Point and provided best business practices regarding development of Operation Outreach Program and creation of a State Veterans Ombudsman position at Mid-Winter Conference, Washington, DC
• Presented subject matter information at the Missouri State Social Workers Conference in Columbia—*The True Welcome Home*
• Presented subject matter information to the Department of the Navy Ombudsmen at the regional ombudsmen training in St. Louis
• Developed "Life After War—It's About Making A Plan" booklet
• Coordinated "A Grateful Nation Remembers" legislative recognition, "75th Missouri Veterans Commission Anniversary Celebration and the 9th Support Your Troops Event outreach
• Provided support for the State Women Veterans National Conference, Branson, Missouri, May 2007

State/national outreach/awareness

Prepared and submitted testimony to a VA Committee re GWOT gaps/solutions

Prepared and submitted testimony to the Presidential Task Force on OEF/OIF issues

Provided education support relative to GWOT legislation for the Missouri Association of Veterans Organizations (MAVO)

Provided support to Missouri Military Preparedness Enhancement Commission

Created a Power Point outlining development of *Operation Outreach Program* which has then been used as a prototype for other programs

Created one-pager relative to *Operation Outreach* which was used as prototype for other MVC programs

Prepared and supported grant proposal presented to Senator McCaskill re GWOT/Veterans' needs

Participated in the development of a liaison between Mental Health, MVC, and VA

Wrote the initial white papers that supported the Joint House and Senate Committee on Veterans Affairs and the more recent Governor's Advisory Council

The Ombudsman has been integral in providing information to support the passage of several bills benefiting veterans and servicemembers to include the Missouri Military Family Relief Fund. A bonus of the efforts of the Ombudsman has been coordinating financial assistance for prior service veterans.

Additionally, the Ombudsman has been asked to serve on the new American Legion, Army Wounded Warrior 2 "Hometown Heroes" initiative to assist the extremely injured transition back to their communities.

The State Veterans Ombudsman has been contacted by servicemembers, new veterans or their families from some 30 states with questions relative to programs created within *Operation Outreach*. She participated in the development of the statewide Traumatic Brain Injury plan with the Department of Health and Senior Services.

The Ombudsman creates programs that raise awareness not only of the needs of GWOT veterans but increases the awareness of prior service veterans about their Federal benefits along with benefits from the Missouri Veterans Commission. She speaks to organizations representing them as well and has been invited to speak to national organizations on ways to assist prior service veterans.

Additional MVC Specialty Programs for Outreach

The Missouri Veterans Commission has also created: Women's Veterans Program, Minority veterans program, Reintegration Program.

Additional Accredited Veterans Service Officers have been added throughout the state as well as increased budget for Missouri Veterans Commissions Veterans Homes.

The Veterans Service Grant Program funding has been increased to $1 million to provide additional support to Veterans Service Organizations who have Accredited Veterans Service Officers.

Memorandum of Understanding

Created on how state agencies (MVC, DOL) and the National Guard can provide services to returning Troops and their families

ADDITIONAL STATE PROGRAMS

Education/Scholarships (Also see legislation and other programs)

Hero At Home Program (DED) Available to spouses of Guard and Reserve who are deployed and extends the program to cover the first year after discharge from deployment, to cover Reservists, and to cover situations in which an individual cannot return to his or her previous employment;

Missouri Returning Heroes Education Act (Higher Education) (creates a $50 tuition per credit hour limit for combat veterans who have served since September 11, 2001)

Injured and dependent Scholarships Allows the spouse and children of a soldier who was killed in action after September 11, 2001, or who became 80% disabled as the result of an injury sustained in combat action after September 11, 2001, to receive an educational grant for tuition at a public or private college or university in Missouri. The Coordinating Board of Higher Education will award up to 25 grants annually. If the waiting list of eligible survivors exceeds 50, the board can ask the General Assembly to increase the number of grants it is authorized to award. The tuition grant cannot exceed what is charged for a resident by the University of Missouri-Columbia.

The Veteran must have been a Missouri resident when first entering military service or at the time of death in order for his or her survivors to receive this grant. In addition to the full cost of tuition, the grant includes $2,000 per semester for room and board and the actual cost of books up to $500 per semester. Children are eligible to receive the scholarship until age 25. Spouses are eligible until age 45. No eligible student will receive a grant for more than 100% of the tuition costs when combined with other similar funds given to the student;

Employment

Veteran's preference for consideration in employment with the State of Missouri and Federal agencies

(Also see Hero At Home Program)

Dept. of Mental Health/PTSD

Additional dollars have been added to the Department of Mental Health's budget to provide counseling to families of GWOT Veterans at provider networks throughout the state.

Additional general revenue dollars have been allocated for PTSD outreach through St. Patrick's Center, St. Louis, Missouri.

Governors Advisory Council for Veterans Affairs which identifies the needs of Missouri's aging Veteran population, develop strategies for improving the delivery of services, increase services to and awareness about the number of women veterans in Missouri and promote Missouri as a "military friendly state"

Missouri Military Preparedness Enhancement Commission

The Missouri Military Preparedness and Enhancement Commission was established in 2005 when Governor Matt Blunt signed Senate Bill 252 into law.

The Commission is tasked with making recommendations regarding community relations and interstate cooperation on military issues. The Commission will also serve as a clearinghouse for information regarding Federal actions affecting military installations and their potential impact on the state and local communities.

Conservation

Free hunting and fishing permits for Veterans with 60% or more VA disability rating

Reduced price hunting and fishing permits for Missouri Veterans who mobilized in the previous 12 months.

Department of Revenue

Waiver of Missouri CDL driving examination requirement with military CDL certification (other conditions apply)

Missouri Army and Air National Guard

Have created additional programs to support families and military

Legislation passed to Support GWOT Servicemembers, Veterans and their families (highlights for GWOT)

SS HB 1687 (some of the provisions)

Allows a military dependent who has completed an accredited prekindergarten or kindergarten program in another state to enter kindergarten or first grade even if the child has not reached the required age for Missouri schools by August 1;

Authorizes the State Board of Education to develop recommendations regarding alternate assessments for military dependents who relocate to Missouri during the school year;

Requires the state board to establish a rule to allow the issuance of a provisional teacher's certificate before the completion of a background check to the spouse of a military member who holds a teacher's certificate in another state that requires a background check and who has relocated within the last year;

Allows school districts to accept a course in government completed in another state when a student transfers to a Missouri high school in ninth to twelfth grade to satisfy the state's graduation requirement;

Allows the spouse and children of a soldier who was killed in action after September 11, 2001, or who became 80% disabled as the result of an injury sustained in combat action after September 11, 2001, to receive an educational grant for tuition at a public or private college or university in Missouri. The Coordinating Board of Higher Education will award up to 25 grants annually. If the waiting list of eligible survivors exceeds 50, the board can ask the General Assembly to increase the number of grants it is authorized to award. The tuition grant cannot exceed what is charged for a resident by the University of Missouri-Columbia.

The veteran must have been a Missouri resident when first entering military service or at the time of death in order for his or her survivors to receive this grant. In addition to the full cost of tuition, the grant includes $2,000 per semester for room and board and the actual cost of books up to $500 per semester. Children are eligible to receive the scholarship until age 25. Spouses are eligible until age 45. No eligible student will receive a grant for more than 100% of the tuition costs when combined with other similar funds given to the student;

Renames the Guard at Home Program to the Hero at Home Program and extends the program to cover the first year after discharge from deployment, to cover reservists, and to cover situations in which an individual cannot return to his or her previous employment;

Specifies that military service and out-of-state employment, by itself, is not sufficient to justify a modification of a child custody or visitation order; and authorizes Missouri to enter into the Interstate Compact on Educational Opportunity for Military Children and establishes the Interstate Commission on Educational Opportunity for Military Children. The compact becomes effective upon its adoption by 10 states. Military children include the kindergarten through twelfth-grade children of active duty members of the Armed Services including the National Guard and the Reserve, as well as the children of members who die while on active duty, retire, or are medically discharged for a period of 1 year afterward. The compact covers issues including facilitation of enrollment, both in classes and extracurricular activities; placement; graduation; and information-sharing. The commission is made up of one voting member from each participating state. The duties of the commission include dispute resolution between member states, enforcing the rules of the commission, and providing training and other administrative functions. The bill contains provisions for the formation of the commission's executive committee, budget, liability, and legal status.

SB 830—tuition limitation bill for combat veterans serving since September 11, 2001 to $50 per credit hour at state institutions

• Secretary of State is to waive reinstatement fees and procedures in the event a corporation was administratively dissolved due to a failure to file an annual registration report when the failure was due to the business owner's active military service. All late fees are waived, and certificate of dissolution is canceled and corporation is reinstated.

• Enacted legislation allowing a homeless Veteran to use the post office box or voice mail address of certain charitable or religious organizations on applications for Federal or state assistance by agreement.

• Enacted legislation exempting a person who presents proof of permanent disability from the United States Veterans Administration from the 4-year certification requirement for renewal of disabled license plates or placards.

• Created the "Veterans' Historical Education Fund"

• Enacted legislation giving a preference in all state purchasing contracts to certain disabled Veterans doing business as Missouri companies when the quality of work is equal or better and the price is the same or less

• Enacted the "Specialist Edward Lee Myers" law to protect families from funeral protests

• Enacted legislation requiring all government buildings to fly the U.S. and Missouri flags at half-staff when any Missouri resident is killed in combat

• Increased funding for Veterans Homes, Veterans Service Grant Program, Dept of Mental Health outreach on PTSD

• Created a "Some Gave All" license plate for family members of KIA (see Dept of Rev)

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