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HEARING ON MENTAL HEALTH ISSUES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

APRIL 25, 2007

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APRIL 25, 2007

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HEARING ON MENTAL HEALTH ISSUES

WEDNESDAY, APRIL 25, 2007

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

The Committee met, pursuant to notice, at 9:11 a.m., in Room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Rockefeller, Murray, Brown, Tester, Webb, and Craig.

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

Chairman AKAKA. This hearing will come to order. Good afternoon, everyone. I will be brief as I am eager to hear the testimony of the witnesses before us.

The very real truth of the war is that the toll will be felt by servicemembers and their families for years to come. We have focused much attention recently on the physical wounds sustained in combat. Today, we are taking a long overdue look at the invisible wounds, wounds which cannot be seen but are every bit as devastating as physical wounds.

We know that many of the men and women who are currently serving in Iraq and Afghanistan will require treatment for mental health issues. We do not know yet if we will see the widespread chronic PTSD that followed Vietnam. I hope we do not, but veterans will need help readjusting back into society, and unfortunately, many will abuse drugs and alcohol to ease their pain. Some will commit suicide because of their pain. Still others will quietly suffer with PTSD and the profound wounds caused by sexual trauma.

Without question, the Administration should have been taking the necessary steps at the start of this war to ensure that VA was prepared for the growing demand for mental health care. We know that the VA mental health system has long suffered from funding cuts and long waiting lines for care. Indeed, VA's own advisory groups and high-level officials have pointed out the shortcomings. A former high-level official charged that waiting lists rendered VA mental health care virtually inaccessible. Now, we know that demand is increasing. The latest numbers from VA indicate constant growth in mental health, with PTSD and abusive drugs as the top two conditions.

Let me be clear about my goal. VA needs to have the finest mental health care available. The demand is too great and the man-

power and expertise are just too broad to relinquish this to the private sector. When partnering with community programs makes sense, I am open to that. But I do not believe VA should shy away from its direct responsibilities in this area.

A special thanks to our witnesses. We are so glad you are here with us today. I especially want to say thank you to those who are here to share personal stories. I also want to thank our staff, who have worked hard to put this together, and others, as well. I want to tell our witnesses that we are deeply in your debt.

So let me, at this point in time, call on Senator Craig for his statement.

STATEMENT OF HON. LARRY E. CRAIG, RANKING MEMBER, U.S. SENATOR FROM IDAHO

Senator CRAIG. Mr. Chairman, thank you, and thank you for focusing on this most important issue. I also want to extend a warm welcome to our panelists today, particularly to Tony Bailey, certainly to Randall and Ellen Omvig. We are truly grateful for your willingness to share with the Committee your stories and you have my deepest condolences for the loss of your loved ones. This country owed them a debt of gratitude for their sacrifices and their services and that debt we now owe to you.

Just as the Committee is concerned about the bodies of returning servicemembers, we want to be sure that those troubled in mind by what they experienced protecting our freedoms receive the same kind of care. We must ensure that all are aware of their access to care and are not afraid to seek that care.

I first made this statement in a series of seamless transition hearings over two years ago and it remains true today, that healing the veteran's mind is as equally important to this Committee as healing the veteran's body. The goal is to be sure that those with mental illness can return to live, work, learn, and participate fully in their communities. That means we must identify unmet needs and barriers to services or accepting the services available.

We must identify innovative treatments and services that are demonstrably more effective. We must improve coordination amongst case managers and providers at DOD and at VA. And we must focus on the desired outcome of mental health care, which is to provide for each individual an opportunity to attain a full and productive life through employment, self-care, interpersonal relationships, and community participation.

These are tough goals and they require that we ask tough questions, questions such as whether our servicemembers are prepared to manage the stress of combat before they set foot on the battlefield, questions such as have we created a barrier to wellness by compensating for mental illness without requiring a focus on recovery and rehabilitation from it? Are we setting appropriate benchmarks to evaluate the effectiveness of prescribed treatments?

These are very difficult questions that are going to be required of us in taking the appropriate actions necessary. But the price for not addressing these questions and this issue are simply too high.

To our two witnesses, to the fathers who have lost their sons, you know that price better than any of us. For the loved ones attending, you know that price better than any of us.

As VA continues to implement its mental health strategic plan and its mental health initiative, including efforts at suicide prevention, I am committed to addressing these very difficult questions with my colleagues, but we owe a great deal to all of you for coming today to put a face on this issue and for sharing with us the reality of it.

I thank you, Mr. Chairman, for convening this hearing.

Chairman AKAKA. Thank you very much, Senator Craig of Idaho, for your warm message.

Senator Murray from the State of Washington?

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

Senator MURRAY. Well, Mr. Chairman, thank you very much for holding this really important hearing on mental health care issues that are affecting our veterans. I want to thank all of our witnesses especially today who are here to share their very personal and very painful stories. You need to know that all of you are speaking out for many others who can't be here, and I and all the Members of this Committee are really committed to using your experiences to help us help other veterans.

Mr. Chairman, we all know that going to war has a profound effect on those who are sent to fight, and the wars in Iraq and Afghanistan are no exception to that. As the Iraq War now enters its fifth year, it is pretty clear that the fighting overseas has taken a tremendous toll on the lives of our troops who have served this Nation so honorably and on their families who have supported them so fully.

We do know that more and more of our veterans from Iraq and Afghanistan are seeking care for mental health care problems when they return home. In fact, according to the VA itself, one-third of all returning Iraq veterans who have enrolled in the VA are seeking treatment for mental health problems. That is a pretty astounding statistic, and tragically, it is probably too low. We know that many of our returning servicemembers and veterans aren't looking for care because of the stigma surrounding treatment or because they fear that mental health diagnosis might negatively impact their military or civilian careers, and those veterans aren't being factored into the VA's own statistics and all too often we are finding those soldiers self-medicating their mental wounds.

We have also heard reports of servicemembers being shipped back to war after doctors did recognize PTSD symptoms. Last month, in fact, the mother of an injured soldier sat right here at this table and told us about her son, who was not given medication to treat PTSD because if he was, then he would be called unfit to redeploy.

Mr. Chairman, we also know that troops are deployed overseas for the third or now even the fourth time, a tour of duty, and the risk of positive screening for PTSD and other mental health care conditions increases with each deployment.

So to me, it is really clearly time for the VA to really redouble their efforts to fight the PTSD stigma and increase their screening, their outreach, and their treatment.

We also know that the Iraq War has created challenges for the VA to provide care for all of the veterans who are seeking mental health care treatment, and we have known about these problems for some time. Last year, the GAO issued a report that indicated the VA did not spend all of its mental health care funding that it was provided by us and that unclear directions from the VA central office likely resulted in mental health care funds being used for other health care priorities.

Last spring, a VA under secretary said that VA mental health care was, he called it, virtually inaccessible because of the long waiting lines. And then this past February, the American Psychological Association released a report that servicemembers and their families are not receiving mental health care because of limited availability and difficult access.

Our National Guard and Reserve members aren't faring any better. These are citizen soldiers who leave their families and their jobs to serve our Nation overseas and they often live, as we know, in very far-away areas which makes it very difficult for them to receive care when they come home. I hear, and I know my colleagues do, as well, from Guardsmen and Reservists and their families all the time about the problems they are encountering trying to get access to the VA, and to me, that is really unacceptable and we need to change.

Mr. Chairman, now we are hearing that Vet Centers, which are an integral part of our VA's mental health care network, don't have enough staff to meet the growing numbers of veterans who are accessing these centers.

And finally, according to this *USA Today* article that was just out, "Staffing at VA Centers Lagging," it says that the number of returning veterans from Iraq and Afghanistan has gone up by more than 100 percent since 2004—100 percent since 2004, and yet the staffing levels at our Vet Centers has only gone up by 10 percent.

So, Mr. Chairman, we have some real challenges, and we are making progress and I want to commend you and others for working with us in the Senate budget to increase the number for VA to $43.1 billion, and the money in the emergency supplemental that is going to come to the Senate, and I hope that the President signs, that will increase by $1.8 billion for veterans.

But this hearing is really important for us to hear personally about this issue of post-traumatic stress syndrome and how we as a Committee can really start to focus on making sure that those men and women who fight for us don't have to fight a health care system when they come home.

So thank you very much for holding this hearing. I really appreciate it.

Chairman AKAKA. Thank you very much, Senator Murray from Washington State.

Now I would like to call on the Senator from Montana, Senator Tester.

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

Senator TESTER. Thank you, Mr. Chairman. I want to thank Ranking Member Craig and all the other Senators that are here today, and I especially want to thank the panel, Dr. Best, Mr. Campbell, the Omvigs, and Mr. Bailey. Thank you very much for being here today.

I can tell you that, as from the testimony that has already been given and the opening statements, we have got a problem. I look forward to each and every one of your testimonies on this panel and the next one to help further delineate ways by which we can fix this problem.

Tony, I have got a daughter who is 27 years old. I cannot imagine what each one of you have been through. When the Members of this Committee talk about us being indebted to you, it is right on. But we have got a problem here. We have come to this Committee to try to get the testimony and get the kind of input necessary so we can solve this problem by working together. And I really do appreciate the fact that you are willing to take the time out of each and every one of your busy schedules to talk about a subject that, for some, is very, very difficult.

Thank you very much.

Chairman AKAKA. Thank you very much.

Now I would like to call on Senator Rockefeller for your statement.

STATEMENT OF HON. JOHN D. ROCKEFELLER IV,
U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman. I almost don't know where to start, and so I probably shouldn't, but let me just say that for those of us who have been on this Committee and who care about it and who understand that this Nation has sort of a tendency—I don't hold ill will toward the Nation, but I hold ill will toward the results—of honoring the warfighter while the warfighter is fighting, and then the warfighter gets hurt, visibly or invisibly or both, comes back, and gets subject to a budget which, as Senator Murray pointed out, is entirely inadequate because it is within the budget of the United States as opposed to the warfighter's war, which is subject to the loans of China, Japan, and South Korea. So one gets everything they want, although that did not happen, but the second definitely doesn't.

I think that you will not find a group of people around here who approach you with more respect, more sadness, more desire to help, more frustration, more anger at our own government, both Democratic and Republican Administrations, it doesn't make any difference. It seems that we never seem to give people their due.

And then something comes along like Building 18, which in some ways is a gift to the Nation because it tells us how little we know, how little attention is paid to this and how much we have to do. I don't think there is anybody on this Committee on either side who doesn't have a heart full, a full heart.

I know a little bit of something about suicide. I know nothing about suicide, Mr. Omvig. It has happened in my family. I don't know anything about it from the point of view of a parent. I don't

know what I would do. I don't know what brings it on. I don't know if it is sudden.

I do know that I talk almost every weekend I go home to West Virginia, which is not a big and powerful State but has unbelievable people, and I just sit down with 12 or 13 wounded veterans, visibly, invisibly, for 2 or 3 hours, no staff allowed, no press—they never know that it happens, no pencils. It is just—and then you start. And then people begin to say things that you could never imagine that people could say unless you were in there and the rhythm of the whole thing, their bonding, their anger, their need to leave the room sometimes just to vent and then come back in and join or not join.

So I feel like Senator Murray, who has just been unbelievable on all of these things, as have our Chairman and Vice Chairman, but we aren't doing the job, and I think the beauty of your being here is that finally, there is a call to conscience on the part of the American people and I think you have helped cause this to happen. When the American people are really stirred and angry and emotional about a subject, they will not take excuses.

Most Americans don't know that the Chinese, the Japanese, and the South Koreans pay for our war. Most of them don't know that we fail to pay for the results of that war in human terms because it is under something called a government budget, which is always inadequate no matter what the Administration is. It is always inadequate.

Patty Murray talks about the mental health. There is just so much to learn. There is so much to do. We have to start and you have to understand that we are trying, whether we are beginning to try or however you want to interpret it.

But take us as real people and let us make that our beginning point, that we sit here and you sit there. It is all a table. We are all human beings and we want things to work out for you and people who have served and people who are hurting, people who have passed, some people who are wounded who maybe wish they had passed because the agony is so deep. So those are my words.

Chairman AKAKA. Thank you very much, Senator Rockefeller from West Virginia.

Now from Ohio, Senator Brown.

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

Senator BROWN. Thank you, Mr. Chairman and Senator Craig. Thank you. My comments will be brief. I would just echo the words of Senator Rockefeller. I don't have the breadth of experience he does but have seen and heard so many of these stories and have been increasingly overwhelmed by the failure of our government to do what it needs to do for the families of our soldiers. We cheer them on as they go to war and do so little in so many cases when they come back.

To take the issue of the polytrauma centers, we hear so much about they are doing tremendous work. However, the four polytrauma centers around the country have 48 beds among them. Ohio State University at the medical center treats brain injury patients in its world class facility, Dodd Hall. They have 60 beds in

that one facility, 12 more than the four polytrauma centers around the country. That tells me how very much we need to do.

The numbers are staggering. As we know, one-third of soldiers from the wars in Iraq and Afghanistan will seek some kind of mental health treatment. We have not done what we should for the next year or two or three or five. We should be talking even more years into the future for what we need to do for the next four or five decades and what we are going to need to do to serve the men and women who have returned from these two wars.

I so much appreciate the families being here and their sacrifice and their candor and their courage, so thank you all.

Chairman AKAKA. Thank you very much, Senator Brown from Ohio.

From Virginia, Senator Webb.

STATEMENT OF HON. JIM WEBB,
U.S. SENATOR FROM VIRGINIA

Senator WEBB. Thank you, Mr. Chairman. I would say to our witnesses here that this is really your chance to talk to us. We have a chance to talk to each other every day and I don't want to take much time from your opportunity to discuss your issues.

I would say a couple things. One is that I first started working in this area in 1977 after I got out of the Marine Corps and attended law school. I came up here as a Committee counsel working on the Veterans Committee on the House side. One of the constants of American history in terms of when we send people off to war is that they do have readjustment needs when they come back.

A lot of people are kind of surprised by that when we look at all the films about World War II and all the rest of that. But one of the first studies I worked on in 1977 was a National Academy of Sciences study on these sorts of issues and 25 percent of the people coming back from World War II had similar difficulties. Each one of these experiences has a different pattern to it. In the Vietnam era, we basically pioneered a lot of this post-traumatic stress research and this sort of thing.

I have been intimately involved with people who have been serving since 9/11, a lot of it through my friends, a lot of it through my own family. I have two daughters who are engaged to enlisted veterans. You may know my son is currently in Iraq as an enlisted Marine. We need to stay on these.

And I think, Mr. Chairman, what happened at Virginia Tech last week, I think at bottom when we examine it, we are going to see that we are not paying enough attention to these sorts of issues in our society, issues of mental health and how to talk about them openly and how to help people.

I am looking forward to doing what we can in these situations and am grateful for all of you being here today.

Chairman AKAKA. Thank you very much, Senator Webb from Virginia.

I welcome the first panel. We have asked each of you here for your personal and your particular perspective on VA mental health care.

First, I welcome Tony Bailey. Mr. Bailey is the father of Justin Bailey, who served as a Marine in the first wave of troops on the

ground in Iraq. Mary Kay Bailey, Justin's mother, is here today, as well.

I also welcome Randy Omvig, Joshua Omvig's father. Randy is accompanied by his wife, Ellen.

To the Baileys and the Omvigs, you have traveled long distances to be here today to speak of your sons, both of whom died far too young. You have my deepest sympathy for your loss. You also have my gratitude for being willing to share your stories in the hope that things will be better for other young servicemembers.

I welcome, as well, Patrick Campbell. Patrick represents Iraq and Afghanistan Veterans of America and served in Iraq as a combat medic. He currently serves with the Washington, D.C. National Guard.

Finally, I welcome Dr. Connie Best. Dr. Best is a senior faculty member at the National Crime Victims Research and Treatment Center at the Medical University of South Carolina and served for 20 years in the Navy Reserve.

I want to thank each of you for being here today. I want you to know that your full statements will appear in the record of the Committee.

Before we move to testimony, I should tell you that I received a submission by a woman veteran who served in Iraq describing her service and that of other women. I ask unanimous consent to put it in the hearing record as it provides valuable insights on the experience of some women who have or are serving in combat zones. That will be added to the record.

Chairman AKAKA. Mr. Bailey, will you please begin with your testimony.

STATEMENT OF TONY BAILEY,
FATHER OF JUSTIN BAILEY

Mr. BAILEY. Mr. Chairman and Members of the Committee, I would like to tell you about my son who died on January 26, 2007, at the West L.A. VA Hospital. He was 27 years old and Justin was seeking treatment for PTSD and drug abuse.

Justin joined the Marine Corps in December 1998, approximately 6 months after graduating from high school. Justin was in the infantry and was due to separate from the Marines in January of 2003, but was involuntarily extended due to the impending war. Justin was with the first wave of troops that arrived in Iraq when the war started in 2003. He fought in Nasarija and returned to Camp Pendleton in June of 2003.

While Justin was in Iraq, he sustained an injury to his groin. He underwent two different surgeries about 6 months apart. In between these surgeries, he waited around, basically doing nothing, until he was discharged in April of 2004. After his discharge, Justin still complained of pain from his injuries and he was diagnosed with PTSD. He began taking prescription drugs that were prescribed by the VA and were not monitored. He was also using illegal drugs.

In November of 2006, Justin checked himself into the West L.A. VA Hospital. According to his medical records, Justin went in taking Xanax and a pain medication and 2 weeks later was on Xanax and four other different prescription drugs. Justin had been on

Xanax since 2004. We were later told by the medical staff after Justin's death that Xanax is inconsistent with the treatment of PTSD. Justin's pain medication had been changed to methadone, which received an FDA alert in November of 2006 and had been highly publicized due to its addictive and unpredictable nature.

After 2 weeks in the hospital, Justin was sent to the domiciliary, which is described by the VA as a residential substance abuse treatment program. On the night of January 26, I learned that Justin was being taken to the ER at the hospital. He had just received his new prescriptions the day before and now he had died of an apparent overdose of his prescription drugs.

Looking back, I was very happy for Justin that he made the decision to get help and that he was going to the VA for help. I assumed that being a large VA facility, that they would be the best equipped and would have the best experience with PTSD and related drug abuse issues. I was wrong.

Despite warnings from friends, family, and notations in his medical records that Justin had a tendency to over-medicate himself on prescription drugs, the L.A. VA Hospital determined that after a mere 2 weeks at their hospital, that he had the ability to self-administer his medication.

Two days after Justin died, my wife and I visited the hospital and were greeted with a total lack of sympathy and faced bureaucratic hassles to get basic information. And despite the VA's touting of its electronic medical records, we were sent on a wild goose chase throughout the hospital looking for Justin's records. We met with his medical staff. They indicated that Justin had missed several of his PTSD appointments but they did nothing but reschedule a new appointment. They should have made face-to-face contact with him. Patients with PTSD and substance abuse are notoriously difficult to reach.

We left the hospital with unanswered questions. We went from place to place and got nowhere. I can only imagine what a veteran with mental illness would go through.

Other than some classes required by the domiciliary program, it functioned as a residential facility, and while many veterans need a place to stay as they are transitioning to civilian life, Justin was there primarily for drug treatment and he needed more.

I will tell you that after our experiences with the hospital, they are making some changes, including reducing dosages, surprise inspections, increased weekend staffing. It is my hope that these changes will remain in effect and that these changes will occur systemwide.

I cannot express the emotion that I feel over Justin's death and the thought that all of this could have been prevented. I don't believe that this facility is equipped to deal with PTSD and drug abuse problems, which are so prevalent. I believe with some veterans, that there is a lag between the return from war and their acknowledgement and/or diagnosis of PTSD and we have yet to see our VA hospitals overwhelmed with mental illness from this war.

It would help to increase the budget of the VA hospitals, but not before a thorough evaluation of these facilities is conducted. Adding money to facilities that have systematic issues is not going to increase their effectiveness.

When I spoke to Justin on the Sunday before he died, he said, "Dad, I know this is my last chance and I want to get better." He was very positive about what he was going to do when he got out of the program. He had plans for his career and wanted to do something with his life. His stepmom and I were very happy for him, and for once in a long time, we had hoped that he would be able to lead a happy and healthy life.

Thank you for allowing me to speak to you today.

[The prepared statement of Mr. Bailey follows:]

PREPARED STATEMENT OF TONY BAILEY, FATHER OF JUSTIN BAILEY

Mr. Chairman and Members of the Committee:

I would like to tell you about my son, Justin Bailey, who died on January 26, 2007, at the West LA VA Hospital. He was 27 years old. Justin was seeking treatment for PTSD and drug abuse.

Justin joined the Marine Corps in December 1998, approximately 6 months after graduating from high school. He was in the infantry and was due to separate from the Marines in January 2003, but was involuntarily extended due to the impending war. Justin was with the first wave of troops that arrived in Iraq when the war started in 2003. He fought in Nasarija and returned to Camp Pendleton in June 2003. While Justin was in Iraq, he sustained an injury to his groin. He underwent two different surgeries at the Naval Hospital at Camp Pendleton about 6 months apart. In between surgeries, he waited around basically doing nothing until he was discharged in April 2004.

After his discharge, Justin still complained of pain from his injury, and he was diagnosed with PTSD. He had trouble sleeping, nightmares, and short term memory loss. He began taking prescription drugs that were prescribed by the VA. Over approximately the last two and a half years, the VA prescribed the following different drugs: alprazolam (xanax), diclofenac, quetiapine fumarate, buspirone, benztropine mesylate, aripiprazole, hydrocone, acetaminophen, olanzapine, hydroxyzine pamoate, divalproex, magnesium hydroxide, clonazepam, lithium carbonate, trazodone, prazosin, bupropion, levalbuterol tart, lorazepam, oxycodone, omeprazole, ibuprofen, doxepin, amitriptyline, temazepam, mirtazapine, and methadone. It doesn't appear as if the drugs were monitored effectively and in my opinion he was given drugs and sent on his way instead of being properly diagnosed and treated. He also began using illicit drugs.

In November 2006, Justin checked himself into the West LA VA Hospital. According to his medical records, Justin went in taking xanax and hydrocone for pain, and 2 weeks later was on xanax, buproprion and trazodone, which are antidepressants, prazosin, and methadone, which he was given for pain. Justin had been on xanax since 2004. We were later told by medical staff after Justin's death that xanax is inconsistent with the treatment of PTSD. Justin's pain medication had been changed to methadone, which received an FDA alert in November 2006 and has been highly publicized due to its addictive and unpredictable nature. The FDA alert explained the risks of methadone and cautioned the medical community to ensure that the benefits of prescribing methadone outweigh the risks.

After his 2 weeks in the hospital, Justin was sent to the domiciliary, which is described by the VA as a residential substance abuse program.

On the night of January 26th, I learned that Justin was being taken to the ER at the hospital. He had just received his new prescriptions the day before. And now he had died of an apparent overdose of his prescription drugs.

Looking back, I was very happy for Justin that he made the decision to get help and that he was going to the VA for help. I assumed that being a large VA facility they would be best equipped and would have the most experience with PTSD and related drug-abuse issues. I also assumed that Justin would only receive his prescriptions in small individually controlled dosages. I was wrong.

Despite warnings from friends and family and notations in his medical record that Justin had a tendency to over-medicate himself on prescription drugs, the LA VA hospital determined that after a mere 2 weeks at their hospital that he had the ability to self administer medications. The day before he died, he was given five different prescriptions in dosages of 14, 15 and 30 days.

Two days after Justin died, my wife and I visited the hospital and were greeted with a total lack of sympathy and faced bureaucratic hassles to get basic information. And despite the VA's touting of its electronic medical records, we went on a wild goose chase throughout the hospital looking for Justin's records.

We met with his medical staff. The PTSD professionals indicated that Justin had missed several of his PTSD appointments, but they did nothing but reschedule a new appointment. They should have made face-to-face contact with him. Patients with PTSD and substance abuse are notoriously difficult to reach. They also indicated that although they knew that Justin had problems with over-medicating on prescription drugs, they had to listen to the patient when it came to his care. And, they told us that Justin had not seen a psychiatrist since being in the domiciliary. He had been there approximately 6 weeks already, and a psychiatrist had not yet been assigned to him. We found it disturbing that the primary care physician and RN continued to give Justin prescriptions that he had been prescribed in the hospital, without evaluating him to see if the drug interactions were OK or the drug treatment was even effective.

We left the hospital with unanswered questions. We went from place to place and got nowhere. I can only imagine what it must be like for a veteran with mental illness. Every office that we visited seemed to act independently without knowledge of what others were doing. There was obviously inadequate communication between offices and medical staff, but yet that seemed to be the norm and didn't concern the people that we spoke to. The only communication network that did seem to function well in this hospital was the communication to the organ donation people. I received a phone call 4 hours after my son died at 2:30 in the morning in which I was asked questions about the condition of my son and specifically about his eyes.

Other than some classes required by the domiciliary program, it functioned as a residential facility. And while many veterans need a place to stay as they transition to civilian life, Justin was there primarily for drug treatment, and he needed more.

I will tell you that after our experience with the hospital, they are making some changes, including reducing dosages, surprise inspections, and increased weekend staffing. It is my hope that the changes will remain in effect and that these changes will occur system-wide.

I cannot express the emotions that I feel over Justin's death and the thought that all of this could have been prevented. I don't believe that this facility is equipped to deal with PTSD and drug abuse problems, which are so prevalent.

I believe with some veterans, there is a lag between their return from war and their acknowledgment and/or diagnosis of PTSD, and we have yet to see our VA hospitals overwhelmed with mental illness from this war. I have a concern that our Iraqi veterans with mental illness will give up on our VA hospitals, because of the complexity and apathy. We can do better than that. We send them to war to fight for our country and it is our responsibility to take care of them when they return.

It would help to increase the budgets of the VA hospitals, but not before a thorough evaluation of these facilities is conducted. Adding money to facilities that have systemic issues is not going to increase their effectiveness.

When I spoke to Justin on the Sunday before he died, he said, "Dad, I know this is my last chance and I want to get better." He was very positive about what he was going to do when he got out of his program. He had plans for his career and wanted to do something with his life. His step-mom and I were very happy for him and for once in a long time, we had hope that he would be able to lead a happy and healthy life.

Thank you for allowing me to speak to you today.

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

Now, Randall Omvig.

STATEMENT OF RANDALL OMVIG, FATHER OF JOSHUA L. OMVIG; ACCOMPANIED BY ELLEN OMVIG, MOTHER OF JOSHUA OMVIG

Mr. OMVIG. Ellen and I would like to thank you for the opportunity to address the Senate Veterans' Affairs Committee. We have submitted two newspaper articles from the *Des Moines Register* and the *Waterloo Courier* from Iowa for your examination. We also hope that you have had time to look at Josh's memorial Web site, which was created by Josh's aunt, Julie Westly. This site was created to help others with as much information as we could find on PTSD, post-traumatic stress disorder.

There is no way we could go through in 5 minutes the events leading up to and the day Josh took his life in front of his mother.

We would like to voice our strong support of the Joshua Omvig Veterans Suicide Prevention Act, S. 479, reintroduced by Senator Harkin and Senator Grassley. This bill has Josh's name on it, but it represents so many men and women before and after Josh who were unable to live with the physical, mental, and psychological effects of their service.

One of the most important issues we see in the past and today is the way we are bringing our troops back, regular service and especially the National Guard and Reserve units who are going back to civilian life. Josh's company went from Iraq to Thanksgiving dinner with their families in less than 1 week. One or 2 weeks of decompression or defusing is not enough. This, however, is more the rule than the exception. A few days later, Josh was back to his civilian job.

All the troops know how to fill out the form asking if they are having any problems. They know if they say yes, they will be held back, won't be able to see their families and loved ones. The one thing they have been thinking and dreaming about is the homecoming and they won't do anything to delay that.

Josh's company was put on a 90-day call-up period when they got back, whereby if they were needed, they would be called back to active duty. During this time, there is no drill, no contact with the people he spent such an intense time with. There was no one around him to talk over things with. After a week or two of being home, reality starts to set in. Things are not the same.

Why didn't Josh and so many others seek help when they got back? We train our soldiers well, mentally and physically, to handle any situation that comes up, to survive, the "I can do," "I can handle it" attitude. When we would ask Josh how he was doing, it was, "I am OK. I can handle it." When we hear that now, we know there is a soldier that is having problems.

Josh wouldn't tell us very much about what he did in Iraq. He had to sign secrecy papers that they would not say where they were or what they did. Josh tried to keep his promise. Little things here and there in conversations would come out. He would tell us, "We couldn't tell anyone." How can you seek help if you couldn't tell anyone what his service experiences were? And we have heard this from other veterans, too.

When Josh got back, he was always sick with some type of upper respiratory or gastrointestinal problem. We finally got him to go to our family doctor, who he was friends with. We told him to talk to her about some of the problems he was having. She later told Ellen to get him some help. We tried to get Josh to go to the VA hospital, but he wouldn't go. He said it would affect his military and personal career. We told him we would set up an appointment with a private doctor, but he said the Army would find out. We even told him that we would set up an appointment under our name so the Army wouldn't find out. He couldn't believe we would really do such a thing. It wasn't right.

It is usually a crisis or a tragedy that brings the veteran to see that they can't handle it alone and they need help, or the family that finally pushes the situation of seeking help. This is why it is so important to have the appropriate support, training, and counseling for family members before their soldiers come home. This

will help them to understand the changes that may happen, what to look for, where to go for help, what action can be taken to help their soldier.

We received the present information families get before Josh got home. Give them space. Don't push them to talk. Give them time to acclimate. It didn't work. Peer training and counseling is needed to help the veteran and their families. The VA delivery system, presentation, and implementation of mental health and psychological services hasn't changed much. It is still mainly up to the veteran and their family to identify the problem and go seek help.

There is still no comprehensive prevention program during the defusing or decompression time to start dealing with the emotional and psychological effects of their service, to provide group peer counseling, training, coping mechanisms, and strategies.

The first counseling of Josh's company had come at the first drill after Josh's death. They brought in chaplains and counselors to have group and private sessions, to talk over what happened with Josh. Something amazing happened. The conversation went from what happened to Josh to what troubles some of the other soldiers were having. Some of them went on to get more counseling and treatment after that.

We feel the decompression time should take place after the soldiers have left to see their families. After the experience of homecoming and being with their families, the soldier will be able to deal with the paperwork and assimilation training to civilian life. When back home, we must assure that there are accessible, timely services, education, and outreach programs for the veterans and their families.

The day after Josh's suicide, the Grundy Center Police Department and Fire Department had a defusing time where a professional counselor was brought in to help them cope and deal with what happened that day. Do we as a Nation take the same humanitarian measures for our troops who have served for us for months in a combat area? Are we providing our military men and women with the appropriate services to help them assimilate back to civilian life? Are we providing them with what they need to survive the peace?

Ellen and I have to say, no, not at this time.

We can and we must do more. This is no time to bury our head in the sand, to take a defensive posture, to try and justify or explain the problems of the past. It is time to make a major process check in the implementation of preventative programs. Research has proven that if treated early, the chance of coping with mental and psychological problems is better and may keep them from going to the chronic stage.

We have and we will have brave men and women serving for us. It is our duty to see that they receive the best services possible so they can once again have good lives. As we see it, they are the ones who have actually earned this right.

[The prepared statement of Mr. Omvig follows:]

PREPARED STATEMENT OF RANDALL OMVIG, FATHER OF JOSHUA L. OMVIG

Ellen and I would like to thank you for the opportunity to address the Senate Veterans' Affairs Committee. We have submitted two newspaper articles from the *Des Moines Register* and the *Waterloo Courier* from Iowa for your examination. We also

hope you have had the time to look at Josh's memorial Web site, *http://joshua-omvig.memory-of.com/about.aspx* which was created by Josh's Aunt, Julie Westly. This site was created to help others with as much information as we could find on Post Traumatic Stress Disorder (PTSD). There is no way we could go through in 5 minutes the events leading up to and the day Josh took his life in front of his mother.

We would like to voice our strong support of the Joshua Omvig Veterans Suicide Prevention Act, S. 479, reintroduced by Senator Harkin and Senator Grassley. This bill has Josh's name, but it represents so many men and women before and after Josh who were unable to live with the physical, mental and psychological effects of their service. The major points of the bill are the following:

1. De-Stigmatizing Mental Health
2. Training of employees and other personnel on suicide and suicide prevention.
3. Family education and outreach.
4. Peer support program.
5. Health assessments of Veterans
6. Counseling and treatment of Veterans
7. Suicide prevention counselors
8. Research on the best practices for suicide prevention among Veterans.
9. Substance abuse treatment
10. 24-hour mental health care.
11. Telephone Hotline.

One of the most important issues we see in the past and today is the way we are bringing our troops back, regular service and especially the National Guard and Reserve Units who are going back to civilian life. Josh's company went from Iraq to Thanksgiving dinner with their families in less than a week. One or two weeks of decompression or defusing is not enough. This however, is more the rule than the exception. A few days later Josh was back to his civilian job.

All the troops know how to fill out the form asking if they are having any problems. They know if they say yes they will be held back and won't be able to see their families and loved ones. The one thing they have been thinking and dreaming about is the homecoming and they won't do anything to delay that.

Josh's company was put on a 90 day call-up period when they got back whereby if they were needed they would be called back to active duty. During this time there is no drill, no contact with the people who he had spent such an intense time with. There was no one around for him to talk over things with. After a week or two of being home reality starts to set in, things are not the same.

Why didn't Josh and so many others seek help when they got back? We train our soldiers well, mentally and physically, to handle any situation that comes up to survive. The Can Do, I Can Handle It attitude. When we would ask Josh how he was doing it was "I'm OK, I Can Handle It." When we hear that now we know there is a soldier that's having problems.

Josh wouldn't tell us very much about what he did in Iraq. They had to sign secrecy papers that they would not say where they were or what they did. Josh tried to keep his promise. Little things here and there in conversations would come out and he would tell us we couldn't tell anyone. How could he seek help if he couldn't tell anyone what his service experiences were. We have heard this from other veterans too.

When Josh got back he was always sick with some type of upper respiratory and gastro-intestinal problem. We finally got him to go to our family doctor whom he was friends with. We told him to talk to her about some of the problems he was having. She later told Ellen to get him some help. We tried to get Josh to go to the VA hospital but he wouldn't go, he said it would affect his military and personal career. We told him we would set an appointment with a private doctor but he said the Army would find out. We even told him we would set up an appointment under our name so the Army wouldn't find out, he couldn't believe we would really do such a thing it wasn't right.

It is usually a crisis or tragedy that brings the Veteran to see they can't handle it alone and they need help or the family that finally pushes the situation of seeking help. This is why it is so important to have the appropriate support, training and counseling for family members before their soldier comes home. This will help them to understand the changes that may happen. What to look for, where to go for help and what action can be taken to help their soldier. We received the present information families get before Josh got home. Give them space, don't push them to talk, give them time to acclimate—it didn't work. Peer training and counseling are needed to help the Veteran and their families.

The VA delivery system, presentation and implementation of mental and psychological services hasn't changed much. It is still mainly up to the Veteran and their family to identify the problem and go seek help. There still is no comprehensive preventative program during the defusing or decompression time to start dealing with the emotional and psychological effects of their service. VA and DoD need to provide group peer counseling, training, coping mechanisms and strategies.

The first counseling Josh's company had came at the first drill after Josh's death. They brought in chaplains and counselors to have group and private sessions to talk over what happened with Josh. Something amazing happened. The conversation went from what happened to Josh to what trouble some of the other soldiers were having too. Some of them went on to get more counseling and treatment after that.

We feel the decompression time should take place after the soldiers have leave to see their families. After the experiences of homecoming and being with their families, the soldier will be able to deal with the paper work and assimilation training for civilian life. When back home, we must assure that there are accessible, timely services, education and outreach programs for the veterans and their families.

The day after Josh's suicide, the Grundy Center police department and fire department had a defusing time where a professional counselor was brought in to help them cope and deal with what happened that day. Do we as a Nation take the same humanitarian measures for our troops who have served for us for months in a combat area? Are we providing our military men and women the appropriate services to help them assimilate to civilian life? Are we providing them with what they need to survive the peace? Ellen and I have to say "No" not at this time. We can and must do more!

This is no time to bury our head in the sand, to take a defensive posture, to try and justify or explain the problems of the past. It is time to make a major process check to implement preventative programs. Research has proven that if treated early the chance of coping with mental and psychological problems is better and may keep them from going to the chronic stage. We have and will have brave men and women serving for us. It is our duty to see that they receive the best services possible so they can once again have good lives. As we see it, they are the ones who have actually "earned" this right.

[From the Des Moines Register, May 12, 2006]

PAIR HELP IRAQ VETERANS 'SURVIVE PEACE'

(By Jennifer Jacobs)

GRUNDY CENTER, IA.—The secrets that troubled veterans confide to Randy and Ellen Omvig weigh heavily on their shoulders.

Their son, Joshua, a 22-year-old Iraq veteran, was so anxious to clear his mind of the trauma of war that he killed himself in front of his screaming mother. A Web site they created in his memory: *http://joshua-omvig.memory-of.com/About.aspx* has become a whispering wall of sorts, a safe place where other soldiers confess their silent suffering.

"It's been hundreds a day—so many heartbreaking stories," Ellen Omvig said, holding on her lap the note her son left, explaining his own torment. "It's like the same story over and over again, just different names, different towns. A lot of them will make you cry, there's so much pain."

The Omvigs, of Grundy Center, will be at the State Capitol Rotunda today with Congressman Leonard Boswell and Gen. Wesley Clark, who will speak at 3:30 p.m. on the need for better services for troops with post-traumatic stress disorder, returning from Iraq and Afghanistan.

"You know the phrase you've got to be careful of?" Randy Omvig said. He paused, his breathing ragged. "When they say: 'I'm fine. I can handle it.' That means: 'I'm having trouble.'"

It took 4 months for the Omvigs, who are intensely private, churchgoing Republicans, to agree to share Josh's story publicly.

Randy Omvig, a wrestling coach with a rock-like stature and stoic personality, nearly skipped his son's funeral in December because, he told himself, he couldn't have everyone see him break down. His wife has been unable to work full time since a semi hit her car 8 years ago, and these days she is even more fragile.

"The time to help Josh is over," Randy Omvig said, and this time his bass voice was unwavering.

"But we can't ignore the others. They're coming back here safe. We've got to help them survive the peace."

MESSAGES OF TORMENT

The messages come in the dead of night, from insomniacs who tell the Omvigs that they nurse a deep need to be alone. They trust no one but their combat buddies. They can't kick the flashbacks and nightmares. They lose their temper at work. A few have admitted they expect to divorce soon. Some have lashed out with their fists. Some say getting drunk seems to be their only relief.

And some have felt the scratch of rope around their neck or the chill of a gun muzzle on their head.

"Instead of killing themselves, they'd rather re-enlist and get shot," said Josh's aunt, Julie Westly of Sioux City, who helps the Omvigs keep up with the 15 to 50 e-mails that arrive daily from soldiers and families in Iowa and elsewhere. "They'd rather die with honor," Westly said.

That was Josh's plan, his family said. He thought diving back into the war zone would ease his restlessness—and spare some other soldier from being separated from family.

The kid known as the joker who cracked everyone up barely cracked a smile after he got home in November after 11 months of high-level security work north of Baghdad.

Josh, who was with the U.S. Army Reserve 339th Military Police Company of Davenport, said he felt honored to defend his country, and he knew why he had to do the things he did. But he was never able to recover from them.

"He'd say, 'Mom, I don't want you to hate me,'" Ellen Omvig recalled, her eyes red and tired behind delicate glasses. "I'd say, 'How could we hate you? You were in the war.'"

Every time he left the house, he hugged his parents fiercely and said he loved them.

Unable to sleep, he would work himself into exhaustion, pulling double shifts as a security guard in the skywalks of Des Moines before driving 90 miles to Grundy Center. Then he'd hide out in his bedroom, playing war video games with loud music in his headphones.

At least his hands had stopped shaking. For a while, he couldn't button his clothing or grasp items in his pockets. He'd see something on the side of the road and for a few seconds his racing heart told him it could be a bomb. He was startled by sudden movements, like a bird landing on a stop sign.

A FINAL NOTE

The shaking stopped, but the hyper-vigilance didn't. And his mood worsened.

He refused to go to counseling. He was certain the Army would find out, and that there would be repercussions. He figured that with his symptoms, his goal to be a police officer was ruined.

Four days before Christmas, Josh went out drinking. A friend whose car had slid into a ditch in Black Hawk County called him for help, and Josh was arrested for first-offense operating while intoxicated.

When he got home in the morning, he shaved, changed into his desert uniform, and told his mom the recruiter had asked him to tag along to meet some possible recruits.

Ellen Omvig detected nothing unusual about his behavior, and told him she was going to hop in the shower. Josh casually handed her a note, saying, "You can read it later," and walked out the door.

"Mom & Dad," she read. "Don't think this is because of you. You did the best you could with me. The faces and the voices just won't go away." He's re-enlisting, she thought.

" . . . I will always love you. Josh."

She sprinted after him, figuring she could persuade him not to sign anything until he talked it over with his father.

And then the realization hit her, and she was yelling for Josh to stop, stop, stop, stop. She fumbled for the locked door handle of his pickup, grabbed the side-view mirror, pleading.

"Terry's coming," Josh told her. "He'll take care of it."

Ellen Omvig saw the handgun. As supervisor of his security crew, Josh was permitted to carry one.

She was screaming, and Josh kept telling her she didn't understand. His battle buddy had been killed, he said.

His parents aren't sure how he knew that. Maybe he got a letter. Neither parent has entered his bedroom since he died.

Josh kept repeating that he should have been there taking care of him. He had to be with him now. He said he'd been dead ever since he left Iraq.

"His eyes were just dark, and it was like he wasn't really there," Ellen Omvig recalled, her hands hugging her sides, not touching the tears sliding down her face. "I said, 'No! Your dad's counting on you to take care of me if anything happens to him.' And that's when he broke and the pain and the anguish was so clear and he said, 'How can I take care of you when I can't take care of myself?'"

Then a squad car rolled up, Ellen Omvig said. Josh had telephoned police officer Terry Oltman and asked him to be at the Omvig house in 10 minutes. Josh, a reserve officer and volunteer firefighter, knew every cop in town. "Go!" Josh ordered his mother.

Oltman was shouting for Ellen Omvig to get away, but she wouldn't leave her son, and Josh angled his head so the bullet's path wasn't aimed at his mother.

That was December 22, 2005.

HELPING THE LIVING

It never hit Ellen and Randy Omvig until later that Josh's problems were classic symptoms of post-traumatic stress disorder. After posting information at *http://joshua-omvig.memory-of.com*, they've heard from military families worldwide who say the problem is extensive.

"It's a terrible thing," Ellen Omvig said. "There are a ton of things that can be done so that people can live with it and at least put it on the back burner in their lives instead of letting it be the driving force in their lives and being permanently disabled." The Omvigs think the U.S. military isn't doing enough to address veterans' mental health or to ease the stigma of getting treatment.

Officials with the Veterans' Administration and Department of Defense said they have taken steps to offer more mental health services, but servicemembers are not always receptive to that.

A Government Accountability Office report issued Thursday states that of returning troops found to be at risk for PTSD, 88 percent were not referred by government health care providers for further help.

"We're not political one way or another about should we be over there, should we not be over there," Randy Omvig said. "We hear they're on a 'humanitarian mission.' There must also be a humanitarian mission when they get home. We can't let another generation suffer the way the Vietnam generation suffers."

Now the Omvigs write to politicians and military officials, applying pressure. When Boswell's office called Wednesday, they agreed to come to the Capitol.

"I'm willing to talk to anybody I have to," Randy said. "This isn't going to end in a year."

[From the Waterloo-Cedar Falls Courier, May 12, 2006]

GRUNDY CENTER COUPLE WHO LOST SOLDIER SON VISIT CAPITOL TODAY

(By Dennis Magee)

GRUNDY CENTER.—Randy and Ellen Omvig will go public this afternoon with their grief. They would rather not.

"Truth be told, we'd rather go fishing," Ellen said.

But then, many things in their life are not as they would wish.

The couple's son, Josh, killed himself in December. He was 22 years old and a veteran of the war on terrorism. He managed for about a year after his return to Iowa.

Randy and Ellen Omvig blame post-traumatic stress disorder for their son's death. As the name suggests, the psychological condition is triggered by horrific events that overwhelm a person's ability to cope.

In a series beginning Saturday, the *Courier* will examine issues related to post-traumatic stress and what the disorder will mean to soldiers, their families and the state of Iowa.

The Omvigs will appear at 3:30 p.m. in the State Capitol Rotunda with Rep. Leonard Boswell, who will talk about proposed legislation. Boswell, a Democrat representing Iowa's 3rd District, will appear with Gen. Wesley Clark, a onetime and possibly future Democratic candidate for president.

Boswell served for 22 years in the U.S. Army and completed two tours in Vietnam. He is expected to talk about House Resolution 1588, a bill introduced by Rep. Lane Evans, D-Illinois in April 2005, but still stuck in the first stages of the legislative process! The measure calls on the Federal Government "to improve programs for the identification and treatment of post-deployment mental health conditions, including post-traumatic stress disorder, in veterans and members of the armed

forces, and for other purposes," according to a Web site maintained by the Library of Congress. The bill also suggests a requirement to study factors that decrease the likelihood of developing chronic post-traumatic stress disorder related to combat.

The [bill] is backed by more than 100 congressmen, almost exclusively from the Democratic side of the aisle, but including Rep. Jim Leach, a Republican from Iowa. Boswell signed on as a co-sponsor May 9 of this year. Last legislative action on the bill came April 25, 2005, when it was forwarded to the House Subcommittee on Health.

During a recent interview, the Omvigs talked about their reluctance to become public figures—and their commitment to do so.

Burying their heads and hearts would be easier and safer than speaking out.

"But it wouldn't have been just to Joshua," Randy said.

"Or to anybody," Ellen added.

The couple view their participation with trepidation.

"Exciting is not the word we think of. Frightening is the word we speak of to each other," Ellen said Thursday.

Not of anyone or anything in particular. Or of the probable media horde and crowd.

"We feel ill-suited, not qualified, to speak on the behalf of others," Ellen said. "I do not have the right words to explain how we feel."

She has a powerful message nonetheless.

[From the Waterloo-Cedar Falls Courier, May 13, 2006]

PARENTS PUSH FOR SOLIDER'S STORY TO CONTINUE BEYOND SUICIDE

(By Dennis Magee)

First in a series

GRUNDY CENTER.—He always intended to be a policeman. To get there—with his parents' guidance—Josh Omvig became a soldier.

"He was a nice young man," Ellen says.

A mother's pained love.

"He was a pretty straight arrow," Randy says.

A father's wounded joy.

They knew Josh experienced combat in Iraq as an Army reservist. By connecting the dots, they concluded their son probably participated vigorously. Too late, they realized the person they got back from the war on terrorism was not the young man they sent.

Sadly, they say, post-traumatic stress disorder was only a vague concept until they saw Josh's world unravel.

"In retrospect, we probably should have pushed harder," Randy says.

His tone conveys little confidence the couple actually believe they could have saved their boy. As they see it, odds weighed heavily against their son.

"I keep thinking about it," Randy says. "But it was a no-win situation for Josh." The soldier told his mother once he died in Iraq. But he kept living for another year.

BURNING DESIRE

Josh, a former Boy Scout with a newspaper route, wanted to join the military early. His parents refused to sign paperwork required of a 17-year-old and made him wait.

"'It is an adult decision. It is 7 years of your life,'" Randy remembers telling his son.

Later, the couple insisted their son investigate several branches of the armed forces before making a commitment. And they helped.

"Josh was pretty focused," Randy says.

He enlisted with the 339th Military Police Company based in Davenport.

"When he signed up they hadn't been activated in more than 30 years," Randy says.

The choice was logical for an aspiring policeman or sheriff's deputy.

"He figured the best way to get some experience was to go into the reserves," Randy says.

Josh graduated a semester early from Grundy Center High School. Within 2 days he was training at Fort Leonard Wood in Missouri.

The company deployed to Guantanamo Bay, Cuba, guarding suspected members of al Qaida. But Josh was not yet ready. Meanwhile, he enrolled in law enforcement courses at Hawkeye Community College.

"But sitting in the classroom was kind of tough on him," Randy says.

Josh seemed to enjoy much more the ride-alongs he arranged with sheriff's deputies in Tama, Grundy and Hardin counties.

"He liked the action part of it," Randy says.

Josh started working for a security company in Des Moines and became a supervisor. He moved to Altoona.

In 2003, the soldiers in the 339th—back from Cuba—and Josh and his parents anticipated what lay ahead.

"They kept telling them all summer, 'You're going to be activated real soon . . . ,'" Ellen says. "That went on for months."

Josh got ready, had his teeth checked and deposited DNA samples with the military. Officials activated the 339th once again in December 2003 and the company deployed to Iraq in February 2004.

The soldiers' mission included guarding people and enemy munitions. They at times also protected convoys. Shifts were 15 hours long. Their camp at one point was mortared daily.

Temperatures inside tents exceeded 100 degrees at night, Josh said, and soldiers resorted to flea collars on their beds and around ankles to stop the pests. But that didn't work too well, Ellen says, because the toxic chemicals irritated the soldiers' skin.

"It was pretty rough conditions for them," Randy says.

At the time, the couple didn't know where their son was. They later learned he served in the Sunni Triangle, a region northwest of Baghdad and home to many of Saddam Hussein's most loyal followers.

The 339th worked out of a "forward operating base," according to the Omvigs. There were no showers and only sporadic electrical service, Josh said. Telephone reception was poor and calls were frequently interrupted.

Soldiers in the company encountered close combat in urban conditions. Josh mentioned tall buildings crowding streets narrower than H Avenue where his parents lived in Grundy Center. Gunmen would pop up in windows a few feet away from convoys. Josh indicated a handgun might have been more effective than the grenade launcher he manned.

Josh never talked about killing anyone but said the 339th came under fire. He was usually in the company's lead vehicle and "he was their best shot," Randy says.

The couple received one letter from their son in 11 months. Josh later said he was firing off notes every month. Josh also occasionally skipped opportunities to call home, at least in part to allow fellow soldiers with spouses and children access to available phones.

"Another reason was he said it was too hard talking to us," Ellen says.

BREAK IN THE ACTION

In early September 2004, Josh returned to Grundy County for a few days of rest and relaxation. He found little of either, according to his parents.

"He shook for 3 days," Randy says.

He remained vigilant and seemed unable to let down his guard.

"He was in pretty bad shape when he got back," Randy says.

The effects were apparent enough that others noticed. One of Josh's first desires was a meal at McDonald's. While there, the family encountered a veteran of the Vietnam War.

The older man saw the jitters and addressed Josh.

"'I know. It will get better. Thank you for your service,'" Ellen remembers the man saying.

Josh only shared information about Iraq in one or two-sentence fragments at a time. But as they spent time together, his parents learned driving presented perceived threats to the veteran. Deer along the road. Headlights in the rear view mirror. Ordinary items, like culverts, that to Josh represented hiding places.

"His head was on a pivot," Randy says.

While home, Josh withdrew periodically from family festivities.

"'You've got to forgive me. But I can't be around people too much,'" Ellen remembers him saying.

But he was glad to be in Grundy Center.

"He kept saying, 'I'm so happy to be home,'" Ellen says.

Randy remembers Josh taking time to smell flowers and touch leaves still hanging on trees. He talked little about what he had experienced. Peace eluded Josh, especially at night.

"Of course, you heard him. The bad dreams," Ellen says.

Their son would call out while sleeping, usually "No" or "Stop" or some other military command.

"He didn't really want to go back. But he didn't want to leave his buddies either," Randy says.

Josh fulfilled his obligation. He returned to Iraq after about 10 days.

"We just got him pretty well rested and fed," Ellen says.

The couple was concerned. Looking back, they realize they witnessed the serious effects of combat-stress reaction.

"'I'm fine. I can handle it. I've got it under control,'" Ellen remembers Josh repeating several times.

"I didn't know enough," she adds.

"And he was putting on a pretty good act for us," Randy says.

HEADED HOME

Josh completed his tour of duty in Iraq on his 21st birthday in November 2004. He later told his parents the company expected to spend 3 weeks in Kuwait. At another point, Josh believed he would be at Fort McCoy in Wisconsin for 3 months.

In reality, the soldiers were in Iowa within a week.

As the Omvigs explain the transition, Josh "went from fifth gear to first gear" in a few days.

For many troops returning to the United States, the fastest way out is the preferred path. Though sick, Josh declined an opportunity to visit the infirmary in Wisconsin.

Randy explains a soldier's option at that point.

"Do I say yes and have to stay, or do I say no and go home to my family?"

When he arrived in Iowa, the next day was Thanksgiving. On Friday, Josh returned to work in Des Moines.

Ellen and Randy knew their son was suffering. Josh, however, continued to assert he could handle the situation. He expressed concern that talking with an Army counselor, admitting a mental health issue, conceding he needed help would damage his career.

"We even tried to get him to go get private help that we would pay for," Ellen says. "He said, 'Nope. They will find out.'"

Ellen suggested seeking therapy by using an assumed name. Josh rejected the idea, shocked his mother might condone lying.

The specifics about what troubled their son and to what extent remained a mystery.

"You get short conversations," Ellen says. "Loving and kind. But short." Other veterans later told Randy and Ellen that Josh at times appeared to want to discuss something. The veterans did not press the issue, giving the soldier space to proceed at his pace. Josh inevitably let the moments pass, the veterans said.

The security firm put out pink slips and Josh was out of work. He moved into his parents' home in Grundy Center and—still considering a career in law enforcement—enrolled at Ellsworth Community College.

While waiting for classes to begin, Josh commuted to a part-time job in Des Moines. At one point, he shared a conversation with his father, notable because of its length and content.

"'Dad, I just want to be happy like you,'" Randy remembers.

Josh repeated the thought several times.

An aunt, Julie Westly of Sioux City, and others in the family also knew about Josh's "deep, deep depression."

"We all encouraged him to get help. But he was so afraid because he thought his career would be over," Westly says.

Weeks played out, and casual observers in Grundy Center might not have noticed any change in Josh. He started helping as a crossing guard for the elementary school, setting out stop signs. He volunteered with the Grundy Center Fire Department, bounding out of the Omvigs' home when his pager sounded.

"He loved it. He loved to help people," Randy says.

Getting up in the night for an emergency hardly seemed an inconvenience.

"'Well I don't sleep anyway, Mom,'" Ellen remembers him saying.

Josh altered his career goal slightly. He still wanted to be a policeman, but in a small community.

"Mostly, he wanted to be happy," Randy says. "I knew what he meant."

Besides restless nights, Josh experienced flashbacks. Unfamiliar sounds sparked an undeniable urge to examine his parents' property—in military terms, to secure the perimeter.

Ellen and Randy know Josh would circle their lot. He may have gone farther into the neighborhood.

"I don't know. We didn't follow him," Ellen says.

Josh occasionally shared thoughts that his mother did not understand.

"'I don't want you to hate me,'" she remembers him saying.

At the time, Ellen interpreted the comment as a reflection on tasks performed in combat. Attempts to reassure that she would never hate her son were only marginally effective.

"'What you had to do over there is what you had to do to survive,'" Ellen remembers saying.

Josh admitted another problem.

"He talked about hearing voices, seeing faces," Randy says.

Ellen pressed her son on one occasion about what he meant.

"He said Iraqi people."

BAD TO WORSE

Josh had an ally in Iraq. Ellen and Randy know him only as Ray.

The soldiers were assigned to each other as battle buddies during boot camp because they were standing in line together.

"They ended up good friends," Ellen says.

Toward the end of December, Josh apparently learned Ray had been killed in Iraq. The soldier's death followed unfortunately close to the funeral for Jimmie Kitch, Ellen's mother.

On December 21, Josh went out drinking, an uncharacteristic event, according to his father and others.

"I've never seen him drink a beer," Westly says.

At some point during the evening, Josh's truck and another vehicle went into a ditch along Orange Road and got stuck in snow. Josh and the other driver left the area. When they returned in a third car with two other people, a police officer from Hudson and Black Hawk County sheriff's deputies were at the scene.

According to their report, the deputies smelled alcohol on Josh's breath and he failed two of three field sobriety tests. They arrested Josh for operating a vehicle while intoxicated.

Josh got out of the Black Hawk County Jail at 9 a.m. Ellen remembers by 11 he was home in Grundy Center. It was a Thursday.

He shaved and put on his desert fatigues. He said he wouldn't be going to work. At the time, Ellen remembered a conversation about visiting a friend and didn't think anything unusual. There was also mention of helping a recruiter talk with prospective young men and women, which Josh had done in the past.

He asked his mother for their pastor's telephone number. And a sheet of paper. He wanted to write a few things down.

Ellen tore a piece out of a spiral notebook, shearing off one corner. Josh said the damaged page was good enough. Ellen remembers her son's demeanor as calm.

Josh later handed his mother a note and went out a back door. Ellen read the words but didn't understand. Josh described joining his buddies. She at first thought that meant re-enlisting, a possibility Josh had entertained.

She went after him.

"I wanted him to talk to his dad," Ellen says.

"Then it finally hit her what he was talking about," Randy adds.

Josh was in his truck. The doors were locked. Ellen pleaded with her son to not do what he was contemplating. Her appeals turned to screams.

Ellen did not [know at] the time Josh had already called a friend, police officer Terry Oltman. He asked Oltman to stop by the house in a few minutes.

Seeing what was developing, Oltman ordered Ellen away from the car, she remembers. Ellen refused to leave her son.

Josh raised a handgun and fired a single shot. He turned his head slightly to avoid possibly injuring his mother.

"I just can't believe how much can happen in one minute," Ellen says.

Father and mother want information in their son's suicide note held privately. Save for the closing thought:

"I will always love you. Josh."

POSTSCRIPT

The family buried their soldier with help from the U.S. Army Reserve 339th Military Police Company. Josh Omvig was 22.

"He thought it would get better because he was home," Westly says. "And it never got better. It got worse."

Josh told his mother once he died in Iraq. But he kept living for another year.

[From the Waterloo-Cedar Falls Courier, May 13, 2006]

FAMILY OF DEAD SOLDIER WANTS GOVERNMENT TO DO MORE TO TREAT POST-TRAUMATIC STRESS

(By Dennis Magee)

DES MOINES.—He served in Iraq. He came home. Then Army Spc. Josh Omvig killed himself. His parents blame post-traumatic stress disorder.

Only reluctantly did Randy and Ellen Omvig agree to share their son's story.

"We already live with what happened to Josh," Randy says. "Every day."

"And night," Ellen adds.

Friday afternoon—against their impulse to maintain private lives—the couple was near center stage in Iowa. They participated in a press conference organized by Rep. Leonard Boswell, a Democrat seeking re-election in Iowa's 3rd District. Gen. Wesley Clark, a onetime and possible repeat Democratic candidate for president, also addressed a small crowd and a few television cameras.

The Omvigs sat in the State Capitol Rotunda in the front row, introduced late in the hour-long event. Hearing the words "he took his own life" moved the couple near to tears.

"We know our deep feelings will never replace Joshua," Boswell said.

The event served as both campaign stop for Boswell and an opportunity for the candidate to address the Federal Government's response to its returning soldiers.

"We're trying to stir up a little tension. Others are, too," Boswell said.

Specifically, he said, the time for action on House Resolution 1588 is well-past. The measure would boost benefits for veterans and address issues related to post-traumatic stress disorder.

Rep. Lane Evans, D-Illinois, introduced the bill in April 2005. Boswell signed on as one of more than 100 co-sponsors last week.

"I didn't want to come out here and tell you I support it if I wasn't on it," he said.

The last action on the bill was referral to the House Subcommittee on Health toward the end of April 2005.

"I can't believe they've had that for more than a year," Ellen Omvig said.

Boswell suggested part of the hang-up is related to the cost, a notion he rejected.

"And we can't find the money? In the United States of America? It's absurd," he said.

He also emphasized the bill's intent to strengthen cooperative efforts between the U.S. Department of Defense and the U.S. Department of Veterans Affairs.

Clark later attacked President George W. Bush, saying the administration needs "to get its priorities right."

The retired four-star general, who was severely wounded in Vietnam, also shared his experience with life after combat. Nine years after his service in Southeast Asia, Clark said he experienced flashbacks.

"It takes a long time for these feelings to surface and for veterans to be able to vocalize what they went through," he said.

"I was lucky. I didn't suffer much," Clark added.

Josh Omvig did.

The young man from Grundy Center suffered through nightmares, difficulty sleeping, involuntary shaking, physical health concerns, intrusive memories and a sense that he must be hypervigilant to supposed dangers.

"He never was well," Ellen says.

She and her husband witnessed their son's struggle for about a year. They and other family members tried to intervene but their suggestions were rejected. Josh was in a place—had been to a place—his parents could not reach.

"We always thought we had a pretty good rapport, that he could tell us anything," Randy says. "But he couldn't tell us about that."

Toward what turned out to be the end, they attached a name to Josh's condition—post-traumatic stress disorder.

"We didn't associate it with Josh until he started talking about the voices and faces," Randy says.

"Nobody gave us any reason to know about it," Ellen adds.

Josh used a handgun to end his pain. His parents buried him in December. He was 22.

"It's hard to just get up in the morning," Randy says. " . . . As a matter of fact, it's getting harder. The numbness is wearing away."

The couple's other son is in the Army. Their daughter is in high school.

"People ask, 'How can you go on?' I have other children," Ellen says.

In their grief, the Omvigs sensed a need early on to address issues they believe vitally important to soldiers and their military families. Randy's sister, Julie Westly, created a Web page devoted to her nephew and to post-traumatic stress disorder.

"We tried to research post-traumatic stress disorder and it was so hard to even find out what it was called," Westly says. "I was searching for 'military suicide' and it took a good week to even find out it even had a name."

Their sad experience spawned what the family says will be an extended commitment to spreading the word about post-traumatic stress disorder.

"What we can do for Josh is over. But we don't want what we went through to happen to any other families," Randy says.

But it apparently is, though the extent of the problem is difficult to quantify. The National Veterans Foundation, a private nonprofit organization, reports at least 65 soldiers and 32 Marines have taken their own lives, either while serving in Iraq or after returning to the United States.

"It's the worst thing for any parent—to see your child die—let alone suicide," Westly says.

HELP NEEDED

Josh's parents have a short list of items they maintain returning troops deserve.

• Guarantees those who seek medical care, physical or mental, do not face reprisals in their military or civilian careers.

One of Josh's stated reasons for not seeking counseling was fear an admission he needed help would damage his professional life.

• Transition periods between active duty and their return to civilian lives.

"We want to make sure the troops coming back have time to decompress, have this down time," Randy says.

The Omvigs stipulate the time should be spent on ground that troops consider safe. A month in Kuwait will not serve. The transition, in their view, would be most effective on U.S. soil. But not in their homes and hometowns, either.

• Intact units until ultimate release from duty.

The Omvigs advance—and research supports—the notion that soldiers should be surrounded by their colleagues. After returning to home bases or reserve centers, soldiers should be required to check in periodically and maintain contact with other troops.

• Mandatory counseling with fellow soldiers with similar backgrounds.

Veterans tell the Omvigs they prefer to talk with people who understand conditions on the battlefield.

"Because they won't talk or listen to someone who hasn't been there," Ellen says.

That includes relatives, including parents and spouses.

"Their family is the one safe place that hasn't been affected by their service," Ellen says.

Home is a good place, set aloft on an idealistic pedestal.

"They don't want it to change that. . . If they tell you anything, it will soil it," Ellen says.

• Information for families.

The couple also believes spouses and parents should receive more training on how to cope with returning soldiers. Information on how to recognize symptoms and treatment options should be readily available.

"They don't prepare the families for what comes home," Ellen says.

ROLE MODEL

The Omvigs draw comparison to how soldiers in World War II returned from Europe or the Pacific—on very slow ships over the course of weeks and months. And all the while, the troops were surrounded by fellow fighting men and women, who knew the score on the battlefield.

"You had a chance to wind down. There was nothing from the outside world you had to deal with. Indeed, there was no way you could," Ellen says.

The Omvigs adamantly resist entering the debate about the war in Iraq. The Web site in Josh's honor refers only to his life, offering hundreds of resources related to

post-traumatic stress disorder. There are also dozens of links to additional Internet sites they believe veterans and their families will find helpful.

Those who would argue the merits of the conflict should go elsewhere.

"This is not the platform or the forum for that discussion," Ellen says. The after effects of combat cross boundaries between countries, between political parties and between religious convictions.

The political arena is relevant to the Omvigs for one reason only: They want state and Federal legislators to address issues related to post-traumatic stress disorder.

"This is isn't politics. This is humanitarian," Randy says.

If government officials continue to deploy military units, including guardsmen and reservists, they should also prepare for their return.

"OK. Take him as a citizen-soldier. But how are you going to bring him back as a citizen?" Randy asks.

"From the Revolutionary War on down, the attitude has been, 'Buck up. Be tough. Deal with what you've got,'" Ellen adds. "But that doesn't work."

The Omvigs understand proposals to hold soldiers longer, to provide mandatory therapy sessions, carry a price tag But, they reason, paying now will cost less than paying later.

"Can we afford to have these people—who served so heroically—to have problems for the next 10, 20, 30, 40, 50 years?" Randy asks. ". . . How much is it going to cost in the future if they can't be productive citizens, if they can't hold a job?" They also cite as possible—even likely side effects—alcohol and drug abuse, divorce and child abuse. And suicide.

According to the National Veterans Foundation, the post-traumatic stress disorder cases treated within the Veterans Administration system increased by tenfold within the last year. More than 16,000 veterans of Iraq and Afghanistan already carry the diagnosis.

"We're expected to be humane to the rest of the world. Well how about being humane to these soldiers?" Randy says.

Ellen and Randy, however, view the public stance their taking as "a necessary evil." Dealing with their grief privately is the preferred course.

"That's really what their goal is, to get the word out," Westly says.

Burying their heads and hearts would be easier and safer than speaking out.

"But it wouldn't have been just to Joshua," Randy says.

"Or to anybody," Ellen adds.

Josh's Web site on at least one occasion attracted a hurtful comment about his abilities and courage—and though they state no political viewpoint—about the family's sense of patriotism.

Five months after their son's funeral, the Omvigs and Westly are speaking out anyway. They want others to know about the danger to soldiers posed by post-traumatic stress disorder.

"We are ready to make a lifelong commitment to this, until it doesn't exist any more," Westly says. "We don't want to see this happen to any other families." Ellen says the family has no choice.

"We know now. We've been enlightened. It's our responsibility."

"So now it's your responsibility," Ellen adds to those who hear her words.

"There's other families. There's other moms."

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

Patrick Campbell?

STATEMENT OF PATRICK CAMPBELL, OIF VETERAN, CONGRESSIONAL LIAISON, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Mr. CAMPBELL. Thank you very much for having this opportunity to speak. I am here with the Iraq and Afghanistan Veterans of America and I am not the only Iraq veteran here. If I could have the other Iraq veterans in the crowd please stand up. I know there are at least four of them here.

[Applause.]

Mr. CAMPBELL. They might not be standing because they are a humble group.

The system that the Department of Veterans Affairs employs to treat servicemembers with mental health issues suffers from a fun-

damentally fatal flaw. It is a system that waits. It is a system that waits for a servicemember to acknowledge that they have a problem. It is a system that waits for a servicemember to ask for help. The system is broken and we must fix it before we lose this generation of heroes.

I know everyone in this Committee has heard the statistic that one in three Iraq veterans and one in nine Afghanistan veterans will suffer a mental health problem as a result of their service. As you have heard here today, every statistic like this represents both a name and a tragic story.

I am here to tell you what my counselor at the D.C. Vet Center told me on my very first counseling session when I finally admitted that I had a problem a year later. No one goes to war and comes home the same person they were before they left, no one.

In preparation for this testimony, I exhibited a classic symptom of post-traumatic stress disorder, denial. I wrote this whole entire testimony wanting to talk about someone else because I was too embarrassed to admit to you, even though I have done it numerous times, that I personally have post-traumatic stress disorder. I have been diagnosed. I wrote this testimony about someone else because it was easier to tell their story than my own. I am still going to tell theirs because I think his is better, but I know that I am fooling myself when I think that I am healed.

I did use this as an opportunity to talk to my brothers who I patrolled with in Iraq. What I found not only disturbed me, it scared me. Two years later, there is a picture in each of your folders. The Alpha Company Killas, my brothers, are now struggling to find their place in the world. From my lieutenant all the way down to the gunners, no one has been spared. I heard stories about strained marriages, ruined engagements, methamphetamines, alcohol, and sleepless nights. These are just some of the stories.

I want to talk about the icon of this war, the gunner, the guy who has to make life or death decisions every day. Three out of our four gunners are suffering from severe post-traumatic stress disorder and substance abuse. The fourth one is on active duty because he could not stand the idea of being surrounded by civilians. All of them desperately need help but are too proud to ask.

One story in particular breaks my heart. We call him Manimal, and he is the picture on the bottom, half-man, half-animal. He has a smile like Clark Kent, a contagious hearty laugh, and a deadly right hook. He is a simple giant who the kids loved in Iraq. On more than one occasion while we were serving in Iraq, a car would come too close. They would either ignore or not hear the warning shots and Manimal would have to do his job. On three or four occasions, I saw Manimal put a hundred rounds in a car, because when it came down to choosing between us and the unknown face in the car coming toward us, he was the most loyal friend you could ever possibly have.

I remember finding Manimal in the corner of a tent one day. He was sitting by himself. He never sits by himself. He is the center of attention. I said, "Hey, Manimal, what is up?" He started talking, but he never made eye contact with me. He said, "I saw that bullet hit that man in the chest. I saw his face as he lost control of the car. I watched that car hit the wall as we drove by. I couldn't

say anything because—well, because we just kept on driving." This man watched this man die that he just shot and we just kept driving.

As a medic, I had to make life and death decisions when an emergency arose. Manimal had to make them every time we got on the highway. When he got home, he never could keep a job for more than 2 weeks. He couldn't stand being told what to do by an 18-year-old who never saw what he saw. He drank too much and once was caught, got a DUI and had his license suspended. He would call me late at night, usually at two or three in the morning, just to talk, to talk to someone whom he trusted.

Finally, I was able to work with Manimal and we decided a profession for him. He would become a medic like myself. He finished the EMT class and passed the test, which was a bit step for someone who never graduated high school, only to be told because he didn't have his driver's license, he couldn't start his job. As he waited to start his job, he spent all his money on a woman who said she loved him, but when the money ran out, so did she.

Now a man who finally found his path after coming home is still being held back by his past. Currently, he is living on his mother's couch, still drinking too much, and is up to his ears in debt. And the last phone call—he has been calling me. He called me seven times in the last month asking for the phone number on how to volunteer to go back to Iraq. He will not stop calling me because he says to me it is the only way he can get out of debt and Iraq is the only place that makes sense. It is the only place where he can be someone again.

Manimal has a GED and I go to law school. We have very different backgrounds, but we are so incredibly similar. We both got home and we drank too much. We made impulsive decisions. We shut the world out and tried to fill that gaping hole in our souls with women. We are both too proud to ask for help and too scared to admit that we have a problem. Two years later, the only difference between Manimal and I is the fact that I have a friend who intervened and said, "I will not be your friend anymore unless you go get help, because you are not the man I knew. You are not the man who I was friends with." Sadly for Manimal, his support network collapsed under the weight of his problems.

The answer to the problems that Manimal and I face require face-to-face counseling. Every servicemember who comes home from a combat zone deserves this. Only then will we be able to remove the stigma and fear of asking for help. Don't misunderstand me. The soldiers will complain, just like a kid complaining about taking a bath after playing in the dirt all day. Everyone knows we just need to do it.

Now, just getting into the door is not enough. We need to make sure that once they get in that door, they spend more time in the counseling room than they do in the lobby waiting for help. As Senator Murray already said, the *USA Today* article says the number of Iraq veterans who are using the Vet Centers has almost tripled and the staff has only increased by less than 10 percent. We must fully staff these facilities.

Lastly, Manimal only has a few months left to enroll in the VA to be treated for conditions that potentially can be related to his

combat service, such as his readjustment issues. The 2-year eligibility window is unrealistic and confusing for a National Guard soldier who thinks that being in the Reserves means that they are not a veteran, especially those who are in a unit that are planning on redeploying in a couple months. A 5-year eligibility period would let our servicemen and women have the opportunity to settle back into their lives before they start losing their benefits.

I am sorry I didn't tell you my personal story, but I appreciate you listening to what little pieces I did tell you. Thank you for listening to Manimal's story, and I know Manimal is at home watching this right now. Thank you, Manimal, for letting me tell yours because it was much easier to tell yours than it was to tell mine.

I have been here for a year. I have been doing this job for a year and I can tell you that we, as a Congress, and we, as a veteran community, have come a long way. I appreciate that we are speaking first, the people who have had to pay the price of this war. I know that each one of the veterans sitting behind me, especially the ones who wouldn't even stand up, and the veterans watching this right now, they are counting on you because they will never ask for help. It is not in our culture. We have got to get the help to come to them. Thank you again.

[The prepared statement of Mr. Campbell follows:]

PREPARED STATEMENT OF PATRICK CAMPBELL, OIF VETERAN,
LEGISLATIVE DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Mr. Chairman and Members of the Senate Committee on Veterans' Affair, on behalf of the Iraq and Afghanistan Veterans of America (IAVA), thank you for this opportunity to address, "The VA's response to the mental health needs of today's veterans."

My name is SGT Patrick Campbell and I am a combat medic for the DC National Guard, an OIF vet and the Legislative Director for the Iraq & Afghanistan Veterans of America. IAVA is the Nation's first and largest organization for veterans of the wars in Iraq and Afghanistan. IAVA believes that the troops and veterans who were and are on the front lines are uniquely qualified to speak about and educate the public about the realities of war, its implications on the health of our military, and its impact on national security.

Everyone on this Committee has heard the statistic that one in three Iraq veterans and one in nine Afghanistan veterans will suffer from a mental health problem as a result of their service. Every statistic like this represents a name and a heart wrenching story. I am here today to tell you what my counselor at the DC Vet Center told me in my first session, "No one goes to war and comes home the same person they were when they left."

The system that the Department of Veteran Affairs employs to treat servicemembers with mental health issues suffers from a fundamentally fatal flaw. It is a passive system. It is a system that waits. It waits for servicemembers to acknowledge that they a problem. It is system that waits for servicemembers to ask for help. The system is broken and we must fix it before we lose this generation of heroes.

In preparation for this testimony, I decided that rather than searching my heart for another dark shadow to bring into the light, I would use this as an opportunity to check in with my 20 brothers from Iraq. What I found not only disturbed me, but scared me. Two years later with redeployments looming on the horizon, the once proud Alpha Company Killas are now struggling to find their place in the world. From my Lieutenant down to the gunners, no one has been spared. Strained marriages, ruined engagements, methamphetamines, alcohol and sleepless nights are just some of the stories I have heard.

Three out of the four gunners are suffering from severe PTSD and substance abuse. The fourth went on active duty because he could not think of being surrounded by civilians again. All of them are desperately in need of help, but too proud to ask. One story in particular breaks my heart. We call him Manimal (half man, half animal). He had a smile like Clark Kent, a contagious hearty laugh, and deadly right hook. He was a simple giant, whom the kids in Iraq loved to play with.

On more than one occasion while serving in Iraq a car would come too close, would ignore warning shots and Manimal would have to do his job. I personally witnessed him light up three or four cars essentially riddle them full of bullets because when the choice was between us and them, Manimal was the most loyal friend one could ever have. I remember one day finding Manimal alone in a corner and I asked him how he was. He whispered but never made eye contact with me and stated, "I saw my bullet hit that driver in the chest. I saw his face as he lost control of his car. I watched the car hit the wall as we drove by. I couldn't say anything because . . . well because. We just kept driving." As a medic I had to make life-and-death decisions when an emergency arose, Manimal made them every time we crossed on to a highway.

When Manimal got home he never kept a job longer then 2 weeks. He couldn't stand being told what to do by an 18-year high school graduate who never saw what he saw. He often drank too much and one night he got caught. He was charged with a DUI and lost his driver's license.

He would call me late in the night, just to talk . . . just to talk with someone who understood. Finally Manimal decided he wanted to be a medic. This profession would be his penance for the lives he took. He finished Emergency Medical Technician (EMT) classes and passed the test (a huge step because he never graduated high school) only to be told he couldn't start till he got his driver's license back. As he waited to start his job he spent all his money on a woman who said she loved him, but when the money ran out so did she. Now a man who found his path after coming home is still being held back by his past. Currently, he is living on his mother's couch, still drinking too much, and is up to his ears in debt. He only sees one solution out of this mess, to go back to Iraq and be someone again.

Although we come from different backgrounds Manimal and I are very similar. When we got home we both drank too much, made impulsive decisions, shut the world out and tried to fill that gaping hole in our souls with women. We are also too proud to ask for help and too scared to admit when we have a problem. Two years later, the only difference between Manimal and I is that I am blessed with friends who forced me to get counseling. I was given an ultimatum, "Go to counseling or lose another friend." Sadly, Manimal's support network broke under the weight of his problems.

The answer to the problems Manimal and I face requires face-to-face counseling with a licensed mental health professional for every servicemember returning home from a combat zone. Only then will we remove the stigma and fear of asking for help. Don't misunderstand me, because the soldiers will complain, but just like a kid complaining about taking a bath after playing all day in the dirt . . . everyone knows we just need to do it.

Once we get these servicemembers in the VA's door we need to make sure they are in the counseling room and not waiting for hours in the lobby. A recent *USA Today* article stated that although the number of Iraq and Afghanistan veterans using the Vet Centers has nearly tripled over the past 3 years, the number of staff has been increased by only 9.3 percent. We cannot wait for the storm to come to start preparing, we must fully staff these facilities and look to expand them to new communities.

Lastly, Manimal has only a few months left to enroll in the VA to be treated for conditions "potentially related to his combat service" such as his readjustment issues. The 2-year eligibility window is unrealistic and confusing for a National Guard soldier who thinks that being in the Reserves means they are not yet a veteran, especially those in a unit that will probably be redeployed in a matter of months. A 5-year eligibility period would let our servicemen and women have the opportunity to settle into their lives before they start to lose their benefits.

Thank you for listening to my story. Thank you for listening to Manimal's story. And thank you for listening to all of our stories. This Congress has come a long way over the past 4 months, as evidenced by the fact that Veterans and not administrators are the first to speak at these hearings. Going forward, we have an obligation to create a culture where veterans' needs also come first, and returning troops do not have to beg for help because the help is already there.

Chairman AKAKA. Thank you, Patrick Campbell.

Dr. Connie Best?

STATEMENT OF CONNIE L. BEST, PH.D., SENIOR FACULTY MEMBER, NATIONAL CRIME VICTIMS RESEARCH AND TREATMENT CENTER, MEDICAL UNIVERSITY OF SOUTH CAROLINA

Dr. BEST. Good afternoon, Senators. It is indeed an honor to address this Committee and to sit on this panel. I have been asked to discuss the ability of the Department of Veterans Affairs to meet the needs of veterans who have experienced military sexual trauma with particular attention to the Guard and Reserve.

I am a clinical psychologist and a professor in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina. Today, I am speaking to you from several perspectives. First, I am a psychologist who has treated victims of rape and sexual assault for more than 25 years. Second, I am someone who spent more than 20 years in the Navy Reserve, retired in 2004 at the rank of captain, which is an 06. Finally, I am a civilian psychologist who has served in a variety of consulting and advisory capacities and positions for the Department of Defense.

According to the VA term, military sexual trauma, or MST, refers to both sexual harassment and sexual assault that occurs in the military. It can be experienced by both men and women. Numerous studies have documented in varying numbers the number of rapes in the military in the veteran population. One study of users of the VA health care system found that 23 percent of them had reported experiencing at least one sexual trauma while in the military.

There are aspects of sexual trauma that are unique to the military. MST occurs on military installations where the victim both lives and works, and so often the victims remain in close proximity to their perpetrators. The perpetrators are frequently their supervisors or a higher-ranking peer who would be responsible for making decisions about their promotion and their duty assignments, so the risk of re-victimization is quite real. These factors combined with the value placed on unit cohesion, particularly in combat theaters, add to the reluctance of victims to come forward.

The devastating effects of military sexual trauma are clear. As any veterans or their family members can tell you, victims may suffer for years. They may develop post-traumatic stress disorder, major depression, substance abuse problems, and functional impairment in social, vocational, interpersonal situations. The effects of military sexual trauma do not stop once the servicemember leaves the military.

With approximately 76,000 Reservists currently deployed worldwide in support of the War on Terrorism—and actually, in 2005, that number was 120,000 higher—members of the Guard and Reserve face their own unique sets of challenges when they experience MST. Once released from active duty recall, they do not remain on military bases. They return to their hometowns. This is an understandable urge to return as quickly as possible to their spouses, children, jobs, and their normal lives. Once returning home, they are away from their unit members and from other military support systems.

During their post-deployment health assessment, which is conducted immediately after returning from deployment, they are

given the opportunity to indicate if they have experienced MST or that they might be experiencing other mental health issues related to that trauma. Reservists are acutely aware that if they do endorse a serious mental health concern such as post-traumatic stress disorder, they will likely be retained on active service and not allowed to return to their civilian lives.

A 2006 study by mental health professionals at Walter Reed Army Institute of Research found that the prevalence rates of reporting a major mental health problem among servicemembers returning from Iraq and Afghanistan are 19 and 11 percent, respectively, with combat experience being the most frequently cited reasons for their problems. If a servicemember was unfortunate enough to have experienced both combat-related trauma and military sexual trauma, the risk for developing significant mental health problems would increase exponentially.

One study found that members are also twice as likely to report mental health problems at the three or four-month time period after returning from deployment. That is a time that the post-deployment health assessment has been over with and that the Guard members and Reserve members are typically at home.

I believe that the VA is staffed by some of the best mental health care providers that there are and some have excellent expertise in working with military sexual trauma. However, I believe the problem facing the VA is one of sheer numbers. The significant number of veterans who may be experiencing MST or a combination of MST and combat-related trauma, compounded by the fact of the long-lasting nature of PTSD, means that the VA must be prepared to meet the needs of a growing number of victims and of veterans over the years to come.

To quote a line from a well-known movie, "Jaws," when one of the characters saw the shark go under the boat for the very first time, he uttered in understated and prophetic words, "We're gonna need a bigger boat." That is what I would say to the VA. We are going to need a bigger boat. That means more qualified and appropriately trained providers must be available. Those clinicians must be able to provide specialized services, sexual assault services, and understand sexual trauma in addition to combat-related trauma. They must be sensitive to the issues of the Guard and Reserve communities. Perhaps now it is time to consider some of the following:

1. The addition of specialized training programs for current providers in the treatment of MST;

2. Adding additional training program and internship sites for psychologists and psychiatrists. Internship training sites are very cost effective and it is a good way to ensure that you will have mental health providers in the pipeline to address the needs of our veterans in the years to come;

3. Collaborations with academic medical centers with expertise in sexual trauma who can assist the VA in their training of their own clinicians; and

4. The creation of specific outreach programs to address the needs of returning Guard and Reservists who face significant barriers to treatment.

Thank you for this opportunity to address you and for the pleasure of sitting on this panel.

[The prepared statement of Dr. Best follows:]

PREPARED STATEMENT OF CONNIE LEE BEST, PH.D., SENIOR FACULTY MEMBER, NATIONAL CRIME VICTIMS RESEARCH AND TREATMENT CENTER, MEDICAL UNIVERSITY OF SOUTH CAROLINA

Good Afternoon Senators. It is indeed an honor to address this Committee. I have been asked by this Committee's Chairman, the Honorable Senator Akaka, to discuss with the Committee the ability of the Department of Veterans Affairs to meet the needs of veterans who have experienced military sexual trauma, with particular attention to the National Guard and Reserve.

I am Dr. Connie Lee Best, a Clinical Psychologist and Professor in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina. Today I am speaking to you from several perspectives. First, as a psychologist who has spent more than 25 years treating victims of sexual assault. Second, as someone who spent twenty years in the United States Navy Reserve, retiring in 2004 at the rank of Captain (06). Third, as the Director of an office at the Medical University responsible for responding to complaints of sexual harassment within the University. Finally, as a civilian psychologist who has served in a variety of consulting and advisory positions, both paid and unpaid, for the Department of Defense.

According to the VA, military sexual trauma (MST) refers to both sexual harassment and sexual assault that occurs in military settings. It can be experienced by both men and women. Sexual harassment is defined as repetitive, unwanted sexual attention or sexual coercion. Sexual assault is sexual activity against one's will.

Numerous research studies have documented rates of rape ranging from lows of 6 percent for active duty women and 1 percent for active duty men to rates that are significantly higher. One study found that 23 percent of female users of VA healthcare reported experiencing at least one sexual assault while in the military.

There are aspects of sexual trauma that are unique to the military. MST most frequently occurs where the victims live and work so that often the victims remain in close proximity to the perpetrators. The perpetrators are just as frequently their supervisors or higher ranking peers who will be responsible for making decisions concerning the victim's promotion or duty assignments. The risk of re-victimization by the same perpetrator is real. These factors, combined with the value placed on unit cohesion, especially in the combat theaters, add to the reluctance for victims to come forward. Even given the relatively new system in the military that allows victims to seek medical and psychological care without required reporting to law enforcement, the unique aspects of MST have the effect of reducing the likelihood that victims will seek psychological services.

The devastating affects of MST are clear. As any veteran or their family members will tell you, victims may suffer the effects for years. Those who have experienced MST often develop post traumatic stress disorder (PTSD), major depression, substance abuse problems, and functional impairment in social, interpersonal, and employment settings. The effects of MST do not stop once the servicemember leaves the military.

As of April, 2007, there are approximately 76,000 Reservists deployed worldwide to support the War on Terrorism. In 2005, that number was 120,000 higher. Members of the Guard and Reserve face their own unique sets of challenges when they experience MST. Compared to their regular active duty counterparts, many members of the Guard and Reserve may not be as familiar with the resources available.

Once released from active duty recall, they do not remain on a military base; they return to their hometowns. There is an understandable urge to return as quickly as possible to their spouses, children, jobs, and their "normal" lives. Once returning home, they are often far away from needed resources, away from other unit members, and away from their military social support systems. Although during their Post-Deployment Health Assessment conducted immediately after returning from deployment, they are given the opportunity to indicate if they had experienced a MST or are experiencing mental health effects associated with that trauma, Reservists are acutely aware that if they do endorse serious mental health concerns such as PTSD, they will likely be retained on active status and not be allowed to return to their civilian lives. Furthermore, the victims of sexual trauma may feel that if they could just return home to their families and jobs, they will be able to overcome this experience on their own.

For Guard and Reserve members who have also experienced combat-related trauma, the suffering can increase exponentially. A 2006 study by mental health professionals at Walter Reed Army Institute of Research, found that the prevalence rates of reporting a mental health problem among servicemembers returning from Iraq and Afghanistan were 19 percent and 11 percent respectively, with combat experiences as the most frequently cited reason for their problems. If a servicemember was unfortunate enough to have experienced combat-related traumas and was also a victim of sexual trauma, the risk would be expected to be great for the development of significant mental health problems.

Another group of military researchers found that servicemembers are twice as likely to report mental health concerns 3 or 4 months after returning from deployment rather than immediately afterwards. This time of greater reporting of PTSD and other mental health concerns is a time well beyond when the Post Deployment Health Assessment screening typically would occur. Members of the Guard and Reserve would already likely be demobilized and at home.

I believe that the VA is staffed by some of the best mental health providers and by some with exceptional expertise in MST. However, I believe that one of the problems facing the VA in their responsibility to meet the needs of today's veterans who have experienced MST is one of sheer numbers. The significant number of veterans who may well be experiencing MST, in addition to those who may also be experiencing both sexual and combat-related trauma, combined with the long-lasting nature of PTSD, means that the VA must be prepared to meet what is expected to be a growing number of veterans in need of mental health services in the years to come. To quote a line from a well known movie, *Jaws*, when one of the characters saw the shark for the very first time he uttered the understated and prophetic words—-"we're gonna need a bigger boat." That is what I would say to the VA—we are going to need a bigger boat.

That means more qualified and appropriately trained providers must be available. Those providers must be able to provide specialized sexual assault services and understand the interaction of sexual trauma with combat-related trauma. They must also be sensitive to the special issues of the Guard and Reserve communities. Perhaps now is the time to consider some of the following: adding specialized training programs for providers in the treatment of MST; adding additional training internship sites for psychologists and psychiatrists which are both cost-effective and will ensure that there will be a sufficient number of providers in the pipeline to meet the ever-increasing numbers and needs of veterans; collaborations with academic medical centers with expertise in sexual trauma; and the creation of specific outreach programs to address the needs of returning Guard and Reservists who face significant barriers to treatment.

Thank you.

Chairman AKAKA. Thank you very much for your testimonies.

Let me tell you that according to our schedule, we are expecting a vote to be called, or a series of votes, on the floor. So as a result, I am going to ask each Member to ask one question and then we will move it along quickly. If we have time here for whatever reason, we will have a second round for this panel. We have a second panel waiting here.

So let me ask my first question. Mr. Bailey and Mr. Omvig, what would each of you tell families of those with servicemembers in Iraq about what to watch for when the servicemember comes home, and what to do if symptoms arise? Mr. Bailey?

Mr. BAILEY. The biggest thing I would tell anybody is to not assume and to always ask questions. Do not assume the VA is there to help without somebody who is going to be there to guide them through every step because there are too many walls at the VA. Just do not assume. Nothing will get done if you do.

Chairman AKAKA. Thank you. Mr. Omvig?

Mr. OMVIG. One of the points that we have brought up before is peer counseling for families. As far as peer counseling, we are talking about people that have been through situations like ourselves being able to talk to families before the soldiers come home, being able to give them a little bit of the insight that took us too long

to find out because it starts very slowly and builds and builds up to the perfect storm, and then it is almost too late.

Mrs. OMVIG. I might just like to say that it is really important for, and it has been discussed before, other veterans to be peer counselors, because they understand and so many of the veterans or even active duty service people do not feel safe or have various trust issues and only wish to speak or wish to listen to somebody else that they know really does understand what they have been going through or what they are dealing with and they don't want to have to be educating somebody about something they may not even be understanding themselves. So they need another peer counselor.

Mr. OMVIG. One thing that helped us tremendously early on, and when we got into talking to other veterans, is that the Vietnam veterans who have been struggling with PTSD so long, dealing with their own problems, started helping us understand what was going on with Josh. These guys who are fighting for their lives right now are trying to help us understand what happened to him, and they are some tremendous people.

Chairman AKAKA. Thank you for your response, Mr. Omvig and also Josh's mother, Ellen Omvig.

Senator Craig?

Senator CRAIG. Well, again, I thank all of you for your testimony.

Possibly to you, Patrick, and to the Omvigs and to the Baileys, do any of you know what stress management training or preparations your sons may have received from the Marine Corps or the Army, respectively, prior to the entry into combat that might have helped them cope with what they experienced coming out of it? That is also directed at you, Patrick.

Mr. BAILEY. To my knowledge, the only thing my son talked about was urban warfare training. No stress management training. He was prepared to go fight in an urban combat environment, but there were no personal well-being classes that I am aware of.

Senator CRAIG. OK.

Mr. CAMPBELL. Actually, I was very blessed. The thing that saved me was right before we got into theater in Kuwait, we had a police officer who does police officer training that talked about what happens when you are in a stressful situation and the physiological reactions. At the very end of that, they talked about secrets and how the secrets that you keep are the secrets that kill you. I remember thinking that was my mantra when I got home, that was the only thing that saved me, because the more I buried a story in my head, the more it just grew like a cancer and made it harder for me to function.

That training is something that they give to police officers all across the country as part of their academy training, and I remember thinking, this needs to be told to everyone, what you should expect when you fire your weapon, but also what you should expect when you come home. And that is why we believe that whenever—normally, a police officer, when they fire their weapon and they see a weapon, they go through this type of counseling. I was fired at, shot at, blown up 16 times while I was there and I never once was required to get that type of counseling. The police officer training

that we have in place already throughout this country would serve as an excellent model for pre- and post-deployment.

Senator CRAIG. Thank you. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Craig.

Let me do this by seniority. Senator Rockefeller, your question, and we will follow with Senator Murray.

Senator ROCKEFELLER. Mr. Chairman, I am going to depart from the usual and suggest that—I looked at the votes that we have coming up. I don't think they are going to change the future of the world. As for myself, I have made the decision I am just going to miss them because I think what we are doing here is far more important than what they are going to be doing on the floor of the Senate. So if you want to go on to somebody else, I will be here until you all come back for the next panel.

Chairman AKAKA. Senator Murray?

Senator MURRAY. Let me just say that no apology or excuse can ever make up for the loss that you have endured. We are very grateful for you to have the courage to come here before this Committee and share your story, especially because anybody listening to this will hear something in it for them.

One of my deepest concerns is the men and women who have separated from the service, gone home a year and a half ago, and feel like nobody knows what is going on in their head and don't get the help. So your words have made a difference for us, for the policies that we need to put in place, but hopefully for some soldiers out there that hear you, as well. So I really appreciate it.

And Dr. Best, I wanted to thank you in particular for talking about the really hidden, unspoken story of sexual trauma from this war. It is a difficult issue because I have heard personally from many women I know— and men, as well—who don't want to talk about it for obvious reasons, but also for the unspoken reason that they don't want to put at risk women in the military in general and we have got to figure out how to walk through this. So I hope that at a future time, you and I can sit down and talk about what we can do better to help really bring that into the public and help those people who have been traumatized, but do it in a way that provides them the dignity that they really deserve for what they are doing.

So I only have time for one question and there are many I think I would ask. Patrick Campbell, because you were in the Guard and Reserve and came home, when the war started, and talking to our own Guard and Reserve, they said the most important thing was for the soldiers to get home and have that 90-day waiting period before they were called back to their unit. I heard you say that is too long of a time, that getting back and having the camaraderie of those that you served with was absolutely critical for a number of reasons. Do we need to relook at that for our Guard and Reserve and think about bringing them back sooner, as hard as that is, when we want them to get home to their families?

Mr. CAMPBELL. No, I actually wasn't the one that said it. It was Mr. Omvig.

Senator MURRAY. Oh.

Mr. CAMPBELL. But I will say this, that there was nothing more that I wanted to go than go and just disappear. I think the idea

is that the 90-day period is before you go and work again. That makes complete sense. The idea that you don't come back and just interact and have forced fun time or time where you have to just decompress. That is completely different than having to go clean your vehicles, start checking in the weapons. Those are times that we can talk about.

I think that what Mr. Omvig said was exactly right on.

Let them go see their families. Let them have those moments. Then have them there just during the day. Give them a job for a couple weeks where they go in during the day, they get to meet with their buddies, but at night, they get to go see their families, and that makes all the difference.

Senator MURRAY. Mr. Omvig, I assume that meeting with their buddies is an important way for them to be able to open up?

Mr. OMVIG. It has to be, because they have to start talking about the experiences that they shared together. You know, going in and talking one-on-one with a counselor, they are not going to share their deep thoughts of what went on. But as a group, in group sessions, they are more likely to open up into what actually went on there, and as it starts, it gets to be a snowball and that snowball gets bigger.

Senator MURRAY. Yes.

Mr. OMVIG. And the reason that it has to be during this 90-day period is that the earlier we address the issues of mental health, the faster we can start correcting the problems and keeping them from growing chronic. Once to the chronic stage, it is difficult to treat and deal with. And we need to give all of our veterans the best opportunity to live the best life they possibly can. They need to come back and be able to live the American dream that they are over there fighting for——

Senator MURRAY. Yes.

Mr. OMVIG [continuing].—not being affected and unable to live the American dream because of what they did for our service.

Senator MURRAY. Thank you, Mr. Chairman. I think there are two issues. I think one is the stigma of this, and we have got to all be talking about it more and working with our communities and everybody involved to make sure that people understand that we have to all understand this is part of the cost of war.

And second, Mr. Chairman, I heard loud and clear what one soldier said to me, and that is they trained me to go to war. They never trained me to come home. And I think we seriously have to look at how to train these men and women to come home.

Chairman AKAKA. Thank you very much.

Senator Webb?

Senator WEBB. Thank you, Mr. Chairman.

First of all, I would like to say just very quickly that a number of you mentioned the difficulty with things such as readjustment deadlines for people coming back and sort of the delay fuse that often exists with PTSD. We did the pioneer studies on this literally 29 years ago. I really want to make sure that in terms of the way we look at PTSD that it is an ongoing exercise by government.

I have seen in the people that I served with in Vietnam cycles. It was like an 8-year cycle, and then there was like a 20-year cycle, and then there is a period when your regular career starts to end

when you start to reflect more. We can't lose sight of that when we build these artificial deadlines into when we administer benefits and this kind of thing.

But the question that I would have for all of you is given what has happened and the different situations that you described, how would you describe the reaction of the Department of Veterans Affairs people that you have dealt with after these incidents occurred? Do you feel they are being responsive, or do you feel like we are not getting anywhere here?

Mr. BAILEY. Well, sir, when my wife and I were at the L.A. VA Hospital, nobody would talk to us. Nobody cared. But they sure cared when the ABC reporter got a hold of me and we were on the news We were going to be on the news at 5:30 that night. I got a call at 5:15 from the public affairs guy wanting to know if he could be of any service. So without—I mean, the media takes a big hit, but without the media, my son's story would not have gotten out there.

Mr. OMVIG. At the present time, there is nothing what they call a CO officer assigned to military suicides that are not active, and if this happens to a Guard or Reserve individual that is not on active status, the parents basically take care of everything that is going on. If they were a casualty, then there would be a casualty officer with them for 10 days, taking care of all the paperwork, all the things that may be presented to them for help and everything else. We basically, and I know it was a very difficult time for his unit, his company, but we were given his Honorable Discharge and the papers at the public viewing, the family viewing.

Mrs. OMVIG. Which we lost.

Mr. OMVIG. And I still don't know where they are.

I was not in the frame of mind. I don't know where they were. So I think it is extremely important that we are looking at this aspect, also, of helping families deal with a crisis, the time where they are not thinking logically. They don't know what is out there to assist them. We heard from the chaplain once, but basically we have heard very little from his Reserve unit since Josh was buried.

Mr. BAILEY. I just want to say one more thing. I spent 20 years in the military, also, and the day we finally got to talk to family services there, the one thing I really expected more from my VA and my government was the man who came to give me my son's flag, but it was in a box, just like they just had bought it from Wal-Mart. It was in a box. It was just, like, oh, by the way, here is your flag. Take care. Have a nice day. And getting my son's flag in a box was the biggest insult to my son.

Mr. CAMPBELL. And just so we can tell a full picture, for me, I am very blessed that I go to the D.C. Vet Center, which of the Vet Centers is one under-utilized because people around here are definitely the type of people who don't like to admit that they have problems. At the Vet Center, I get great care. You walk in and you say, welcome home. But I have a very—when you go to a VA hospital, you might have a very different experience.

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

Chairman AKAKA. Thank you.

Senator Tester?

Senator TESTER. Thank you, Mr. Chairman.

Tony, you spoke of improvements in reducing dosages and staffing increases and you made a statement at the end that we are going to have to follow up on later, and that is evaluation of the systematic problems and where to start there, because that is no easy undertaking, but I appreciate that perspective.

I have a question that revolves around the bill that the Omvigs have got the delegation from Iowa to put forth, and I don't know if anybody else at the table has had a chance to look at it, but there are 11 points on it.

Senator Murray talked about not only training to go to war, but also training to come home. I am going to make two assumptions and then I just need to get your opinion. The first assumption is that it would pass. The second assumption is that the things you talked about, the 11 points, would be implemented fully. Is there anything else that we are missing that we might want to take a look at that this bill doesn't address that would solve or, at least, go a long ways in solving the kinds of difficulties we are talking about with mental trauma?

Mr. OMVIG. Toward solving, no. As far as identifying, yes. If you look at what has been going on with the bill, they talked about 1,000 veterans being treated by the VA are dying of suicide each year. Josh wouldn't have been one of those numbers, and there are so many others that wouldn't have been in those numbers. So we really don't know the magnitude of the problem that is really out there. And until we know the magnitude, it is going to be hard to address it one way or another unless we address it right when it comes home.

Senator TESTER. OK.

Mr. CAMPBELL. I mean, just what I said in my testimony, that every soldier who comes home gets a face-to-face—I mean, this is beyond what is in this bill and that is that it is a required face-to-face mental health screening with a licensed professional. It is the only way to take away the stigma.

Chairman AKAKA. At this time, I would like to call on the second round of questions here.

Mr. Bailey, after Justin died, you and your wife visited the domiciliary where he was staying following his 2-week hospital stay. What can you tell the Committee about the level of staffing there?

Mr. BAILEY. Well, the day we got there, we were met by what is called the dom assistant, who made a good effort. He was the only one working and he made a good effort to get a hold of his supervisors. One of his supervisors wouldn't talk to us on the phone. The other one told him to stop talking to us.

Oh, and by the way, we were let in a side door, because we didn't know where the front door was, by a resident, so we could have been there to cause any sort of damage possible. There was no staffing, except for the one dom assistant. This was on a Sunday. Residents packed up my son's belongings and we got them in garbage bags. You know, there was no respect given. We got all of his stuff in a garbage bag.

Chairman AKAKA. Thank you very much.

I should apologize to you in advance. There are a series of votes that have been called and this is why the Members have left, to go to the floor to vote. Senator Rockefeller feels so strongly about

this hearing, he will remain here and conduct the hearing. Following this panel, we have a second panel that will be testifying, and so I would like to pass the gavel to Senator Rockefeller and add my thanks to you for your testimony. Following the series of five votes, we hope to come back again to this hearing.

Thank you very much, Senator Rockefeller.

Senator ROCKEFELLER [presiding]. The question comes about people not wanting to seek help, and I think that is true of all people. Mr. Campbell, you spoke about a state of denial. I am not a psychologist. I am not trained in anything in particular. But I think that is the nature of the human being.

So let us say that you are over in Iraq or Afghanistan, or let us say that you have just come back. Your every instinct is not to go find somebody, and what you have all said in different ways is somebody is going to find you.

But I have also heard you say that it isn't easy to talk about PTSD or any other subject—mental health, trauma, sexual trauma, anything—alone with a counselor, so that if a counselor comes to you, if that was the situation, which gets into the whole Vet Center thing, which I really do want to talk about because I really do believe in that. I think that is the closest thing to making it easier for you to get somewhere where you feel comfortable, which isn't a huge building. But you have also said that you really aren't comfortable with other people, I mean, just doing it all by yourself.

So what is a possible way in your own thinking, if we could get the right kind of money into the Veterans' Administration, that people could reach out to you but still allow you to be able to make that a valuable contact by telling them what you could only tell them when you feel like telling them? It isn't just that they find you and that you meet, it is that they find you and that you begin to disgorge and begin to tell them what they need to know. I am not sure of the conflict of that. Can any of you speak to that?

Mr. CAMPBELL. I have talked about this actually a lot recently with some of the veterans we have in the D.C. area. I remember a couple of weeks ago, I took a veteran who just got off active duty into the D.C. Vet Center, and when he got out, he said, "I wish that he hadn't told me I had PTSD. I wish he told me that I had a suit of armor that said I was impervious to PTSD and I was just having some type of issues." About a week later, he called me back and he said, "I can't believe you made me go. I don't have PTSD." Another week later, he called me back and he said, "Thank you." And a week later, he called me back. I mean, all these calls when he tells me, "I don't have it, but thank you for sending me."

The biggest obstacle for a veteran is going in that first time and seeing that counselor, getting over the idea that you are going to talk about it and just learning where it is. The D.C. Vet Center is at 13th and Taylor. I don't know if you know where that is, but that is nowhere near Metro. It shares a place with a Montessori school. If you don't know what you are looking for, you are not going to see it.

The fact that I went in there and I saw it, I was now able to take people in there. Once people have gone once, it is so much easier to go a second, a third, a fourth time. To be honest with you, what I said in my first session did not help me at all. It was the fact

that I went is what caused me to break down. And about 3 days later—I didn't say anything in that first session that helped me, but 3 days later, I am in a movie theater and I am crying my eyes out because I realized I finally admitted that I have a problem to someone other than my journal. I broke free and all of a sudden I felt like I was a full human being again. Now, I had to face the fact that I was in a lot of pain, but I was feeling for the first time in a year since I got back.

So to answer your question specifically, it is getting people to where they would be asking for help so they train—just like we say in the military, muscle memory, so that you keep doing it and you keep doing it so the next time when you actually really need to do it, your muscles automatically do it. When you know you have a problem, you automatically know the phone number to call or the place to go, because otherwise, I mean, if you have ever tried to navigate the VA, there is a form you have got to fill out. You already know that. You go in. I need to fill out this form. I need to talk to so-and-so. It makes it so much easier.

Senator ROCKEFELLER. Any other thoughts? Yes, sir?

Mr. OMVIG. When he brought up the thoughts of forms, just 2 weeks ago, I was talking to a Guard member and he has a 40-hour-a-week job. He was in an IED attack in Afghanistan and was suffering from a TBI. He went to the Iowa City VA Hospital to get some help. While there, they gave him nine forms to fill out to get services. He said, if it wouldn't have been for a VFW individual in the hallway to help him fill out that paperwork, he would have gave the paperwork back and walked away.

One of the big stumbling blocks we have—if a person has got PTSD, if they have got TBI, if they have got any type of disorder that they are having problems with, how are they going to be able to fill out the paperwork themselves?

There is a big difference between advocacy and case workers. We don't need more case workers. We need more advocates for the veteran when they go in there to see that they get all the benefits they absolutely deserve when they finally break down and they finally go to the office to try to get services, because if you don't fill out the paperwork right, you don't cross all the "T"s, you don't dot all the "I"s, services are delayed and sometimes I have heard two, 3 months before they are even able to get in again.

So we need advocates, advocates that are going to be there for the veteran, not case workers that are looking out to keep the costs down for the company. There is a big difference there and we have heard a lot in the news about having more case workers and calling them advocates. Those are not advocates. Advocates are people that are looking after veterans' interests, not the company's interest in providing service.

Senator ROCKEFELLER. And who might those advocates be? The veterans service organizations? There are a lot of other volunteer groups——

Mr. OMVIG. Excuse me, I am sorry——

Senator ROCKEFELLER. No, please go ahead.

Mr. OMVIG. You have got great advocates right here. You have got advocates in the DAV who absolutely know how to fill out all the paperwork. You have the VFW that is in many of the facilities

that will help fill out the paperwork. But these guys are doing it on a voluntary basis. They are all volunteers, and they are doing a wonderful job for all of us. It is that we need more of those advocates in every single facility today. We don't have a veteran that is having problems that can't hardly describe what is happening to himself try to go in there and fill out nine to ten pages of paperwork before he can even see somebody about his problem. We need to streamline things and we need to get advocacy better.

Mrs. OMVIG. I would like to also say, for outreach in that not every place has a close veterans' clinic or VA hospital and not all the veterans can either get transportation to get to a place, or in the time frame, or to go and wait, have somebody that will drive them somewhere, they wait for 4 or 5 hours to get in, and then drive them the 3 hours back to their home. Not everyone has people that can do these things. There are a lot of places in this country that are not accessible, physically, geographically accessible, and that is saying then if they do have a place that it is a good place, because not all of them are good places. So for both of those things, you need a lot of help.

Mr. BAILEY. You know, talking about the parts of the country, we have recruiters that get our young men to sign up. We could have an outfit or a unit designated for helping when they get back. Put the unit in a truck, tell them Iowa or Idaho is your district, and here is a list of your veterans. You are on temporary duty. You drive around and you go to every one of their houses and knock on their door and say, "Hi, Bob. How are you doing?"

And as far as the paperwork, there is no excuse for nine different copies. When we went to the L.A. VA Hospital, the first form we were given, the next day, we were told it was an outdated form and was no good. And this is by employees of the VA.

But I am saying, you know, we get a truck. You have an active duty unit or a Guard unit, and that is their job, to drive around to these veterans in the rural areas, and even in the cities. You can get lost in the city probably almost easier than you can in a small town. Touch them. Say hi. Ask what can I do, or, how can I help you? Asking for help or having help offered to you, maybe you might make that first visit.

Senator ROCKEFELLER. A couple more questions. I come from West Virginia, which is not exactly San Francisco, OK? It is very rural. We have an enormous number of people who sign up to serve. One of the biggest things that they tell me when they come back, and this also—you could go all the way back to the testing of the atomic bomb way out in the Pacific on instances of this sort—they don't want to go somewhere, even if they know it is for their own benefit.

For example, I will just use one that occurs to me now, spinal cord injury, sort of a scary thing. It is not up here, but it is up here as well as down there. If they have to go to Salem, Virginia, which in West Virginia is where you have got to go if you are going to get spinal cord injury service, many veterans will make the decision not to go because people in rural areas, in Appalachia, with all the mountains and the winding roads and the psychology of Appalachia in general, don't like to have to travel. They don't like to have to go make that journey, even to a Vet Center.

I want to shift to that for a moment. I am a passionate believer in Vet Centers for the sole reason that my very small State of West Virginia has four huge veterans hospitals, and they are, as you would expect, sort of distributed around the State. Most of them have pretty good reputations, up until all of this started. So what we have tried to work on is setting up the system of Vet Venters, exactly what you are talking about, which are user-friendly. They absolutely—they may not be next to a Montessori school, because I am not sure we have many of those in West Virginia——

[Laughter.]

Senator ROCKEFELLER [continuing].—but they are on the street. You walk from the street into the building and then there is somebody, a Vietnam veteran or somebody who is sensitized and they are in it because they believe in helping their fellow veterans. And I don't know the state of their training, but I do know that they are independent and I know they are not under the control of the Veterans' Administration.

And what I want to ask you is if outreach is the deal when you get back, forgetting the complexity of when does it come, time with the family first then 3 weeks later or a month later or whatever. Forget that for a moment. Are Vet Centers something which, if proliferated, could, in fact, help when people go there? Now, if they go there, they will find less service professionally, but they will find more fellow veterans to talk with because it becomes a gathering place, really the only place that veterans can go and be together because they are informal, comfortable buildings. But they are not under the control of the Veterans' Administration. They run themselves. Is that a formula for something that is useful, or is it a good idea? But it is wholly inadequate to what we are going to be facing.

Mr. CAMPBELL. I think the Vet Centers are the model that we need to go to, and the reason why is when I would go into the Vet Center, the form that I need to fill out, it is a quarter-sheet of paper. It asks my name and why I am there. There is a little check box. So I have to write down two things and turn it in and they call Mr. Phillip, who is my psychologist. It is so personal.

I mean, you want that first experience with the VA to be a positive one, because once you have that positive experience and then you need help and they say, where do I go to get such-and-such from the VA, they know the answer to that question. They say, this is the VA hospital. This is the person you need to talk to. This is a good person. Or if they are having trouble with their case, they would be, like, this is the number to the local VFW, DAV, American Legion. Those are the types of things. If close to their house, they will go if it is close, and if they have a good, positive first experience, they will continue to go, and that will be their gateway into the VA, not these monolithic hospitals where you get buried in forms.

Dr. BEST. Senator, I think that we can have a variety of things that we should offer veterans. There is not one-size-fits-all. I think Vet Centers can serve a purpose. They certainly can be an entre where they can get some help, maybe not at the level of care they could in a hospital, but they can also interact with veterans. I think the hospitals that are staffed by psychologists and psychia-

trists can offer very specific behavioral kinds of interventions that some people with PTSD are certainly going to need that level of care.

The one thing we have not mentioned today is the use of the Internet. Our young folks are very savvy. They are very used to doing that. Wonderful things could be done that could be intervention-based, not just a reciting of what PTSD is, but actually you can do assessments online, and then you can tailor things to that and you can make that available to places that are rural that they don't even want to drive—it is 20 miles or 30 miles down winding roads to the next city that might can support a Vet Center.

So I think one of the things we can do is literally have an array of options to offer veterans, because some might want to go to Vet Centers. Some might be near hospitals. Some of the flagship VAs have some great programs and that would be good. But we also need Internet. We need lots of different things, and to make it available so that veterans can pick and choose what suits them, what helps them, and you can have things that are specific for family members that are available online and can address the family needs and answer questions for them.

So I just think that we need to sort of be creative in our thinking. Now is the time to do it. The numbers are already there and they are only going to get more with each passing day and month. And so we owe it to our veterans to think out of the box, to be creative, to have an array and offer it and let them decide what might most work for them.

Senator ROCKEFELLER. Let me come back to you with a question that you brought up earlier, and that is psychiatrists and psychologists. One of the magnificent things about VA health care training is that 50 percent of all physicians in this country intern or do residency at VA hospitals. So automatically, 50 percent of all doctors everywhere in this country, of all kinds, have trained at VA centers. Now, some of them, yes, are doing research and that research is very, very important.

My question for you is, I have never actually heard somebody say that psychologists and psychiatrists are part of that physician group. Do they also get residency training at VA hospitals and thus have a chance to experience as they are going into their professions what happens?

Dr. BEST. We certainly have people here from the VA system, but health care providers, psychologists and psychiatrists, do not have to do an internship at a VA in order to become a VA employee. Some of them that do participate in internships there can remain on staff, but it is not a requirement. So you may have a professional, a doctoral-level professional join the VA system as a health care provider who has not done an internship at the VA.

Senator ROCKEFELLER. OK. Let me just understand that. I am not saying that they have to—I am going back to my 50 percent of all physicians. Do they fit into that category or do they not, the psychologists and psychiatrists?

Dr. BEST. I do not believe that 50 percent of the psychiatrists and psychologists—are you talking about in this country?

Senator ROCKEFELLER. Yes.

Dr. BEST.—have had internships at a VA.

Senator ROCKEFELLER. That sounds like something to think about. Please.

Mr. OMVIG. Speaking for the Guard and the Reserve when we bring them back and a possible changing of that defusing time, a good idea would be to bring in a team from the VA during the drill period when you are going to be able to get everybody there as a group and start the initial process of dealing with what they have all been through. And if you bring the team in and give them a good first appearance and that you are really going to try to handle what has gone on with them and create a process here, not just a one-time deal and we are gone, here deal with it, but that we are going to continually work with you to try to help you deal with it, it is easier if you are with the group that you were actually with. You can talk about like experiences. I understand what happened to you. I saw it, too. I am also having problems with it.

Mrs. OMVIG. I would like to also explain that even—I think a lot of people are under the false assumption that all the Guard goes as a group or all the Reserve go as a group. They cherry-pick out to fill in their ranks. One thing we got asked, well, why didn't your son drop by after work and tell them that he needed to talk to someone? Well, when my son decided the way to cope was to be a workaholic. So he worked all the double shifts because it kept him very busy and thought that was going to serve his purpose.

Another thing is his base was over 3 hours away from his home and thus he couldn't drop by after work on their hours at the base to say something to someone. And he wouldn't have done it anyway because it would have, not just the stigma, but the way the laws are written up now, it would have affected his military and his personal career choice of being a police officer. I mean, he wasn't just dreaming that one up. It was real.

So I wanted to discuss that kind of thing. There were people that were brought in also that were from other States into his company to fulfill how many people they needed to have in their company. So his Reserve company, they spread out all over Iowa, they spread out all over Illinois because it is right there on the river, Davenport. They brought in people from other States besides those two main States to fill them in, so they were gone. Everybody was gone. There was nobody close, a few that did live in the area, but other than that, they were just far-flung. Guard also do that type of thing, too. So contrary to what you think, they don't all go over as a unit and all come back as a unit. It is all different.

Mr. CAMPBELL. I just want to add one real quick thing if you don't mind me, Senator. The VA has a great program that they are implementing as a pilot where they go into a Guard unit, they show a couple of videos and use that as an opportunity to have discussions. Sadly, the day that they did that with my unit back in Louisiana, they did it for 40 soldiers, which happened to be my platoon. But the guy who I lived next door to was in another platoon and he decided that day he was going to take his life because he didn't get to go to the training.

For me, I mean, these tools exist. We have created them and we are really good at this. It is just about implementation. We can go—we know what we need to do when we go into these units. I remember when I called my lieutenant about this, when he told me

that this soldier had committed suicide, that everyone was laughing about—this is before we knew—they were laughing, oh, you are going to cry, or you are going to tell some story. As soon as the video came on, it wasn't some cheesy DOD movie where everyone is happy, it was a serious look at post-traumatic stress disorder and kinds of the experiences people have, everyone got quiet and then people started telling their story.

I remember my lieutenant saying, this is the most amazing thing ever, and then he called me an hour later and said, I can't believe what I have to tell you. I just think if it just had been First Platoon as opposed to Second Platoon, that guy would still be here today. That was a pilot program. We know it works well. Why aren't we doing it?

The only last thing is that you have three different types of Reservists. You have the Reservists who stay in their unit. You have the Reservists like myself who volunteer as a filler. I have never been back to Louisiana since then. And then you have the people who get out. We have a whole different population of people we have got to worry about, the people who separate the day they get home.

They say, "I am done with the military." We have still got to go after those people because they are almost in more danger.

Senator ROCKEFELLER. Sure. Let me ask a final question of this panel and then we have to move on. I don't want to, but we have to.

I am going to start this off with my very first experience on this Committee 24 years ago, when I was very junior and I remember right back there were the television cameras. They had a guy who I think had come back from Bimini and it was the time before the Second World War when the United States was testing different things in places where possibly nobody would know about or whatever. His testimony, he said, "I want you to understand what it is to have been given cancer by your government and to be dying from that cancer," which he was fairly close to doing, "because I want you to understand how I feel."

OK, now we skip forward. It is very hard to skip by World War II, North Korea. What people went through in North Korea is unbelievable, but you get to the Vietnam War and there was this thing called Agent Orange. We used that to defoliate so we could find the enemy and in the process thousands of our people were getting cancer and dying. But the government and the military would never admit that. And the only thing that made it possible for people who were dying from cancer or who had been exposed to Agent Orange and therefore might be but might not know it yet was when an admiral's son—remember Admiral Zumwalt? His son died of cancer of Agent Orange. He came and testified before some Committee, and all of a sudden, Agent Orange compensation was made available. It is a pretty horrible way of conducting government policy.

Skip one war forward, Gulf War and something called the Gulf War Syndrome. I was Chairman of this Committee at that time and I absolutely knew the DOD said that this problem did not exist and I was just making up stuff. But every soldier was required to take a pill in Kuwait called pyridostigmine bromide, and that pill—

I talked to some people back home in West Virginia and they said they took one and they knew it was just going to tear them apart. They just stopped. But that is what you had to do every morning.

So you wander around West Virginia, and obviously around the rest of the country, and the country is full of tens and tens and tens of thousands of people who cannot read, who cannot sleep, who cannot keep a marriage, who break out in rashes. I remember one woman who was absolutely normal, except if you touched her on her right arm, she would start screaming in just unbelievable ways, and everything else about her was perfect.

The military to this day denies any such thing ever happened. And now we have this. The story really of all of you is, whether it was the garbage bag, which is horrible beyond description to hear you even say it, the flag in a box, the papers which became outdated the next day, it is almost like you went over there to fight for the country and you ended up fighting the people that you were fighting for, which is why it always troubles me when people talk about not standing up for the troops. Everybody salutes the troops. It is the policymakers, the civilian policymakers who make the policy that get the troops in trouble or the VA, whatever it is. They are the ones.

My question to you is philosophical. We are a generous and a great country. We are not particularly generous to the rest of the world. We don't do foreign aid. We don't worry about Africa. We don't worry about all kinds of places where the War on Terror is building. What, in your view, is it that makes it like this? Is it something as simple as a lack of money? Why does this happen in America?

Mr. BAILEY. Well, sir, my answer is pretty simple. Apathy and complacency, which is what I ran across at the VA. They could have a wonderful program. Apathy, complacency, and just not caring. That is what I ran across, and I am sure there are people who do care, but I didn't run across them.

Senator ROCKEFELLER. I am sort of talking about people at the top level, to be honest with you, the people that run the VA hospitals locally, the people that run the VA in Washington, the people who make military policy wherever it is made, DOD, the White House, all the rest of it. They don't get it. We have this hearing. Will they get it after this hearing? Will they take up the budget?

I think we will, and I think we will for one reason, because of a building which I have now come to cherish called Building 18 at Walter Reed Hospital, which has caused an explosion of anger here in Washington and across the country, which has suddenly delineated the difference between the warfighter and the warfighter who comes back, maybe shot through with some of those Iranian shards of metal so that they can't remove them surgically without cutting an organ or cutting an artery, so the person is in a wheelchair, probably wondering whether it would have been better for him to have been shot and killed rather than sit in a wheelchair in agony for the rest of his life. Why?

Mr. OMVIG. At one point, you talked about money, and I want to ask you, who in our society in the United States deserves more the appropriations and the funds to take care of them than our veterans. Who?

Senator ROCKEFELLER. Nobody.

Mr. OMVIG. Then we should take care of them.

Senator ROCKEFELLER. But you see, the problem is——

Mrs. OMVIG. You all have to decide that you are going to do it, and if you don't think that your constituency is going to vote for you, then you have a job of helping to sell this, and there are a lot of people that would be glad to help you to help sell this idea, that the veterans earned their right, implied or contractually, and that they deserve this.

Senator ROCKEFELLER. Doesn't it strike you as odd that we are fighting in Afghanistan and we are fighting in Iraq, and forget what one thinks about Iraq, and we are doing it all on borrowed money, so there is no budget. We have borrowed off of the Chinese, the South Koreans, and the Japanese, and a few others. So there is no end to what you can spend.

But then you come home injured or you come home uninjured or you come home thinking you are uninjured—I don't know how people come home who aren't injured after an experience like that—and then all of a sudden you fall under a national budget which has a limit. It is a national health care system, the only one in the country. No borrowing of money, but a budget. To me, that is obscene, where you can endlessly spend and borrow to fight, but you are under a tight budget when it comes to the pain at the end.

Mr. OMVIG. My question is, what does this tell the rest of the world about the United States of America and our policies——

Senator ROCKEFELLER. Well——

Mr. Omvig [continuing].—how we are dealing with the people that are serving for us when we—these are our people. These are our people, and how we are dealing with them. How does the rest of the world look at that?

Senator ROCKEFELLER. I suspect that the rest of the world looks at that as pretty unimpressed. On the other hand, what I am trying to find out is what we can do about it right here, right now. I mean, if anybody has anything else they want to say on this——

Mr. CAMPBELL. You know——

Senator ROCKEFELLER. We are a good people. Americans are a good people. And yet how many people know that we are borrowing all that money to fight, that there is no end to the amount that we can do? And how many know that you are under a budget? And people can use that as an excuse, can't they? Well, we don't have the money. We don't have the personnel.

Mr. BAILEY. The only thing—I only have one question, really, and I guess you could call it the intersection question. Building 18—how long was Building 18 there before the *Washington Post* brought it to light?

Senator ROCKEFELLER. You have got it. You said the same thing about your son.

Mr. BAILEY. How long was it there? And now it is on TV. Now people care. It is like the intersection. How many car wrecks does it take to get a stoplight?

Mr. CAMPBELL. For me——

Senator ROCKEFELLER. From my point of view, to end on a hopeful note, I think the climate, and I think the Chairman would agree with me, has been profoundly changed in these square acres and

across this country about veterans because of something called Building 18, which people will never understand and its mold, but it had nothing to do with it. It was the fact that veterans were not being respected. I think, I pray, and I hope that we will—not everything can be solved by money, but you know what? It is not a bad place to start.

I mean—Mr. Chairman, I apologize, I have talked too much—the average nurse in the VA system has served for 27 years. Now, you can say, oh, that is because the benefits are great. I don't think so. I think it is because the average nurse in the VA system believes in trying to help people, and that is a life cause for them. So they do it for their life. I think that is the way we are as people. It is just that we don't seem to be able to function that way.

I think that we are 6 years into this now and I think America has been changed in many ways, many, many ways, some for the better, some for the worse. I am deciding this is a way that we are going to change for the better.

Thank you, Mr. Chairman.

Chairman AKAKA [presiding]. Thank you, Senator Rockefeller. I want to thank you for continuing with the panel here.

I want to thank this panel for your testimony. It will help us make decisions as to what can be done to improve the services that we can provide for returning patriots and soldiers to this country. Thank you for journeying this far to testify here today. So on behalf of the Committee, let me say thank you very, very much. Thank you.

I would like to welcome our second panel of witnesses. We have asked VA to provide three of these witnesses to discuss some of the VA's very best mental health programs in suicide prevention, PTSD, substance abuse, and sexual trauma.

Let me call a brief recess at this time for just a couple of minutes.

[Recess.]

Chairman AKAKA. This hearing will come to order.

We welcome our second panel of witnesses. Dr. David Oslin is the Director of the Network 4 Mental Illness Research, Education and Clinical Center. Dr. Jan Kemp is Associate Director for Education of the Network 19 Mental Illness Research, Education and Clinical Center. Dr. Patricia Resick is the Director of the Women's Division of the National Center for Post-Traumatic Stress Disorder.

They are accompanied by Dr. Ira Katz, VA's Deputy Chief Patient Care Services Officer for Mental Health.

I also welcome Mr. Ralph Ibson, Vice President for Government Relations of Mental Health America. Mr. Ibson testified before this Committee in 2002. We have asked him to pull it all together again for us so that we can focus on bridging the gap between the very best programs and the utter lack of services.

I thank all of you for being here today and want you to know that your full statements will appear in the record of the Committee.

Now, I ask Dr. Oslin to begin with your statement.

STATEMENT OF DAVID OSLIN, M.D., DIRECTOR, VISN 4 MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CENTER, DEPARTMENT OF VETERANS AFFAIRS

Dr. OSLIN. Thank you, Mr. Chairman, and thank you, Mr. Rockefeller, for being here today and doing this important work. We want to express our condolences to the families that were here earlier. This is a very important issue, indeed, and we really want to work with the families and you in moving this issue forward.

I am a physician at the Philadelphia VA. I am the Director of the Mental Illness Research, Education and Clinical Center, MIRECC. I am very proud to be a physician in the VA. I was one of those 50 percent that trained during my residency in a VA and stayed in the VA since that time.

I am here today to talk to you about our substance abuse program in Philadelphia and how we are reaching out to veterans. Our MIRECC supports research on the treatment of addiction. It also runs the integrated care service for our facility.

As a start, I would like to remind the Committee Members of the devastation that addiction brings to patients and families in our veterans. Simply put, addiction is a very deadly illness. As an example, alcohol misuse in this country creates more financial burden to our society than any other health behavior, including smoking and obesity, and it is often neglected. The toll on families, friends, and coworkers is incalculable, as we have heard today.

Despite that devastating nature of the illness, research such as that conducted in our center has clearly demonstrated that addiction is an illness not unlike hypertension or diabetes and that through good care, it is treatable. Our program, we have intentionally built a program that encompasses a broad spectrum of care and incorporates treatments that have an evidence base behind them.

We particularly start in the primary care setting, realizing that a lot of the veterans won't come to us in the specialty care setting. The VA currently and, has for the past several years, annually required screening of all veterans for alcohol misuse. Our integrated care program, called the Behavioral Health Laboratory, provides systematic follow-up for those veterans that screen positive for alcohol misuse as well as PTSD or depression.

That follow-up actually starts with a structured telephone call. We call the veterans in their homes and don't require them to necessarily show up to a clinic visit or the burden of having to deal with the transportation hassles. After that telephone assessment, we determine the level of need of services and reach out to the veteran, including those that are OEF and OIF veterans, who will have particular concerns, as we have heard here today, about the stigma associated with coming to a mental health clinic.

Based on the assessment, we can begin to provide treatment in that primary care setting outside of the stigmatizing setting of mental health, and the variety of services will include things like brief alcohol interventions, psycho-education or education, as well as referral into our specialty care programs. There is pretty clear evidence that these proactive public health initiatives can be very effective in reducing the addiction process and reducing the burden downstream. The effective use of brief interventions also keeps our

veterans from the specialty care services that they so often fear to use.

This part of the program has also brought education and training to our internists, family therapists, family practitioners, and other primary care staff to approach mental health just like another health disorder, just like the diabetes or hypertension.

Moving up the ladder of our program, the next component would be our Addiction Recovery Unit. Here, veterans are assessed using a multidisciplinary team to assist in treatment planning. We offer a wide variety of outpatient treatments, including 12-step programs, pharmacotherapy, opiate substitution therapy, individual psychotherapy, and group therapy. We also have access to inpatient rehabilitation services in our Coatesville and Lebanon facilities and acute inpatient psychiatric care in Philadelphia.

Additionally, another critical element to our program is the integration of physical, emotional, social, as well as addictive components that are afflicting the veterans' lives, the assessment of those issues. Many of our veterans have a multitude of problems, including PTSD or post-traumatic stress, depression, psychosis, and bipolar illness. We have to assess each veteran for their needs in order to provide an appropriate therapeutic environment.

We are particularly proud that our program has integrated primary care within our addiction program so veterans don't have to go to a multitude of different places to get support. We also integrate homeless programs, peer support, family therapy, and the recovery model into the services.

It is clear that the treatment of addiction has changed substantially in the last decade and now includes a wide variety of effective treatments. We are striving in our program to provide the best available treatments to our veterans. In order to accomplish this, we stress the importance of effectively engaging patients in treatment, which entails listening to and honoring their preferences in their treatment, as well. This emphasis is coupled with continually evaluating the program and adapting to a growing evidence base for treatment.

We are also keenly aware, though, that our treatments are not universally effective and we emphasize ongoing research in our facility to develop new treatment options and new opportunities for interventions.

In closing, I would welcome the Committee Members to visit our facility at any time, meet with our staff and the veterans we so proudly serve. Thank you.

[The prepared statement of Dr. Oslin follows:]

PREPARED STATEMENT OF DAVID OSLIN, M.D., DIRECTOR, VISN 4 MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CENTER, DEPARTMENT OF VETERANS AFFAIRS

I would like to thank you for this opportunity to describe our substance abuse treatment program at the Philadelphia VA Medical Center. I am a physician at the Philadelphia VA Medical Center and the Director of the Mental Illness Research Education and Clinical Center or MIRECC. Our MIRECC not only supports research on the treatment of addiction but also runs our integrated care program for the treatment of addiction.

I would first like to remind Committee Members of the devastation caused when the disease of addiction goes untreated. Alcohol misuse creates more financial burden to our society than any other health behavior, including smoking and obesity. Addiction is also a deadly disease. The toll on families, friends, and coworkers is

incalculable. Despite the devastating nature of the illness, research such as that conducted in our center has clearly demonstrated that addiction is an illness not unlike hypertension or diabetes. The critical implication of such research is that addiction is a treatable condition, with a growing evidence base for an array of effective treatments.

In our program, we have intentionally decided to build a program that encompasses the broad spectrum of severity and incorporates treatments that have an evidence base supporting their effectiveness.

We start in the primary care settings. Throughout the VA system all veterans are screened annually for alcohol misuse. Our integrated care program, the Behavioral Health Laboratory, provides systematic follow-up for veterans who screen positive for alcohol misuse. The follow-up begins with a structured telephone assessment that includes questions about a range of mental health symptoms, including illicit drug use and suicidality. It is important to note here that this program has been very effective in reaching OEF/OIF veterans who may be particularly worried about the implications or stigma of going directly to a mental health clinic. Based on both the assessment results and the veterans' preferences, patients are triaged to the most appropriate level of care. We offer a broad array of services including brief interventions, education, and referral to our specialty care clinics. There is a clear evidence base that this type of broad-based public health initiative can identify veterans earlier in the addiction process and prevent substantial burden in the future. The effective use of brief interventions also keeps many veterans from needing specialty care services. This part of the program also provides education and training to internists, family practitioners and the other staff in primary care and approaches addiction just like any other health problem.

The next component of our program is our addiction recovery unit. Here veterans are assessed by a multidisciplinary team to assist in treatment planning. We offer a wide array of outpatient treatments including traditional 12-step programs, pharmacotherapy, opioid substitution therapy, individual psychotherapy, and group therapy. We also have access to inpatient rehabilitation services at the Coatesville and Lebanon facilities and an acute inpatient program in Philadelphia.

Additionally, another critical element of our program is the integration of assessments of the physical, emotional, social, and addictive components of veterans' lives. Many of our veterans not only have addictive disorders but also suffer from posttraumatic stress, depression, psychosis, and bipolar illness. Assessing each veteran for all their health needs is crucial to providing a therapeutic environment. We are particularly proud that our addiction program integrates primary care, homeless programs, peer support, family therapy, and the recovery model for those veterans in need of these services.

The treatment of addiction has changed substantially in the last decade and now includes a variety of effective treatments. We are striving in our program to provide the best available treatments to our veterans. In order to accomplish this goal, we stress the importance of effectively engaging patients in treatment, which entails listening to and honoring their preferences for treatment. This emphasis is coupled with continually evaluating the program and adapting the growing evidence base for treatment. We are also keenly aware that our treatments are not universally effective and we emphasize ongoing research as a mechanism for developing new treatment options.

In closing, I would welcome any of the Committee Members to visit our facility and meet our staff and the veterans we so proudly serve.

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

Dr. Kemp?

STATEMENT OF JAN KEMP, R.N., PH.D., ASSOCIATE DIRECTOR FOR EDUCATION, VISN 19 MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CENTER, DEPARTMENT OF VETERANS AFFAIRS

Dr. KEMP. Mr. Chairman and Senator Rockefeller, thank you for the opportunity to be here. I am one of those 20-year-plus nurses who is not with the VA because of the benefits and I am very glad to have this opportunity.

The VA recognizes that suicide prevention requires a comprehensive plan that involves integrated strategies, coordinated efforts, and a steadfast commitment to implementation and evaluation.

Based on CDC data and not controlling for VHA population-specific factors, it is estimated that there are up to 1,000 suicides per year among veterans receiving care within the VHA and as many as 5,000 per year among all living veterans.

Various strategies have been put into place in order for the VA to understand the problems associated veteran suicide, assess veterans under their care for suicide risk, and provide treatment strategies aimed toward suicide prevention. In addition, the Mental Illness Education Research and Clinical Centers are involved in several clinical research endeavors in the areas of various treatment strategies and neurophysiological approaches to the management of suicide and are working closely with the NIH-funded Suicide Prevention Centers to understand and disseminate current information.

The VISN 19 MIRECC in Denver has implemented a template tracking system which allows identification of suicide attempts within our network in order to provide follow-up care for these veterans as well as to identify system issues that could be resolved in order to improve the care that veterans receive.

To date, we know that over 250 veterans in the Rocky Mountain Network have attempted suicide since October 1, 2005. We have learned a great deal about this particular group of veterans. Thirty-two of them have died as a result of their attempt. A vast majority have been diagnosed with various mental illnesses, including PTSD and major depression disorder. Many have substance abuse problems and many have chronic pain issues.

While knowing the numbers and tracking the statistics is critically important to our work, we are also very cognizant of the fact that we are dealing with individual lives and that each life is invaluable. Implementing treatments that we know are useful with suicidal patients has become our mission across the country. We have begun an extension education and awareness campaign aimed first at mental health and primary care providers. We know that increased awareness of the possibility of suicide will lead to better identification of those who are at risk and improve our ability to implement appropriate suicide prevention treatments.

In March of this year, I was giving a program in Battle Creek, Michigan. A psychologist who was taking urgent care calls that day was pulled from the program because a veteran was on the phone asking for an appointment. She came back to the program and stated since suicide was forefront in her mind, she had asked the right questions and was able to determine that this patient was at extreme risk and had gotten him immediate help. We need to keep suicide in the forefront of all of our providers' minds.

We are currently in the process of implementing demonstration projects that will allow us to gather effectiveness data while providing veterans with the most current treatments in suicide. These include training therapists in cognitive behavioral therapy techniques and the collaborative assessment and management of suicidality problem developed by Dr. David Jobes.

Through the newly established Center of Excellence in Canandaigua, we will initiate intensive suicide prevention programs in VISN 2 and in VISN 7, with national implementation soon after.

We have also begun to use alternative treatment options with those veterans who require enhanced monitoring and management of their cyclic and persistent suicide ideation. This includes the use of our Health Buddy, a tele-health unit that we give to veterans that they use to track their health care concerns and get immediate education and advice.

In Denver, we have seven chronically suicidal patients currently using the depression module on the Health Buddy. Each of these chronically suicidal patients has had several serious suicide attempts. Since they have been working with the Health Buddy, none of them have attempted. One patient told us that he followed the Health Buddy protocols late one night with a gun in his lap. By the time he got to the directions to call for help, he had realized that help was really only a phone call away and that the urge to kill himself had passed. He came into the facility the next day, was admitted, and is currently receiving ongoing treatment and has been doing well with no attempts for over a year.

Another patient said that he feels the Health Buddy is the missing piece of the puzzle he needed to know that his depression and PTSD are manageable.

Each veteran's story is compelling and each treatment success a valuable lesson. It is by working with individuals, assessing their risk, and providing them with appropriate treatment that we will reduce the number of suicides among our Nation's veterans.

New concerns are constantly emerging. Our newer veterans are coming to us with risk factors such as PTSD and traumatic brain injury that both carry with them a high suicide risk rate. We have developed a manual to help the providers who care for patients with traumatic brain injuries understand their patients' risk for suicide.

We are in the process of placing suicide prevention coordinators at each facility that will carry on these approaches in their own local communities. We are developing awareness programs to reach all of our staff and community partners who work with veterans. Mechanisms to share best practices and ideas will be put into place through the Center of Excellence.

We have a large task in front of us. Awareness, training, and access to appropriate mental health care continue to be the major components of our multi-faceted approach to reaching and helping these individuals while we continue our research programs to determine and refine our treatment strategies.

Thank you again, Mr. Chairman, for inviting me today.

[The prepared statement of Dr. Kemp follows:]

PREPARED STATEMENT OF JAN KEMP, R.N., PH.D., ASSOCIATE DIRECTOR FOR EDUCATION, VISN 19 MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CENTER, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, good afternoon.

VA recognizes that suicide prevention requires a comprehensive plan that involves integrated strategies, coordinated efforts, and a steadfast commitment to implementation and evaluation. Based on CDC data and not controlling for VHA population specific epidemiologic factors, it is estimated that there are up to 1,000 suicides per year among veterans receiving care within VHA and as many as 5,000 per year among all living veterans. Various strategies have been put into place in order for the VA to understand the problems associated with veteran suicide, assess veterans under their care for suicide risk and provide treatment strategies aimed toward sui-

cide prevention. In addition, the Mental Illness, Education, Research and Clinical Centers (MIRECC) are involved in several clinical research endeavors in the areas of various treatment strategies and neurophysiological approaches to the management of suicide and are working closely with the NIH-funded suicide prevention centers to understand and disseminate current research information.

The VISN 19 MIRECC in Denver has implemented a template tracking system which allows identification of suicide attempts within the network in order to provide follow-up care for these veterans as well as to identify system issues that could be resolved in order to improve the care that these veterans receive. To date we know that over 250 veterans in the Rocky Mountain Network have attempted suicide since October 1st of 2005. We have learned a great deal about this particular group of veterans. Thirty two of them died as a result of their attempt. A vast majority have been diagnosed with various mental illnesses (including PTSD and major depression disorder). Many have substance abuse problems and many have chronic pain issues. The VISN 3 MIRECC is installing and implementing an evidence-based risk assessment tool which is linked to the alerts and clinical reminders sections of our electronic medical record.

While knowing the numbers and tracking statistics is critically important to our work we are also cognizant of the fact that we are dealing with individual lives and each life is invaluable. Implementing treatments that we know are useful with suicidal patients has become our mission across the country.

We have begun an education campaign aimed first at mental health and primary care providers. To date, over 750 VA clinicians have been provided with up-to-date information on suicide. This includes two regional evidence-based intervention conferences co-sponsored by VISNs 3, 4 and 19. One was held in Atlantic City in June 2006 and one in Denver this past February. At both of these conferences experts from across the country were brought in to share the latest developments in assessing suicide risk and providing care for those at risk for suicide in our population. National satellite programs have been offered and a Web-based program is in development. VISN 19 has held individual face-to-face programs at over 30 medical centers at this point and several others are planned. VISNs 3 and 4 have also extensively trained their providers at regular conferences and programs.

We know that increased awareness of the possibility of suicide will lead to better identification of those who are at risk and improve our ability to implement appropriate suicide prevention treatments. We will continue our awareness campaign. In March of this year I was giving an education program in Battle Creek, Michigan. A psychologist who was "taking urgent care calls" that day was pulled from the program because a veteran was on the phone asking for an appointment. She came back to the program and stated that since suicide was forefront in her mind, she had asked the right questions and was able to determine that this patient was at extreme risk and had gotten him immediate help and he was being admitted. We need to keep suicide in the "forefront" of all of our provider's minds.

We are currently in the process of implementing demonstration projects that will allow us to gather effectiveness data while providing veterans with the most current treatments in suicide. These include training therapists in Cognitive Behavioral Therapy techniques and the Collaborative Assessment and Management of Suicidality (CAMS) program developed by Dr. David Jobes. Through the newly established Center of Excellence in Canandaigua we will be initiating intensive Suicide Prevention Programs in VISNs 2 and 7 with national implementation soon after.

We have also begun to use alternative treatment options with those veterans who require enhanced monitoring and management of their cyclic and persistent suicide ideation. This includes the use of our Health Buddy, a tele-health unit that we give to veterans that they use to track their health care concerns and get immediate education and advice. In Denver, we have 7 chronically suicidal patients currently using the depression module on the Health Buddy. Each of these chronically suicidal patients has had several serious suicide attempts. Since they have been working with the Health Buddy none of them have attempted. One patient told us that he followed the Health Buddy protocols late one night with a gun in his lap. By the time he got to the directions to call for help he had realized that help was really only a phone call away and the urge to kill himself had passed. He came into the facility the next day, was admitted, and is currently receiving on-going treatment and has been doing well with no attempts for over a year. Another patient said that he feels the Health Buddy is the missing piece of the puzzle; he needed to know that his depression and PTSD are manageable.

Each veteran's story is compelling and each treatment success a valuable lesson. It is by working with individuals, assessing their risk, and providing them with appropriate treatment that we will reduce the number of suicides among our Nation's

veterans. New concerns are constantly emerging. Our newer veterans are coming to us with risk factors such as PTSD and traumatic brain injuries that both carry with them a high suicide risk rate. We have developed a manual to help the providers who care for patients with traumatic brain injuries understand their patients risk for suicide.

We are in the process of placing Suicide Prevention Coordinators at each facility that will carry on these approaches in their own local communities. We are developing awareness programs to reach all of our staff and community partners who work with veterans. Mechanisms to share best practices and ideas will be put into place through the Center of Excellence. We have a large task in front us. Awareness, training, and access to appropriate mental health care continue to be the major components of our multi-faceted approach to reaching and helping these individuals while we continue our research programs to determine and refine our treatment strategies.

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

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

Dr. Resick?

STATEMENT OF PATRICIA RESICK, PH.D., DIRECTOR, WOMEN'S DIVISION, NATIONAL CENTER FOR POST TRAUMATIC STRESS DISORDER, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY IRA KATZ, M.D., PH.D., DEPUTY CHIEF, PATIENT CARE SERVICES OFFICER FOR MENTAL HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Dr. RESICK. I would like to thank the Committee for the opportunity to discuss best practices today. I was asked to speak on two separate topics. The first is the National Training Initiative I am currently conducting to train therapists, along with my colleagues, in an effective therapy for PTSD. The other topic I was asked to speak about is the women's programs at the VA Boston Health Care System as an example of best practices for women veterans.

We have effective therapies, particularly cognitive behavioral therapies, such as cognitive processing therapy, that can significantly reduce symptoms of PTSD and can cure it in many cases. Cognitive processing therapy, which I developed almost 20 years ago, is a 12-session treatment for PTSD which can be implemented in groups or individually. It has been shown to be effective for combat, sexual assault, and other traumas. Once cured, we have not found relapse in PTSD over long periods of time that have been assessed in research, and that is 5 to 10 years we have tracked people.

Therapies such as cognitive processing therapy for PTSD require 1-hour weekly therapy for 13 to 14 sessions, including intake appointments. In order to conduct this therapy, therapists have to be trained and provided support, such as case consultation with experts in the therapy. In order to implement cognitive processing therapy effectively, therapists should have no more than 25 cases in their caseload at any given time.

VA's central office has funded an initiative that I am conducting to train and support 600 VA therapists nationally in cognitive processing therapy. To this end, my colleagues and I have written a treatment manual with everything needed to conduct the therapy, have trained qualified trainers for 2-day workshops and case consultation, which will be available 50 hours a week across time zones. Over the next 2 years, we will be providing 22 workshops

throughout the country followed by these support efforts, and that will also include online supports, as well.

On the second topic, VA Boston is a good example of best practices for services for women, because in addition to being able to receive services from any clinical program, women can receive services from specialized women's programs that represent a continuity of care. Like all VA hospitals, we had a Women Veterans Program Manager and a Military Sexual Trauma Coordinator who serve as advocates for information and referrals to appropriate programs. We have a separate Women's Health Center that provides primary care, gynecological care, osteoporosis assessment and treatment, urgent care, and social services.

The Women's Stress Disorder Treatment Team, located in its own wing of the hospital, offers outpatient mental health treatment for post-traumatic stress disorder and other trauma-related mental health problems. A full line of services, including psychiatry, individual and group therapy, psychological assessment, and consultation are available.

There is a separate wing of the Acute Inpatient Psychiatric Program designated for women to provide them security and privacy. We will soon open a residential program for women with co-occurring PTSD and substance abuse disorders. It will be the first of its kind in the country.

The goal is to help women develop skills to maintain abstinence, manage PTSD symptoms, and address their traumas. The program offers assessment, group, individual, and psycho-pharmacological treatment and psycho-educational programs while supporting participants in the development of their own long-term recovery plan.

The Women's Homelessness Program provides an array of services to homeless women and women who are at high risk for becoming homeless. Our transitional residence, called the TRUST House, specializes in the treatment of women with post-traumatic stress, mood and substance use disorders. Up to seven women can live at this residence at a time. The treatment program involves individual therapy, case management, group therapy, house meetings, and paid work experience through the Veterans Industries Vocational Program. Women are assisted in making the transition from VA-supported employment to employment in the community.

Thank you again, Mr. Chairman, for inviting me today, and at this time, I can answer any questions that you or any other Members may have.

[The prepared statement of Ms. Resick follows:]

PREPARED STATEMENT OF PATRICIA RESICK, PH.D., DIRECTOR, WOMEN'S DIVISION, NATIONAL CENTER FOR POST TRAUMATIC STRESS DISORDER, DEPARTMENT OF VETERANS AFFAIRS

I would like to thank the Committee for the opportunity to discuss our program. I was asked to speak today on two topics. First, the national training initiative I am currently conducting to train therapists in an effective therapy for PTSD and the women's programs at VA Boston Healthcare System as an example of best practices for women veterans.

We have effective therapies, particularly cognitive behavioral therapies, such as cognitive processing therapy (CPT), that can significantly reduce symptoms of PTSD and can cure it in many cases. Cognitive processing therapy, which I developed almost 20 years ago, is a 12-session treatment for PTSD which can be implemented in groups or individually. It has been shown to be effective for combat, sexual assault, and other traumas. Once cured, we have not found relapse in PTSD, over long

periods of time that have been assessed in research (5–10 years). Therapies such as CPT for PTSD require 1-hour weekly therapy for 13–14 sessions (including the intake appointments). In order to conduct this therapy, therapists have to be trained and provided support such as case consultation with experts in the therapy. In order to implement CPT effectively, therapists should have no more than 25 cases in their case loads at any given time. VA Central Office has funded an initiative that I am conducting to train and support 600 VA therapists nationally in cognitive processing therapy. To this end, my colleagues and I have written a treatment manual with everything needed to conduct the therapy, and have trained qualified CPT trainers for 2-day workshops and case consultation available 50 hours a week across the time zones. Over the next 2 years, we will be providing 22 workshops throughout the country followed by these support efforts.

VA Boston is a good example of best practices for services for women because, in addition to being able to receive services from any clinical program, women can receive services from specialized women's programs that represent a continuity of care. Like all VA hospitals, we have a Women Veterans Program Manager and a Military Sexual Trauma (MST) coordinator who serve as advocates for information and referrals to appropriate programs. We have a separate Women's Health Center that provides primary care, gynecological care, osteoporosis assessment and treatment, urgent care and social services. The Women's Stress Disorder Treatment team, located in its own wing of the hospital, offers outpatient mental health treatment for post traumatic stress disorder and other trauma-related mental health problems. A full line of services including psychiatry, individual and group therapy, psychological assessment and consultation are available. There is a separate wing of the acute inpatient psychiatric program designated for women to provide them security and privacy. We will soon open a residential program for women with co-occurring PTSD and substance abuse disorders. The goal is to help women develop skills to maintain abstinence, manage PTSD symptoms, and address their traumas. The program offers assessment; group, individual and psycho-pharmacological treatment and psycho-educational programs while supporting participants in the development of their own long-term recovery plan. The Women's Homelessness Program provides an array of services to homeless women and women at high risk for homelessness. Our transitional residence, TRUST House, specializes in the treatment of women with post traumatic stress, mood and substance use disorders. Up to seven women live in the residence. The treatment program involves individual therapy, case management, group therapy, house meetings, and paid work experience through the Veteran Industries Vocational Program. Women are assisted in making the transition from VA supported employment to employment in the community.

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

Chairman AKAKA. Thank you very much for your testimony.

Now we will hear from Ralph Ibson.

STATEMENT OF RALPH IBSON, VICE PRESIDENT FOR GOVERNMENT RELATIONS, MENTAL HEALTH AMERICA

Mr. IBSON. Thank you, Mr. Chairman. I am pleased to be here testifying today on behalf of Mental Health America, which is the country's oldest and largest nonprofit organization addressing all aspects of mental health. I appear before you today as a veteran, a veteran of the United States Army, of the staff of the House Veterans' Affairs Committee, and of the VA. I want to commend you and the staff for putting together an extraordinary panel of witnesses who I think have framed the central issues that confront both the VA and the Congress, and let me try and highlight what I think has emerged from the testimony today. I think it has been exceptional.

First of all, it strikes me that our military operations in Iraq and Afghanistan differ markedly from prior combat engagements in at least two important respects.

First is the extensive reliance on the National Guard and the Reserves, and second, the reliance on multiple tours of duty, repetitive tours of duty. I think both are critically important in terms

of their implications for the mental health of our veterans and the way we approach these issues.

To clarify the point, deploying to a combat zone can be enormously stressful for a soldier and for that soldier's family members, and that stress increases markedly with each subsequent deployment.

Secondly, as I think many of the witnesses emphasized today, members of the Guard and Reserve who make up such a large percentage of our fighting forces overseas are largely returning to rural America and to small towns and communities often very distant from the network of VA facilities and DOD facilities that might otherwise be there to serve them.

I think experts agree, and you heard the same from many of the panelists today, that virtually all returning veterans face readjustment problems and that it is advisable to provide counseling and support to veterans and their families to ease in that transition. I think this Committee historically has laid an extraordinary foundation with the Vet Center program and there are powerful lessons to be learned and opportunities to build on that success. The preventive approach of the Vet Centers, I think, has helped avert the development of serious mental disorders, like depression and substance use disorder, and we should employ such a preventive approach today.

I think a third point is that the prevalence of mental health problems among these OIF/OEF veterans appears to be significantly higher than was anticipated. One statistic that was not aired today that I find compelling is relatively recent DOD data on those who have served in Iraq which show that some 50 percent of Army National Guard members and some 45 percent of Army and Marine Reservists have reported mental health concerns—half of all Army National Guard members report mental health concerns!

A fourth point, certainly heavily emphasized by many of the witnesses, is the profound stigma associated with mental health care and the deterrent effect that has, particularly among the Guard and Reserves, on help-seeking.

Further, family members of OIF/OEF veterans are experiencing mental health problems related to the veterans' service. Research has shown that PTSD, for example, can have a profound impact on members of the veteran's family. We certainly have particular concern for the family members of Guard and Reservists who have faced repeated deployments and, again, who tend to be isolated from the community support systems that may be available to family members of active duty members who live on or close to military bases.

And sadly, despite many outstanding programs and best practices at individual VA facilities, and we certainly have heard about them just now, I think VA as a system can still do more and ought to be doing more. I think the earlier testimony reinforces that point, but let me offer a few examples or recap points made by earlier witnesses.

I think it is true of VA as it is true of most health systems that they are largely passive, and we heard today of the importance of outreach, the importance of the use of peers, the importance of

drawing veterans into readjustment, into care systems, into screening, into help. While VA's 207 Vet Centers play an important role in providing much-needed readjustment counseling assistance to veterans, it strikes me that the Department's more far-reaching network of medical centers, clinics, and other facilities really don't have the opportunity or take the opportunity to provide the kinds of preventive services that experts say all returning veterans need as we heard from several previous witnesses.

Helping these veterans readjust or overcome PTSD often requires working with that individual's family, but there are both fiscal disincentives to that in VA medical centers and what I believe are outright statutory barriers to that kind of engagement. There, too, I think changes are in order.

VA's resource allocation methodology and its decentralized decision-making, it strikes me, give no assurance that the kind of targeted mental health funding that Congress has so carefully dedicated itself to will not be offset by cuts to other VA mental health programs and similarly give no assurance at the facility level where there are such extraordinary pressures competing for scarce dollars that mental health will get the priority it needs as against high-tech medicine or the many other services that lay claim on those dollars.

And although efforts have been made to improve services, it is not clear, at least from my vantage point, that VA's substance use services have been fully restored from the cuts that have been sustained over the years and that this Committee has so carefully sought to reinstate.

And finally, notwithstanding excellent programs and outstanding practices that we see at Boston and other VA facilities, I think the jury is out in terms of women veterans and their perceptions, regardless of the reality, but their perceptions of VA as a welcoming, caring set of institutions, given the breadth of issues we have heard today ranging from the extraordinary combat trauma to which women are exposed in Iraq to the tragic sexual assaults that we learned about earlier.

What does all this tell us? I think I would go a step further than Dr. Best, who called for a "larger boat." I think we need to think about some redesign or reconfiguration of that boat to address some of these issues.

Again, several witnesses stressed outreach, and I believe there would be great value and we heard discussion of the role of peers. I see an opportunity for a robust national VA program of training a cadre of OIF/OEF veterans, veterans who have come back with these kinds of problems—with PTSD, anxiety, other readjustment problems—training those veterans in perhaps week-long sessions. Such programs do exist. After undergoing such training, such individual could be employed in VA and by community providers to do the kind of outreach and to provide the kind of support that Patrick Campbell and others spoke about as so necessary to make VA a help-without-hassles, welcoming place in which the stigma they anticipate is diminished and in which care can be furnished and successfully so. As Sergeant Campbell testified, some veterans just need to talk to someone who will understand, and certainly Josh Omvig and Justin Bailey needed a person like that.

Secondly, I believe there is also a need for time-limited—I would stress time-limited—service-delivery mechanism that would enable OIF/OEF veterans who are returning to those small towns and rural areas that are remote from VA facilities, and remote from DOD facilities, to get the kind of care that they need. I see an opportunity for that in the network of Community Mental Health Centers. Under a carefully designed program, VA can contract for those services and set requirements. It can require, for example, that those centers hire trained peers, and that they meet criteria that VA set. A time-limited program like that can be a very important stop-gap measure to reach veterans who are now not only underserved, but not served at all.

I would concur certainly with Sergeant Campbell in recommending that the 2-year eligibility window for combat veterans is far too short and should be extended to 5 years.

And lastly, I would urge the Committee to consider legislation, again, on a time-limited basis, to authorize VA to provide immediate family members with both support services and, when needed, mental health services to help foster the veterans' readjustment or recovery.

We would certainly be happy to work with the Committee and its outstanding staff to develop those recommendations further, and I would be pleased to join others in answering any questions you might have, Mr. Chairman.

Thank you.

[The prepared statement of Mr. Ibson follows:]

PREPARED STATEMENT OF RALPH IBSON, VICE PRESIDENT FOR GOVERNMENT AFFAIRS, MENTAL HEALTH AMERICA

Mr. Chairman and Members of the Committee:

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

Mr. Chairman, we commend you for scheduling this important, timely hearing, and in doing so, providing visibility and focus for critical questions that must be answered if we are to avoid mistakes of the past. While we know that servicemembers have experienced mental health problems in every war, our operations in Iraq and Afghanistan differ markedly from prior combat engagements, with critically important implications for veterans' readjustment and recovery.

UNIQUE ASPECTS OF OPERATIONS IRAQI FREEDOM AND ENDURING FREEDOM (OIF/OEF)

Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are unique in their heavy reliance on the National Guard and Reserves who make up a large percentage of our fighting forces. Reserve forces alone have made up as much as 40 percent of U.S. forces in Iraq and Afghanistan, and at one point, more than half of all U.S. casualties in Iraq were sustained by members of the Guard or Reserves. These operations are also unique in their reliance on repetitive deployments. Deploying to a combat zone is necessarily enormously stressful to a soldier AND his or her family; that stress increases markedly with each subsequent deployment.

The impact of those deployments on servicemembers has already been profound. The prevalence of mental health problems among OIF/OEF veterans appears signifi-

cantly higher than had earlier been anticipated. To illustrate, recent data from the Defense Medical Surveillance System (reflecting post-deployment health self-assessments since June 2005 of servicemembers who had served in Iraq) show that *50 percent of Army National Guardsmen and some 45 percent of Army and Marine reservists have reported mental health concerns.* Unexpectedly high percentages of OIF/OEF veterans are receiving VA mental health services, many with very serious problems like PTSD and depression. According to VA data, more than 35 percent of OIF/OEF veterans who accessed VA care from 2002 through November 2006 were diagnosed or being evaluated for a mental health disorder.

The high percentages of Guard and Reservists among the OIF/OEF cohort creates unique challenges that VA has not previously faced. First, these "citizen-soldiers" often live in communities remote from VA medical centers. Yet they are as likely to have readjustment issues or to experience anxiety, depression or PTSD as veterans who have good access to VA health care. Long-distance travel is a very formidable barrier to a veteran's seeking (and continuing) needed treatment. That barrier is likely to be even higher for veterans with mental health needs, given the lingering stigma surrounding mental health treatment. Second, with activation to and from active duty associated with multiple deployments, health care responsibility for these servicemembers shifts from DOD to VA to DOD, with each shift in responsibility inviting confusion.

VETERANS' MENTAL HEALTH NEEDS

OIF/OEF veterans are experiencing a broad range of post-deployment mental health issues—some of which require treatment, while others call for some combination of education, support and counseling. VA data identify PTSD (seen in 15 percent of those evaluated at VA facilities), drug abuse (13 percent) and depression (10 percent) as the most prevalent disorders being treated in its facilities. Importantly, another 5 percent were diagnosed with a psychosis, reflecting severe mental illness. A recent study on the mental health status of Iraq veterans in the Maine National Guard provides another illuminating snapshot. That survey found that 25 percent of these veterans reported significant problems with PTSD, alcohol or depression. But the study data also indicate the extent to which these veterans are experiencing readjustment problems. For example, more than 43 percent had problems with anger (compared with 16 percent in Guard members who had not been deployed), more than 35 percent had relationship problems (vs. 15 percent among the non-deployed), and 22 percent reported sexual problems (vs. 10 percent among the non-deployed). Significantly, only 15 percent of those Maine veterans had sought help from a mental health professional.

VA's Special Committee on Post-Traumatic Stress Disorder (a statutorily created panel of clinicians which reports annually to VA and to Congress) has provided a helpful assessment of the wide range of post-deployment mental health issues confronting veterans and their families. Its February 2006 report advised that "VA needs to proceed with a broad understanding of post deployment mental health issues. These include Major Depression, Alcohol Abuse (often beginning as an effort to sleep), Narcotic Addiction (often beginning with pain medication for combat injuries), Generalized Anxiety Disorder, job loss, family dissolution, homelessness, violence toward self and others, and incarceration." The Committee advised that "rather than set up an endless maze of specialty programs, each geared to a separate diagnosis and facility, **VA needs to create a progressive system of engagement and care that meets veterans and their families where they live . . .** The emphasis should be on wellness rather than pathology; on training rather than treatment. The bottom line is prevention and, when necessary, recovery." Importantly, the Special Committee also advised that "**Because virtually all returning veterans and their families face readjustment problems, it makes sense to provide universal interventions that include education and support for veterans and their families coupled with screening and triage for the minority of veterans and families who will need further intervention.**" [Emphasis added.]

Certainly our perspective is too general when we speak globally and without distinctions of "veterans' needs." Of particular significance surely are the contributions that women are making in these ongoing operations. Women represent some 15 percent of those in the OIF/OEF theaters. And while not serving in infantry units, they are more exposed to trauma—driving in convoys, serving in security assignments, and even flying aircraft—than in any other military engagement in our history. It should also be acknowledged that the range of trauma to which women in service are being exposed ranges from the threat of IED's to marital and family stresses.

FAMILY ISSUES

While there is widespread recognition of the prevalence of post-traumatic stress disorder (PTSD) and other war-related mental health problems among veterans of service in Iraq and Afghanistan, less attention has been given to the toll these military operations have had on the mental health of our veterans' families, and the implications of those problems on the veteran's readjustment and health. Research on PTSD, for example, has shown that it has had severe, pervasive negative effects on marital adjustment, general family functioning, and the mental health of partners, with high rates of separation and divorce and interpersonal violence. PTSD can also have a substantial impact on veterans' children. Not surprisingly, in a military engagement that has required multiple tours of duty of many servicemembers and in which the burden has fallen heavily on citizen-soldiers of the National Guard and military Reserves, the impact on families has been particularly hard, and may be implicated directly in mental health problems in family members of the veteran.

Despite recognition in the VA regarding the mental health needs of returning veterans' families and the importance of engaging family members in the veteran's readjustment, current law and practice limit VA's assistance to, and work with, family members. The Special Committee on PTSD reports that "the strength of a war fighter's perceived social support system is one of the strongest predictors of whether he/she will or will not develop PTSD." VA is an integrated health care system which offers a relatively full continuum of care and services for eligible veterans. Family therapy is often a component of the readjustment counseling provided at VA "Vet Centers" that are usually located in population centers and operated independently of VA medical centers and clinics. But veterans and family members who live far from a Vet Center and who rely instead on a VA medical center or clinic routinely encounter a system that discourages family therapy. Most VA health facilities focus exclusively on the veteran-patient (rather than on the veteran as part of a family unit) and provide incentives through measures of "workload" that fail to provide any workload credit for helping the veteran's family. This patient-centered workload system effectively discourages medical-center clinicians from providing family therapy and support services that are routine in a parallel system of VA facilities. There is no sound programmatic rationale for encouraging family support at one set of VA facilities (the Vet Centers) and discouraging it at others. VA health care, and particularly mental health care, would often be more effective if barriers to family involvement were eliminated.

Current law compounds the difficulty. While the law (38 U.S.C. 1710(e)(3)(C)) authorizes VA to provide medical care and services (subject to a 2-year time limit) to a veteran who served in a combat theater, section 1782(b) of title 38 of the U.S. Code would limit counseling for a family member of a combat veteran receiving treatment to circumstances where the counseling had been initiated during a period of hospitalization and continuation is essential to hospital discharge (while family members of veterans receiving treatment for a service-connected condition can receive counseling as needed in connection with the veteran's treatment). Insofar as the law effectively treats the veteran who served in a combat theater on a presumptive service-connected basis for a time-limited period, we recommend that VA be authorized to provide immediate family members with both support services AND (when needed) mental health services to help foster the veteran's readjustment or recovery. And, to ensure that the benefits of such family support and mental health services are realized, we recommend that legislation require the Department to revise its workload measurement system to eliminate the disincentive to, and provide credit for, working with family members of veterans where such education, counseling, or therapy would help foster the veteran's readjustment or recovery. Yet additional consideration should be given to the mental health needs of survivors of those who have lost their life in Iraq and Afghanistan, including parents who generally are not even eligible for VA grief-counseling.

STIGMA SURROUNDING MENTAL HEALTH TREATMENT

There is wide recognition of the importance both of preventing readjustment problems from worsening and of treating behavioral disorders as early as possible. Left untreated, mental disorders like PTSD and depression are likely to become chronic and severely disabling.

The stigma surrounding mental health disorders—and the degree to which that stigma deters help-seeking—has profound implications for the long-term health and recovery of OIF/OEF veterans. Data do show some decline in the stigma associated with seeking behavioral health care (as reported in DOD's May 2006 report of its Mental Health Advisory Team on Operation Iraqi Freedom (MHAT III)), but the level of stigma among these servicemembers remains troublingly high. The MHAT

III report indicates, for example, that among those who met criteria for mental health problems and were asked to identify factors that might affect their decision to receive mental health counseling or services, *53 percent* thought they would be seen as weak. High percentages of OIF/OEF veterans responded affirmatively to concerns that seeking mental health assistance might (a) lead unit leadership "to treat me differently" (29 percent); (b) result in "members of my unit [having] less confidence in me" (26 percent); and (c) "would harm my career" (17 percent).

While substantial numbers of OIF/OEF veterans are being seen at VA facilities with behavioral health problems, there are compelling reasons to question how many are not seeking needed treatment. Congress and VA could learn much from an independent study on the numbers of OIF/OEF veterans who have mental health needs but elect not to seek treatment because of stigma.

VA'S CAPACITY TO PROVIDE FOR VETERANS' NEEDS

This hearing provides an important opportunity to question whether the VA health care system—with all its strengths—is adequately staffed, adequately configured, and operating with appropriate incentives—to meet the mental health needs of returning servicemembers. VA's health system has great strengths, and many centers of excellence within it. But we should be mindful of the gaps in that system, especially with respect to mental health needs, and find ways to fill those gaps.

VA is a facility-based system that does not necessarily provide good access to care for veterans in rural America or in other areas remote from its healthcare facilities. As noted above, these gaps are particularly pronounced in light of the pressing mental health needs of OIF/OEF veterans, many of whom are citizen soldiers of the National Guard and Reserves who have returned from overseas deployments to communities far from VA facilities. Those distances are all the more formidable in the face of the stigma still surrounding mental health care.

VA facilities themselves do not necessarily provide a full range of needed mental health services. To illustrate, experts believe that most servicemembers returning from a combat deployment face readjustment issues during what is essentially a transition from the trauma and horrors of war to reintegration to their communities and families. That need for readjustment should not be seen as a pathology that requires treatment; rather, readjustment counseling, education and support are a preventive, health-promoting measure. Most returning veterans could benefit from readjustment counseling, and the failure to make that these services available can lead to behavioral health problems. But VA's current capacity to provide this important service is generally limited to its array of approximately 200 readjustment counseling centers (Vet Centers). The department's extensive network of medical centers and clinics, which provides a range of intensive treatment services, generally do not provide the largely preventive services furnished by the Vet Centers. While the unique circumstances of the Vietnam era help explain the development of these parallel systems (with their own separate administrative structures), there is no statutory barrier to VA medical centers providing readjustment counseling services, and—given the need—no obvious reasons *not* to make such services more widely available through other health-care facilities. We urge the Committee to explore having VA medical centers provide readjustment counseling services to OIF/OEF veterans and immediate family members. In that regard, it is important to remember that the Vet Center program was established with a "help without hassles" philosophy. For veterans struggling to readjust, and needing help with anger, feelings of grief, or problems with relationships, for example, there is great value in a "help without hassles" approach. And we find no requirement in law that OIF/OEF veterans must enroll for VA care in order to be eligible to receive readjustment counseling in a VA medical center, and urge that such a precondition not be instituted.

Another gap in the VA health care system is the still uneven distribution of treatment resources for veterans who have substance-use problems. VA's arsenal of resources for treating substance-use disorders was profoundly diminished a decade ago with the closure of inpatient programs. It is our understanding that the department's substance-use treatment capacity has grown in subsequent years, but does not appear to have been fully rebuilt. There is also need to question the breadth of the gap between women veterans' mental health needs of women veterans and VA's capacity to meet those needs, consistent both with expectations of privacy and of a welcoming climate. It would be most helpful in this connection to survey women OIF/OEF veterans, in order to understand their experiences and perceptions regarding care in a system long seen as an enclave for treating an almost exclusively male population.

To its credit, Congress has appropriated additional funds in recent years to upgrade VA mental health and substance-use services. It is difficult, however, to gauge the adequacy of mental health staffing and capacity in this large health system. VA is unquestionably seeing more patients with PTSD, for example. But is that due to increased staffing or some contraction in the intensity of service-delivery? The complexities associated with distributing and allocating funding in the VA health care system invites question as to whether new funding finds its way, dollar for dollar, into increases in mental health staffing. Are there medical centers that receive new money for a specific mental health initiative, but offset such increases in part by cutting staffing of other mental health programs? It should be possible to monitor and measure the net gain in staff associated with efforts to expand mental health funding, and we urge the Committee to direct such action. But unless such monitoring is done with rigor and with consequences, one cannot be certain that the system's capacity will reflect congressional expectations.

In that connection, we also recommend that the Committee examine the incentives and disincentives in VA's resource allocation methodology (VERA) as it relates to mental health service-delivery. To its credit, VA leadership embraced the recommendations of the President's New Freedom Commission on Mental Health with its emphasis on the importance of fostering recovery from mental illness rather than simply managing symptoms. Many fine VA mental health programs are essential to fostering veterans' recovery from mental illness, and should be encouraged. But among those programs, valuable initiatives, like supported employment and peer supports, do not add to "workload" and therefore are not rewarded by VA's resource allocation methodology. We urge the Committee to explore avenues to ensure that VA fiscal incentives reward efforts to foster recovery from mental illness, not simply efforts to increase numbers of patients served.

Finally, anecdotal data suggest that some veterans are encountering barriers in getting needed VA mental health services. How many more veterans would get VA services if travel distances were not so great, or if stigma were not so pervasive, or if VA staff were perceived as more welcoming, or if VA conducted active outreach efforts using peer outreach workers? It would not be difficult to conduct an independent survey of OIF/OEF veterans to gauge the relative ease of access to VA mental health care, to determine the percentages who are not able to get services, and to identify the factors, if any, that discouraged veterans from getting needed help. We urge the Committee to consider directing the conduct of such a survey.

CLOSING GAPS IN VA SERVICE-DELIVERY

The principle that a veteran with a service-incurred health problem should have equitable access to treatment (that is, that a veteran should not be barred from getting needed care) regardless of where he or she lives is well-established. In our view, there is a growing need to establish a time-limited mechanism that could be implemented relatively quickly to provide high quality mental health and readjustment services to OIF/OEF veterans who do not have reasonable access to VA care. *Specifically, we see great benefit for veterans in the development of a targeted mechanism (in areas distant from VA medical centers) that would combine (a) outreach and ongoing support from trained OIF/OEF peers with (b) provision of mental health services by clinicians knowledgeable about PTSD, the combat experience and the unique circumstances of military service and veteran status.* Such a mechanism could be established through VA contracts with community mental health centers for provision of needed services for OIF/OEF veterans who live far from VA mental health centers under which such centers would be required to (1) participate in a VA-conducted national training program; (2) employ an OIF or OEF veteran who has completed a peer outreach/support training and certification program; (3) secure prior approval from VA (in accordance with a VA-provided protocol) before the Department would incur any liability for provision of services for an OIF/OEF veteran; and (4) provide VA with annual summary data on numbers of veterans served, diagnosis, course of treatment, and demographics. We recommend further that VA contract with a not-for-profit national mental health organization to train OIF/OEF veterans for employment as "stigma-busting" peer outreach workers and peer counselors. (The use of peer-counselors and support specialists is a well-established, cost-effective modality in mental health care that has been employed with success at a number of VA centers.) Instituting such a training/employment program is a step that would not only help participating OIF/OEF veterans further their own recovery, but pave the way to overcoming the stigma that remains a formidable barrier to needed counseling and treatment.

NEXT STEPS

VA and DOD have unquestionably taken important steps to understand and address the mental health needs of OIF/OEF veterans, and Congress has played a vital role in mounting much-needed oversight and providing needed funding. Yet there remains much to be done, and, in our view, compelling reason to pursue new directions: (a) to work to fill the wide mental health service-delivery gaps in the VA health care system, (b) to address (in at least a time-limited way) the war-related mental health needs of veterans' family members, (c) to make peer-outreach and support in VA service-delivery the norm rather than the exception, (d) to develop better data to support Committee oversight and VA mental health management, and (e) to align fiscal incentives with clinical imperatives.

Such steps, in our view, will go a long way toward fostering the readjustment and reintegration of returning veterans, and the recovery of those who have experienced mental health problems as a result of their service to their country.

We look forward to working with the Committee to help achieve those goals.

Chairman AKAKA. Thank you very much for your testimony, Mr. Ibson.

I want to welcome Dr. Katz here on the panel. Dr. Katz, Mr. Ibson's testimony points to, among other things, shortages of informal counseling services in VA clinics and a substance abuse program which has not been fully rebuilt since the reductions were made several years ago. My question to you is, how do you respond to the previous panel and Mr. Ibson's testimony?

Dr. KATZ. Well, let me focus. I was, as everyone else in the room, profoundly affected by what we heard. I want to say with respect to the issues that the Bailey family raised that my colleague from the Office of Mental Health Services is in Los Angeles now looking very carefully at that program and looking for lessons to be learned to improve residential and other forms of care in the VA.

I have been struck by the Omvig family's work and I admire and applaud their willingness to talk about it. VA is grateful for the House, Mr. Boswell, and for Mr. Grassley and Mr. Harkin for raising that bill, the Omvig's veteran suicide prevention bill. We are implementing it already. The suicide prevention coordinators called for in the bill are being hired as we speak throughout our system. There will be one in each medical center. We are working hard to take the lessons that we have learned from hearing about Joshua Omvig to make sure it doesn't happen, or to decrease the rates of suicide among veterans.

We are expanding and enhancing mental health services throughout VA, not only in the specialty care setting, but by making mental health an important part of primary care.

It is a way of easing the stigma, making it easier for veterans to receive care. We call this an in-reach approach. At the same time, Dr. Butteriss, my colleague, is working very hard to expand the veterans center program through outreach and now at most post-deployment health reassessment, there is a veterans center outreach person there to meet veterans and to talk about the VA.

There is no wrong door. The Vet Centers are often the only mental health care that is needed. When it is not, it is an important point of entry to mental health services. It is what we often call stepped care. If the Vet Centers work, wonderful. If not, a referral to mental health services in medical centers and clinics is helpful. In the same way, the integration of mental health and primary care is another important way to facilitate access. We are making care available.

About substance abuse, the number of beds in inpatient substance abuse care settings has decreased, but the overall number of beds, including other forms of residential care and homeless programs focusing on substance abuse, have actually increased. What we have done in large part is to work to overcome the siloing of care that is often a problem. Let me give you an example of that.

If I, as a middle-aged man, were to have a heart attack tomorrow, I would get depressed over it and I would probably drink to treat my depression. With three related problems like that, I would have to get care in three different settings and I probably couldn't manage it. We need to fix that and we are working for it.

So 40 percent of substance abuse care in VA is in specialty substance abuse care. About 30 percent is in other mental health services, and about 30 percent is in primary care. We want accountability. We should be held accountable for serving these veterans with substance use problems. But the way we look at this has to go beyond the narrow silos that characterize care in the past.

I see time is up. So much has been said. These have been some first thoughts in response.

Chairman AKAKA. Thank you, Dr. Katz.

Dr. Katz, the National Center continues to give VA the best tools to deal with PTSD. Has funding and has staff for the center increased in recent years?

Dr. KATZ. Our look at the budget for the National Center for PTSD includes a number of components. There is the core funding for the National Center and a number of additional mechanisms for funding other components of their activities.

So, for example, Dr. Resick receives funding for the Women's Division of the National Center that she directs.

She also receives funding for the implementation and dissemination of the cognitive processing therapy she talked about. Dr. Friedman receives funding for his division and for the overall direction of the National Center. He also receives funding for studies, for example, of the primary care treatment of PTSD.

So if one looks at the entire VA support of the National Center, including both its core funding and its project-specific funding, it is increasing over time.

Chairman AKAKA. We have been trying to increase the budget of the Department of Veterans Affairs and have been able to do that, as you know. Of course, the hope is that it will give you license to, if needed, increase personnel wherever it is necessary and deal with some of these complaints, let me say, and shortfalls that have occurred. So we look forward to working this with you, as well, to try to bring this about and give the best kind of service we can to all veterans. This is what it is all about.

Dr. KATZ. Yes.

Chairman AKAKA. I want to thank all of you for being here, for your testimony. We truly appreciate your taking the time to give us all a better understanding of the challenges facing VA mental health care and of efforts to meet those challenges. I look forward to continuing to work with you on that.

My expectation is that VA will adapt to meet the mental health needs of the newest generation of veterans and to prevent the tragic stories we have heard today from happening again.

So again, thank you so much for all of this. This hearing is now adjourned.

[Whereupon, at 4:53 p.m., the Committee was adjourned.]

A P P E N D I X

FEMALE SOLDIERS AND SEXUAL TRAUMA: OPERATION IRAQI FREEDOM (OIF) [1]

Define "sexual trauma." When one hears the phrase sexual trauma it is natural to quickly assume we are talking about rape and physical confrontation. Rape is universally understood as wrong, so with its easy definition it is what one focuses on. Although it is a problematic crime in the Army, I do not know if statistics would tell you that it is more of a crime in the Army and/or the military in Iraq, than in society in general. What I do know is that when I asked my fellow female soldiers about it and thought of my experiences and, the experiences of those I served with, I realized sexual trauma has a much broader and murky definition, and everyone had a story. Rape is not the crux of this issue, nor the prevalent issue in my opinion. True sexual trauma in Iraq involves ambiguous Equal Opportunity (EO)/gender issue situations that always exist within Army culture. However, EO violations are exacerbated in the Iraqi environment where males, are supposed bastions of sexual frustration and are in constant and close proximity to limited female soldiers. This close proximity disallows female soldiers the ability to "walk-away" when they find themselves in a situation they would rather not be in.

Furthermore, upon discussing this topic with fellow female soldiers I realize women serving in Iraq get put into categories, as defined by their male counterparts, based on the females' reactions to daily exposure to questionable situations. Army women in a war situation must overlook, on a daily basis, statements against their gender as well as a plethora of images that objectify women, all that would be legally unacceptable in the civilian world. More than once have I heard, "all Rules go out the window in War," and many people believe that justifies violations of the standards. Thus the true sexual trauma in wartime Iraq is when the character of the female soldiers is determined by their male soldiers. I have tried to work out how to paraphrase some of the definitions so I do not offend anyone, but the reality is I cannot, nor should I, because these are the labels female soldiers are given everyday in Iraq and they are not easy to live with and they cannot be sugar-coated. The following are the loose categories for female soldiers that I have come up with: the weak and emotional female who cannot hack it, or the poor sport; the bitch; the good sport or the "pal"; the flirt which will ultimately evolve into "slut"; and/or certain combinations of the above.

Following are five brief stories of five different women who have served in Iraq between September 2005 and present-day:

STORY ONE

My story. I was assigned to a small Infantry base where very few female soldiers lived, or had ever been. Aside from lack of female only facilities (i.e., showers and latrines) I lived in a house with 20 males. Nearly every living space in the house was covered with photos of scantily clad women from *FHM* and *Maxim* magazines. More than one conversation was an inappropriate conversation of a sexual nature. But these are the things I overlooked in order to be a "soldier" and not a "female soldier." However, mainly due to my mature age (usually at least 10 years older than those I was serving with) I found it easy to steer clear of immature conversations and chose not to participate. Nor did I flirt with them as other females did, in order to boost their egos. I quickly became the "poor sport" and/or "bitch." When they mocked me about my age and my appearance, I was deemed a weak female that could not hack it when I took offense at being called unattractive and old.

As the deployment progressed my Team Leader took liberties with my personal space. We were only separated by a thin wooden wall and a curtain for a door. He would routinely bust into my living space without knocking, under the premise that

[1] Submitted by SGT Carolyn Schapper of Virginia National Guard. She served as an Interrogator/HUMint Collector in Iraq from October 2005 to September 2006 with the 221 st MI BN.]

I was a "soldier" and not a "female." I began to weigh my curtain down with heavy items to discourage him, it did not work, he only pulled harder. More than once I was lying on my bed with headphones on only to look up and see he had already made it into my room and was staring at me. I began to dress in the shower room for fear he would walk in at any moment.

In addition, my objection to my Team Leaders included his aggressive actions on missions. My objections got me deemed a weak and emotional female. My Team Leader would act aggressively on the roads and run Iraqi drivers off the road, more for sport, than for safety. One day, it became an almost deadly situation. A male team member who outranked me, said he would speak to our Team Leader about it. Nothing changed. I once found an article about how poor soldier road behavior creates enemies among the civilian populations of Iraq/Afghanistan. I showed my Team Leader. Afterwards, I found out he went to a training weekend that had representatives from several teams with varying ranks in our Area of Operations and was mocking me openly because I was upset when he ran non-threatening Iraq civilians off the road. He made no mention of the male team members who objected, but blamed my emotional predisposition as a female for my protests.

Aside from my Team Leader, I felt safe with those I served with when we went out on missions into the villages. It was only when I returned back to base did I feel ostracized and thus did I isolate myself more and more in the "safety" of my room as the mission progressed. According to the males I served with I was, at the same time, overly emotional and a bitch, two ideas that would seem naturally contradictory.

STORY TWO

Another female that was on my base did play at the game of flirtation to get what she wanted from her male counterparts. She told me once she enjoyed her celebrity-like status on the small base and used it to her advantage. Many guys liked her because she was a "good sport" and would joke around with them. Eventually they turned against her. By the end of our deployment her picture had been posted on a wall in an open office environment with the phrase "Slut of Bayji (our base location)," underneath it. With only two weeks left in Iraq, her work environment had become so hostile that she asked me if I could convince my team leaders to let her work from our office instead, even though it was further away from her living quarters and her chain of command. We allowed her to work with us. Her demeanor had changed completely, she barely talked to anyone in the carefree manner she had before and could rarely be found. She has since left the Army.

STORY THREE

Female Three was to be transferred to our team because her Team Leader had exposed himself to her. When word got out that another female was coming to our house many of the guys I was living with kept saying they hoped she would be put into their room because she was "hot." Similar comments even came from those who knew why she was being transferred. They did not see her as another soldier that would assist our mission capabilities, but as an opportunity for flirting, and perhaps, sex. Fortunately, mission focus changed and she was never transferred to us.

STORY FOUR

The next case I hesitate to bring up because I know the female will be judged before most people get passed the immediate description of her case and will pass judgment on her and may not look beyond it to determine whether she was treated fairly or not, and/or subjected to gender specific punishment. I will set up the situation and then let her own words make her case, she is still currently serving in Iraq under this command.

Female Four is a friend of mine and I have not worked with her in Iraq, but know her personally and feel I can describe her and her likely conduct in Iraq with some authority. Female Four is an attractive, petite and friendly female. Because of her self-confidence she can hold her own in many a "questionable" conversation and would likely overlook these conversations and other aforementioned scenarios as most female soldiers would in order to focus on the mission. She is fully capable of her position as an Arabic-trained interrogator.

Unfortunately, Female Four unknowingly became pregnant during the mobilization process in the States, but it was such an early pregnancy it was missed at the mandatory pregnancy test administered before deploying to Kuwait/Iraq. While conducting missions in Iraq she became very ill. It took several weeks to determine that the cause was morning sickness. It turned out she was pregnant. From here I will let her tell her story in her own words:

"I deployed August 11, 2006 to Kuwait, and found out September 26, 2006 that I was pregnant, 10 weeks pregnant. I informed my First Sergeant [1SG] the same day and told him that it was my intent to have an abortion and return to Iraq as soon as possible.

My immediate chain of command was supportive. Within a few days I had my stuff packed and was in Baghdad, I thought, waiting for a flight. Turns out I was wrong. They did a 15–6 investigation into the incident, which makes sense. During the investigation the officer in charge told me, "you can write whatever you want in your statement but there is nothing in general order number one that says you can not have sex." No matter how many times I said it happened before I got here, I am pretty sure no one outside of the people who know me, believed me. (Note: some females get pregnant on purpose to get out of deployment, in which case an investigation would be warranted, however, a soldier who did it on purpose would not likely get an abortion and request to return to duty.)

I was stuck in Baghdad for over a week and worried because I thought I had only until my 12th week to have an abortion legally. Anyway, I finally got notified that I had a flight and was called into the Battalion Commander's (BN CDR) office the afternoon prior. I assumed it was for encouraging words.

Instead I was read the most horrifically offensive, insensitive, immature letter of reprimand I could imagine. The letter promised that the Brigade (BDE) would personally make sure I was barred from reenlistment, among other downright nasty insults, insults of a personal, not a professional letter.

I was furious. I went to JAG immediately but was pretty much told—see JAG when you get back to the States. All I was able to do was apply for an extension so that I could write my rebuttal (the timing was such that I would most likely get back to the States the day my rebuttal was due, without having had time to go to JAG). My request for a ten-day extension was denied—I was granted five.

Two days after I got back to the States I had my abortion.

I went the next day to JAG, wrote a letter of rebuttal, outlining all of the facts, that clearly showed I became pregnant through normal sexual behavior, clearly had no intention of becoming pregnant, and clearly had no knowledge that I was pregnant. Moreover, I had chosen the mission first and would be returning.

A day later my rebuttal was rejected. My rejection letter reiterated that the Brigade Commander, COL XXXXX had already initiated my bar to reenlistment.

I had to wait in the U.S. five weeks until I finally passed a pregnancy test. I came back to my unit and was welcomed back by everyone. I was told that I was to return to my team in a few days.

A few days later I was told that my team was changing locations and would be moving all of their things to Baghdad, so I would just wait in Baghdad, get my interrogation certification training done, then move out with them to Tikrit. I was in Baghdad for two more weeks when I was told that COL XXX XX had picked me to move to the HARC [a military intelligence office position]. I would be transferring battalions the next day, but they were barely expecting me, they had not been looking for someone to fill the slot and they were shocked to find out that I was a 97E Arabic linguist, an interrogator not an intelligence analyst. They were even more shocked to find out that I did not have a Top Secret clearance and so could not take the job "hand-picked" for me.

When they took this up the chain of command, they were told that they had to keep me and to put me to work in the orderly room. The 1SG, a friend of my original 1SG, said he had no work for me. This saved me.

I got transferred a few days later back to the 502d MI BN. I was put into HHS and told that I would be working in the S3, a logistics position and I had no choice. I met my new NCOIC (Non Commissioned Officer In Charge) and was told that I would be the Air Movement Request person. I would work at the TOC 12 hours a day, and put in flight requests for any of the S02d line companies.

I was freaking out. I went to EO, IG (Inspector General) and JAG. Everyone told me the same thing—it sounds like this is personal, but a commander had leeway to move his assets however he wants. I even asked—so if I do not get an EOT (Equal Opportunity Treatment Complaint), I do not get promoted and I am shuffled around to worse and worse jobs by him personally for the rest of the tour—I have no recourse? The answer was "yes." I asked, "who has oversight?" "No one" was the answer, unless I wanted an open door with a one-star

General who would probably not get a chance to see me until the end of my tour, if ever.

So I went to the logistics position. The CSM (Command Sergeant Major) actually told me to come to his office. He said, I bet you are wondering why you are here. I asked. I asked a lot. And he told me, "the BOE commander had issued a direct order that you will not be on any [Tactical HUMint Team], nor will you have any soldiers under you. Period. We had to fight hard to even get you in the S3—this was the best we could get for you. It is personal from him to you."

Yes, the CSM actually told me this.

So that is my story. Is it sexual trauma—no. But is it harassment of the worst form? Yes. Is it applying a ludicrous series of emotionally fueled assumptions about "female behavior" in general onto one person, with no eye to the circumstances and no attempt to behave professionally? Yes. This man has power, but he uses it when he does not need to.

The only way that I am not barred from reenlistment is that he tried to order my company commander to initiate it and my commander, after going to JAG, refused.

My old team leader even went to the BOE COR and asked for me back. When he said my name the COL got all red in the face and yelled NO WAY!

STORY FIVE

Female Five is the most extreme of cases. She is young, petite, pretty and friendly, all things that would prove to work to her disadvantage. I have worked with her in the past and know her to be of a strong character that does not use her appearance to take advantage of her situation. When she got to Baghdad-area she was separated from the Military Intelligence (MI) command she came with and placed with a group of Military Police (MP) who had specifically requested a female interrogator. She was the lowest ranking of those she served with and the only female. Highly inappropriate conversations of the sexual nature followed her wherever she went. Unlike myself, who felt safe and insulated from derogatory commentary while on missions, for her, her harassment continued. For example, a Senior NCO that outranked her by three ranks would call out over the radio, while on mission, and ask her about her preferred sexual positions. Everyone would hear this and laugh. She was decidedly embarrassed. Other MPs that she worked with would routinely graze her breasts or touch her thigh in fictional scenarios that involved them reaching across her. The following is her story in her words:

As a female in the military, you are considered either a "bitch" or a "slut". A female that keeps to herself, who works hard at her job, and who demands that people take her seriously as a soldier is considered a bitch. Whereas a female that is friendly, outgoing, and that enjoys having fun is thought of as a slut. In a military environment, there is no in-between; both carry stigmas and neither title is avoidable or reversible. I have been both a "bitch" and a "slut" at different times throughout my military career.

I quickly learned that by being the social butterfly that I am gave me "slut" status. I felt like flypaper for freaks. Although having "slut" status meant I could be myself, I was insulted that my guy friends never really viewed me as just a friend. I was not taken seriously and was constantly being disrespected. The general opinion that I was "easy" followed me from my second training station to my third, and when I was finally handed my 00214 release from active duty I vowed to not be quite as personable the next time. So when I was mobilized a year later, I built a wall around myself and reentered active duty with my guard fully up, allowing myself to quickly obtain "bitch" status.

At first I was relieved; no more unwanted attention, no more random guys trying to get my number, nobody knocking on my door at night trying to get me to go out so they could attempt to get me drunk. I was a bitch, and I intended to keep it that way.

Upon arrival in Iraq, I was assigned to a military police (MP) brigade, and my team of two other guys were given a squad of nine MPs to escort us on our missions throughout Baghdad. Each of the men on our squad detested three things in particular: Military Intelligence, "bitches," and above all, taking instructions from "bitches". They had wanted a "slut" as the only female on their squad, and they were beyond disappointed when they got me. I had no intention of taking my guard down; I was there to do a job, and that's all I was going to do.

As the assistant team leader of my tactical human intelligence team, I often planned my team's missions for our squad to escort us out on. My job was to

then inform our squad leader of our plans and it was his job to prepare a convoy plan. But my squad hated taking instructions from me, not only because I was a female but because I was about 10 years younger than each of them. Often times they disregarded my plans and caused our team to lose access to valuable intelligence. I ended up having to have one of my male teammates present my mission plans to our squad just to avoid their disrespect. But that plan backfired on me when they started rumors that I was no longer doing my job planning missions. However, that was the least of my problems. They slowly began breaking me down with their words, each day bringing me closer and closer to giving up completely.

In the Army, they brief you every six months on sexual harassment. They tell you that you should first confront the person bothering you, and if that does not work, utilize your chain of command. So I confronted the two guys that harassed me the most. I told them the things they were saying made me uncomfortable and that they were egging the other guys on. They were surprisingly cool about it; they said they would cut it out. The next day I arrived at our headquarters only to have every guy on my squad making fun of me; cracking jokes and then sneering at me saying, "I'm sorry, did I offend you, Smith? Are you uncomfortable?"

The harassment worsened; I endured countless rude comments, filthy jokes, and inappropriate questions from the MPs. I was disgusted with myself for even coming forward and telling them to quit it in the first place. So disgusted, in fact, that when my First Sergeant got wind of what was going on, I denied everything, saying they were just being playful and they did not bother me in the least. I feared that if my chain of command investigated the situation, the MPs would deny everything and the harassment would only get worse.

My fears came true when my First Sergeant finally went to speak to the MPs. I told him later what had gone on because of his interference in the situation, and asked if I could be removed from the team. I was told there was no other place for me; that a female was necessary on that specific team, and I was the only one available for the job. I was devastated; not only had my situation worsened, but the person who had seemingly been on my side a day earlier was now leaving me to be preyed upon by my harassers.

As a soldier, you are trained to "drive on", no matter the circumstances. "Adapt and overcome!" they say. For 6 months I "drove on". I thought, "Maybe they are right, maybe I am just being sensitive."

But in reality, the harassment was killing me; I lost my appetite, stopped exercising, did not socialize, rarely called home, and was crying on a regular basis.

I began to wonder what it would have been like had I obtained "slut" status instead. Would my deployment have been easier? Would my squad respect me? Could any female soldier, bitch or slut, ever have her male counterparts actually respect her? If respect was impossible to attain, should I have strived for their admiration instead? Upon realization that I was beginning to justify the harassment, I decided that I desperately needed help; I needed a way out of this situation.

So I reluctantly went to my unit's Chaplain, who listened to each of my woes without a word. "Should I beg for them to let me off the squad? Go to my chain of command about the harassment? Or see a psychiatrist because maybe I am just crazy and none of this is really happening?" My mind was full of questions, and what I wanted was an answer to my problems.

I finished speaking and was staring at the Chaplain with a look of desperation on my face. He nodded his head slowly like he understood completely, as if he knew exactly what I should do. I was practically on the edge of my seat when he finally answered. "Smith", the chaplain said, "I've known some great guys that were MPs. Great guys. . . My best friend was an MP. But those guys were exceptions, because MPs are scumbags."

This was hands-down the best piece of information I had ever received. This was better than any therapy session or anti-depressant. It was so simple, yet it made so much sense. These guys were not even worth worrying about. They were scum.

The Chaplain continued to explain that I would meet many more scumbags in both my military and civilian life, and these guys were like practice for the future. If I let these scumbags get the best of me that was like letting them win on behalf of scumbags everywhere.

With that, I left his office feeling not so lucky to be tested by a bunch of scumbags under such stressful conditions, but still feeling a whole lot better.

The next day I woke up half an hour earlier than usual. I was the first one at headquarters, and had my vehicle cleaned and fully maintained before the rest of my squad even showed up.

Every day, I arrived a little earlier and worked a little harder than my male colleagues. If they made a filthy comment or cracked a rude joke, I would roll my eyes and shrug it off. I did not try to crack one back; I did not want to lower myself to their scumbag level. I went out and collected more Intel than ever, and produced 75 percent more reports than my male teammates. This was not a competition; I was not trying to prove myself to them or anyone else. I was showing them that they could not break me. That I was not backing down. I made it nearly impossible for them to give me any grief. By not appearing uncomfortable by their crude talk, their harassment even began to subside. They had nothing on me.

Before I knew it, my deployment was ending. I had had 17 Intel reports published nationally since my talk with the chaplain, several more than the 6 months prior. I had accomplished more than some people accomplish in their lifetime. I had not been able to be myself for a whole year, but I had not gone to Iraq to be myself. I had gone there to accomplish a mission, and that is exactly what I did. I cannot say my squad respected me much more than before, but I can say that I was no longer disrespected like the "sluts" were.

Being considered a "bitch" really sucks, but it has more pay-offs than being considered a "slut". I left Iraq with something way more precious than a long list of admirers. I left Iraq with more courage, greater confidence in myself as a soldier, and most importantly, self-respect.

Female Five now holds the strongest opinion against females serving in a war-zone. She does not think any female should be sent to a war-zone unless she specifically volunteers because the hostile work environment is so severe that it is debilitating. What I found most troubling about her story was that the Chaplain told her scumbags were everywhere. When I told her that in my 13 years of civilian employment I had never been treated poorly due to my gender and that the civilian world is 180 degrees different than the military she was relieved that the severity of issues she experienced would not likely be repeated on the civilian side. She has since gone through therapy to work through these issues.

To conclude, we do our female military personnel serving in Iraq and Afghanistan a great disservice by focusing on rape as the definition of sexual trauma. Respective chains-of-command can often be the problem or fail to offer a solution to harassment at its most basic levels, so why would female soldiers trust them when the stakes increase? As these stories have shown a woman enters war often at a disadvantage that she will never overcome no matter what her behavior. This is sexual politics and trauma of the most extreme kind. Every soldier, female and male, needs their head in the game when at war and female soldiers should not be suffering from physical or emotional trauma from their fellow soldiers simply because they were born female while they deal with the stress of war.