***STATEMENT OF***
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***OF THE***
***DISABLED AMERICAN VETERANS***
***BEFORE THE***
***COMMITTEE ON VETERANS' AFFAIRS***
***SUBCOMMITTEE ON HEALTH***
***UNITED STATES HOUSE OF REPRESENTATIVES***
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Mr. Chairman and Members of the Subcommittee:

Thank you for inviting written testimony by the Disabled American Veterans (DAV), on behalf of our 1.3 million members, concerning active duty service members and veterans who may be suffering from Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI). We are pleased the Subcommittee is examining the current data and treatment trends for PTSD and TBI to ascertain what initiatives are currently underway to mitigate long-term mental health consequences for these veterans. Also, we are mindful of emerging literature strongly suggesting that even "mild" TBI patients may have long-term mental and medical health consequences, a matter that we hope will be of rising interest to the Subcommittee as well.

This testimony will discuss the variety of specialized mental health programs administered by the Department of Veterans Affairs (VA), with a focus on the quality and availability of those programs to support the needs of older veterans as well as younger and newer veterans now returning from military service. The testimony also will review our concerns about the long-term obligations of VA in the care (including mental health care) and rehabilitation needs of our newest veterans who have been severely wounded with TBI.

Many DAV members have experienced catastrophic disabilities as a result of their military service and are war-wounded veterans of major conflicts, including World War II, Korea, Vietnam, the Persian Gulf War and the current wars in Afghanistan and Iraq, among other U.S. military engagements. Therefore, the government's responsibility to provide appropriate health care services, including mental health services, to veterans suffering from PTSD and TBI, is very important to DAV members as well as the American people in general.

Without question, the Veterans Health Administration (VHA) has the most comprehensive mental health programs in the nation to treat veterans with readjustment issues stemming from military combat including combat stress, and acute and chronic PTSD. The VHA is home to a cadre of highly skilled clinicians and researchers who specialize in and are dedicated to helping veterans deal with the unique mental health challenges they face as they return to civilian life from a military combat theater. For these reasons, the Department of Defense (DoD), the VA and Congress must remain vigilant to ensure that federal mental health programs are sufficiently funded and adapted to meet the unique needs of the newest generation of combat service personnel and veterans, as well as continue to address the needs of our older veterans with PTSD and other combat-related mental health issues.

Historically, VA has had a special obligation to veterans with mental health challenges, given both the prevalence of mental health and substance-use problems among veterans and the high

numbers of those whose illnesses were of military service origin. Although mental health services are a major component of VA health care, internal VA funding to underwrite a robust mental health program has been a continuing struggle similar to that which has been well documented and publicized in private sector health care.

**Issues Affecting Our Newest Generation of Combat Veterans**

The ongoing wars in Iraq and Afghanistan are difficult, dangerous assignments for American troops, whether they are regular active duty members, Reserve or National Guard. Adding to the stress, many service members have served multiple tours of duty in Operations Enduring and Iraqi Freedom (OEF/OIF). These soldiers, sailors, airmen and marines, along with their families, are making extreme sacrifices so that this nation can free the world from terrorism.

The VA and DoD are well aware that combat veterans of OEF/OIF are at high risk for PTSD and other mental health problems. The 2006 study conducted by Colonel Charles Hoge, MD of the Walter Reed Military Research Institute, published in the *Journal of the American Medical Association*, evaluated relationships between combat deployment and mental health care use in the first year following return from the war, lessons learned from the post deployment mental health screening efforts, correlation between screening results and use of mental health services, and attrition from military service.

The study found that 19 percent of soldiers and marines who had returned from Iraq screened positive for a mental health problem, including PTSD, generalized anxiety, and depression. Col. Hoge reported that mental health problems recorded on the post deployment self-assessments by military service members were significantly associated with combat experiences and mental health care referral and utilization. Thirty-five percent of Iraq war veterans had accessed mental health services in the year after returning home, with 12 percent diagnosed with a mental problem. According to study findings, mental health problems remained elevated at 12 months post deployment among soldiers preparing to return to Iraq for a second deployment. Col. Hoge concluded that although OIF veterans are using mental health services at a high rate, many soldiers with mental health concerns do not seek help, due to stigma and other barriers. Hoge reported finding that service members resisted care because of personal concerns over being perceived as weak—or having a negative impact their military careers. Finally, Col. Hoge noted that the high use rate of mental health services among veterans who served in Iraq following deployment illustrates the challenges in ensuring that there are adequate resources to meet the mental health needs of this group, both within the military services themselves and in follow-on VA programs.

We also see increasing trends of health care utilization among OEF/OIF veterans in the VA health care system. As of July 2006, according to VA, within the 588,923 OEF/OIF veterans who have separated from service, 184,524 have sought VA health care. VA reports that veterans of these current wars contact VA with a wide range of possible medical and psychological conditions, including mental health issues such as adjustment disorder, anxiety, depression, PTSD and the effects of substance abuse (to date, nearly 64,000 of these individuals have sought care for one of the above-noted mental health conditions or been provided a provisional mental health diagnosis). The VA has intensified its outreach efforts to OEF/OIF veterans and reports that the relatively high rates of health care utilization among this group reflect the fact that these veterans have ready access to VA health care following separation from service for problems possibly related to their wartime experiences. VA estimates that over 109,191 veterans of Iraq and Afghanistan wars will be seen in VA facilities in 2007 (1,375 fewer than it expects to see in 2006). With increased outreach and internal mental health

screening efforts underway we are concerned that VA's estimates are low and could result in a shortfall in funding necessary to meet probable increasing demand.

We recognize the many challenges that combat veterans face upon returning home to their families and communities. Some have been able to move forward with their lives following a normal and expected readjustment period. Others have experienced persistent and significant mental health and maladjustment issues related to their military experiences, resulting in personal and family crisis, job loss, new claims for VA service-connected disability compensation and other mental health consequences.

Most experts believe the problem of PTSD has been with us throughout the history of warfare. In the nineteenth century, PTSD was termed "war weariness," and in the twentieth century, it was known as "shell shock," and later "battle fatigue." In 1980, the American Psychiatric Association added PTSD to the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III).

Regrettably Mr. Chairman, even today in the face of an abundant research portfolio of over 25 years, and with the full acceptance of the validity of PTSD by all American mental health authorities, insurance regulators and the federal government, a small minority of health policy analysts and clinicians has questioned PTSD in its chronic manifestation as a valid psychiatric diagnosis. Others argue that by financially compensating veterans for the disabling effects of chronic PTSD, VA is contributing to the problem by paying people to "stay sick" and exacerbating the challenges of clinical care that would improve these veterans' health. We believe that concern erroneously assumes that a veteran who has experienced a personal and traumatic event in a combat deployment later would be willing to embrace a label of chronic mental illness—with the stigma many in society still apply to the mentally ill—for the express purpose of receiving VA disability compensation. This argument also suggests either that these veterans have the internal strength to "will away" their disabilities when needed, or they are committing a fraud against the government. The argument also seems to expose a potential prejudice against health problems that result from psychological trauma as opposed to those that come from physical trauma—possibly suggesting another type of stigma. Leading experts on PTSD have cited objective data from recognized research to refute suggestions that substantial numbers of veterans with chronic PTSD discontinue their VA treatments to keep their distressing symptoms active for the purpose of remaining disabled and receiving disability compensation.

At a memorable hearing before this Subcommittee on March 11, 2004, a vigorous debate occurred among a number of witnesses who are experts in the field of PTSD. We believe Dr. Thomas Horvath, Chief of Staff at the Michael Debakey Veterans Affairs Medical Center in Houston, Texas, encapsulated in his remarks the essence of that discussion, as follows:

> "To this day, some people confuse a set of political and cultural attitudes, the post-Vietnam syndrome, with a clinically coherent, statistically valid diagnostic entity, Code 309.81, 308.3 of DSMIV, which is triggered by a range of catastrophic stressors, including combat, ambush, carnage and rape. Yet to this day, many people regard this PTSD as a weakness, a yellow streak, and not the red badge of courage. This despite CT scan findings of the shrinking of a part of the brain involved in emotion and memory, which correlates with combat intensity scores. This despite persistent biochemical changes which eventually lead to higher rates of cardiovascular disease and of mortality in general, shown in World War II veterans, POWs and Holocaust survivors. PTSD is a persistent biological condition that maims the body as well as the mind. It correlates with combat intensity. But unit cohesion and warm homecoming support partly protects

> from it. Regrettably, the VA 30 years ago did not provide these. However, we've come a long way. Twenty-five years ago we had no PTSD services, no [V]et [C]enters, no homeless programs. We did, however, have a set of substance abuse services that we no longer have. Still, the growth of PTSD programs has been gratifying, but not quite enough for the demand. These demands will now increase, especially by the many reservists who on their return from overseas are judged [RPGs] (unintelligible) while nation building, will be eligible for the VA. But PTSD is only one of the consequences of stress: Suicide, unexplained physical illness, depression, even the precipitation of psychoses and addictive disorders or others.

Overall, we are pleased with the direction VA has taken and the progress it has made with respect to its mental health programs. We are also pleased that DoD acknowledged it needs to conduct more rigorous pre-and post-deployment health assessments with military service personnel who are serving in combat theaters, and is working to improve collaboration with VA to ensure this information is accessible to VA clinicians in real time through electronic medical records transfer. Likewise, VA and DoD are to be commended for attempting to deal with the issue of stigma and the barriers that prevent service members and veterans from seeking mental health services when needed. Although we recognize and acknowledge DoD and VA's efforts—we are far from the universal goal of "seamless transition." Several months ago, the federal Health and Human Services Substance Abuse and Mental Health Services Administration sponsored a teleconference, "Stigma in the Military: Strategies to Reduce Mental Health Stigma among Veterans and Active Duty Personnel." The following statement associated with that event, sums up clearly our concern about the ongoing challenges we face in addressing the needs of our newest generation of combat veterans:

> The impact of military reality on individual mental health is complicated further by the pronounced stigma associated with mental illness within military communities. Service members frequently cite fear of personal embarrassment, fear of disappointing comrades, fear of losing the opportunity for career advancement, and fear of dishonorable discharge as motivations to hide the symptoms of mental illness from colleagues, friends and family. This silence and the attitudes and perceptions perpetuating it pose a significant challenge to those charged with making sure that the United States' fighting force is improving itself and taking care of its own members.

All of the challenges mentioned here will require an unprecedented level of interagency cooperation. We recommend VA work more effectively with DoD to ensure it establishes a seamless transition of early intervention services to help returning service members from Iraq and Afghanistan combat to obtain effective treatment and follow up services for war-related mental health problems. Currently, once a service member departs from military service, he or she is eligible to receive cost-free health care and readjustment services through VA for any conditions related to their combat service for two years following active duty. Given the sometimes delayed onset or recognition of mental health symptoms related to TBI and PTSD, we believe this period should be extended to five years. Nevertheless, we believe with proper resources, clearly defined goals and determination to overcome institutional and social barriers our government can fulfill its commitment to providing the best care available to service members and veterans with mental health problems.

## VA's Specialized Mental Health Programs for PTSD

VA provides readjustment counseling in 207 community-based "Vet Centers" located in all 50 states. Vet Centers provide a consumer-friendly, non-threatening environment for veterans in their communities, and offer a variety of services including counseling for veterans exposed to war trauma; those who were sexually assaulted during military service; and, those who need family counseling, community outreach, education, and social services. According to VA, in 2006, Vet

Center programs have experienced rapidly increasing enrollment in their programs. VA also operates a network of more than 190 specialized PTSD outpatient treatment programs in all 50 states, including 162 specialized PTSD Clinical Teams. In addition, VA has 33 specialized inpatient units for brief stays and long-term treatment and five outpatient Women's Stress Disorder and Treatment Teams.

In 1989, VA established the National Center for Post-Traumatic Stress Disorder, as a focal point to promote research into the causes and diagnosis of this disorder, to train health care and related personnel in diagnosis and treatment, and to serve as an information clearinghouse for professionals. The Center offers a monthly 5-day clinical training program to VA clinical staff, and maintains a web site (www.ncptsd.va.gov) with information about trauma and PTSD. The web site includes documents such as the Iraq War Clinician Guide to help clinicians diagnose and treat veterans returning from Operation Iraqi Freedom. Last year, the Center provided a guide for military personnel titled: *Returning from the War Zone.* This guide discusses common experiences in combat, post-deployment readjustment issues including the primary symptoms of PTSD, as well as other common stress reactions such as depression, anger, aggressive behavior, alcohol and drug abuse, shame, guilt, and suicidal ideation. The Center also offers guidance on effects of PTSD on family and work, and notes treatment modalities and common therapies used to treat PTSD. Included in the guide is a checklist of trauma symptoms for self-assessment, eligibility requirements for VA services and guidance for seeking further help.

Although VA has made a concerted effort to improve and expand access to mental health services at its community-based outpatient clinics (CBOCs), such services are still not readily available at all community sites. Likewise, we have been concerned about the decline in availability of VA substance-use disorder programs of all kinds, over time, including virtual elimination of detoxification treatment beds. Although additional funding has been dedicated to improving capacity in some programs, VA mental health providers continue to express concerns about inadequate resources to support, and veterans' rationed access to, these specialized programs. Based on current mental health utilization rates of OEF/OIF veterans, we agree with Dr. Frances M. Murphy, M.D., M.P.H., Deputy Under Secretary for Health Policy Coordination, in her statement on March 29, 2006, before the former members of the President's New Freedom Commission on Mental Health, that, "taken in combination, the findings of Hoge et al and the latest VA data suggest that substance abuse and the associated resources demands may be significantly higher than originally estimated."

**President's New Freedom Commission on Mental Health**

We are pleased that following the release of the report of the President's New Freedom Commission on Mental Health in July 2003, VA undertook an unprecedented, critical examination of its mental health programs. Like other institutions providing mental health care, VA found that it tended to focus on managing symptoms, rather than aiding patients' recovery and restoration. The New Freedom Commission found that many people with mental illness can regain productive lives, and the effort provided the President and the government a bold new blueprint for system change based on the goal of recovery. VA leaders learned the importance of achieving the mental health system change the Commission envisioned and developed an agenda for realizing that goal. The VA established a National Mental Health Strategic Plan as an outgrowth of the President's New Freedom Commission report, and has committed $100 million annually to its implementation. Unfortunately, we understand that VA's internal policy on funding certain new initiatives to address gaps in services related to psychosocial rehabilitation and recovery oriented services included in the National Mental Health Strategic Plan will be limited to only two years. The expectation is that this "seed money"

provided to specific initiatives will generate sufficient creditable patient care workloads through VA's internal resource allocation system so that further centrally funded earmarks will not be necessary after the first two years. This is an untested concept that may dampen local interest in proposing or embracing these new initiatives. If a VA medical center director believes that a centrally controlled earmark is temporary, there may be temptation to limit activity in that program once the earmarked funding is no longer available. This two-year funding policy bears close scrutiny from mental health advocates and your Subcommittee, Mr. Chairman.

Under former VA Secretary Anthony J. Principi's leadership, the transformation that is now underway in VA mental health service delivery—built on an understanding that veterans with mental disorders can recover and lead productive lives—is vitally important to keeping faith with VA's obligations to America's veterans. We have urged current VA Secretary James Nicholson to follow Secretary Principi's example and maintain mental health reform as a major priority in his term of office. We are also encouraged that Dr. Ira Katz, a noted clinician-scholar in gero-psychiatry with a significant professional history in VA's Mental Illness Research, Education and Clinical Center in Philadelphia, has assumed the key position of VA's Chief Consultant in Mental Health. Dr. Katz fully embraces the New Freedom Commission concepts and is beginning a number of new initiatives that we believe will improve the lives of disabled veterans.

While VA and Congressional leaders have taken important initial steps to move VA toward better care for veterans with mental health problems, many serious challenges still face the VA system. Clearly, any transformation or major change—from eliminating the longstanding variability in VA mental health care to changing its mission from symptom-management to recovery—will take sustained leadership and support on the part of VA and Congress. Mr. Chairman, we urge your Subcommittee to play a strong oversight role in monitoring VA's work in mental health reform, and to help give VA the tools and resources it needs to achieve these worthy goals.

Mr. Chairman, in what should be a shared journey, VA must do its part to sustain VA mental health care as a high priority. The system must continue to improve access to specialized services for veterans with mental illness, PTSD, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all the positive benefits this brings to veterans, their families and to our society, becomes the guiding beacon for VA mental health planning, programming, budgeting and clinical care. The DAV is committed to ensuring that the military and VA health care systems remain capable of receiving wounded veterans, whether they are active duty, Guard or Reserve, and can provide the highest quality and level of services to restore them, irrespective of the nature of their injuries.

## Traumatic Brain Injury in Southwest Asia

With all the challenges we face in addressing the unique mental health concerns of our nation's veterans, it is clear that there are many professionals, certainly including Dr. Horvath quoted above, who are dedicated to improving the lives of this newest generation of war-disabled veterans. We were pleased that the Committee on Care of Veterans with Serious Mental Illness, in its Ninth Annual Report to VA's Under Secretary for Health, included a new recommendation concerning OEF/OIF veterans suffering from TBI, a serious condition resulting from physical trauma to the skull that damages the brain's structure and function. The Committee supported additional research in this critical area and noted that brain injuries may cause symptoms that mirror those of mental illnesses, and that it is important to recognize that the effects of this type of trauma may have a delayed onset

and be difficult to recognize. We fully support the Committee's recommendation for the VA Mental Health Strategic Health Care Group in VA Central Office to lead the development of an initiative to address the mental health needs of veterans with TBI.

Mr. Chairman, it has been said that TBI—caused by improvised explosive devices (IED), exploding mortars or artillery, military vehicle accidents, suicide bombers, gunshot or shell fragment wounds, falls, "friendly fire," and other traumatic injuries to the brain and upper spinal cord—may be the signature injury of this, our latest war. Many of the current war's TBI wounded result from blast injuries or powerful bomb detonations that severely shake or compress the brain inside the skull, often causing devastating and permanent damage to those brain tissues. Many service members who suffer skull, neck and facial injuries also experience moderate or severe brain injury, but other milder forms of TBI are sometimes not immediately detectable. It is very possible that many mild brain injuries and concussions have gone undiagnosed or that symptoms for others will surface later, as these veterans return to civilian life. The influx of OEF/OIF service members returning with brain trauma has increased opportunity for research into the evaluation and treatment of these injuries; however, this raises the question of the number of older veterans of past conflicts who may have also suffered similar injuries that went undetected, undiagnosed and untreated.

We believe more research into the long-term consequences of brain injury and best practices in its treatment are needed and are warranted by VA. Individuals suffering brain injury often present with complex, difficult and unique psychological and physiological pictures requiring a cadre of specialists to manage their medical and psychological care and rehabilitation. Most severely injured service members will require extensive rehabilitation and life-long personal and clinical support, including neurological and psychiatric services, physical, psychosocial, occupational and vocational therapies. Currently VA has designated facilities in Minneapolis, Palo Alto, Richmond, and Tampa as TBI "Lead Centers" to provide the full spectrum of TBI care for patients suffering moderate to severe brain injuries. Additionally, VA is expanding similar activity to other facilities in each of its Veterans Integrated Service Networks (VISNs) for follow-up care of TBI patients referred from the four lead centers.

Although VA has initiated new programs and services to address the needs of TBI patients—there are still gaps in services. The VA's Office of the Inspector General (OIG) issued a report July 12, 2006, titled *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*. The report assesses health care and other services provided for VA patients with traumatic brain injury, and then examines their status approximately one year following inpatient rehabilitation.

The report found that there was room for improvement and that better coordination of care was needed to enable veterans to make a smoother transition between DoD and VA health care services. The report called for additional assistance to immediate family members of brain-injured veterans, including additional caregivers and improved case management. According to the report, the goal of achieving optimal function of each individual requires further inter-agency agreements and coordination between DoD and VA. We agree that the true measure of success is the extent to which those severely injured veterans are able to re-enter society or, at minimum, achieve stability of function at long-term care facilities or in their homes.

We are pleased that the VA has designated TBI as one of its special emphasis programs and is committed to working with DoD to provide comprehensive acute and rehabilitative care for veterans with brain injuries. We are also encouraged that VA has responded to the growing demand for

specialized TBI care and, fulfilling the requirements of Public Law 108-422, and established four Polytrauma Rehabilitation Centers (PRCs) that are now co-located with the existing TBI Lead Centers. However, we are especially concerned about whether VA has addressed the long-term emotional and behavioral problems that are often associated with TBI, and the devastating impact it has on veterans and their families. As noted in the July report, "these problems exact a huge toll on patients, family members, and health care providers." The following excerpt from the OIG report is especially telling of the challenges we face in ensuring these veterans and their families get the care and support services they need:

> In the case of mild TBI, the [veteran's] denial of problems which can accompany damage to certain areas of the brain often leads to difficulties receiving services. With more severe injuries, the extreme family burden can lead to family disintegration and loss of this major resource for patients.

The OIG conducted interviews with 52 patients to assess four areas: general well-being, functional status, social adjustment and behavior, and access to health care services. There were several key issues identified by patients and families we believe warrant action by VA and further oversight by this Subcommittee:

- Patients and families highlighted the importance of case managers in facilitating care but reported significant variances in the effectiveness of case managers, rating them from "outstanding" to "poor." One family member interviewed indicated she did not have the help she needed to navigate the VA health care system and had to purchase items out-of-pocket for necessary equipment and services for her son.
- Access to care due to distance from a VA facility was perceived as a barrier for one family and patients living in remote areas found it more difficult to access the specialty care they needed
- One veteran interviewed reported significant problems with discharge planning when she left VA's TBI center. One caregiver reported running out of medications and that they had not received needed therapy or an appointment for follow-up care.
- Some spouses who worked feared they would lose their jobs due to the demands of caring for their loved ones. Some families received the psychological support they believed they needed while others reported they did not.
- Spouses and parents reported feeling isolated and suggested the need for a support network for affected families.
- Many patients interviewed reported difficulty with behavioral problems including memory loss, disruptive acts, depression and substance abuse—common problems associated with TBI. Issues with anger, community reintegration and socialization were also reported.

To address some of these issues, we are pleased that VA requires a case manager be assigned to each OEF/OIF veteran seeking treatment at a VA medical facility. The case manager facilitates communication and coordination of VHA services, including benefits, education and health care services. Additionally, VA has created liaison and social work positions at DoD facilities to assist injured service members with transition to veteran status and help in accessing VA health care services and benefits. We commend VA for its outreach to these new veterans and for trying to improve the knowledge and skills of VA clinicians through educational initiatives defining the unique experience of this newest generation of combat veterans. We acknowledge VA's dedication and commitment to meeting the needs of veterans with TBI through high quality services at its polytrauma and TBI Lead Centers, for ongoing research into this debilitating injury and establishing

effective services with academic and military affiliates to fill gaps in services where they are observed.

Unfortunately, in interviewing case managers, the OIG found continued problems related to: transfer of medical records from referring military facilities, difficulty in securing long-term placements of TBI patients with extreme behavioral problems, limited ability to follow patients after discharge to remote areas, poor access to transportation and other resources, and inconsistency in long-term case management for some TBI patients. The report found that while many of the patients they assessed had achieved a substantial degree of recovery, *"…approximately half remained considerably impaired."* Also noted was the difficulty of obtaining appropriate specialized services even on a fee basis for veterans living in geographically remote areas. It is also notable that VA TBI patients, when compared to a matched group of non-VA patients, had longer times from date of injury to entry into rehabilitation. The report concluded that improved coordination of care is necessary between agencies, including transfer of medical records, and that families need additional support in the care of TBI patients.

OIG recommendations included: improving case management for TBI patients to ensure lifelong coordination of care; improving collaborative policies between DoD and VA; starting new initiatives to support families caring for TBI patients; and ensuring that rehabilitation for TBI patients is initiated by DoD when clinically indicated. It is encouraging that VA concurred with the above-noted recommendations and reported it is revising its policies in response to the report.

Finally, we agree with the OIG that specific management approaches for TBI may be necessary but that supporting these patients for a lifetime of care will be the real challenge for VA.

## Closing

Without question Americans are united in agreeing to care for those who have been severely wounded as a result of military service. This is a sad but continuing cost of national defense. Service members who have suffered catastrophic wounds with multiple amputations or severe burns draw great public sympathy and admiration for their sacrifices. But those that suffer the devastating effects of PTSD, TBI and other injuries with mental health consequences that are not so easily recognizable can also lead to serious health catastrophes, including suicide, if they are not treated. There must be early recognition and intervention of war-related mental health challenges to prevent, when possible, later onset of devastating chronic health problems. We can meet that challenge by ensuring a stable, robust VA health care system that is dedicated to the unique needs of our nation's veterans—one that will be there now for our aging veterans of World War II, Korea and Vietnam, and still be there for the newest generation of war fighters who will need specialized services for decades to come. Veterans should be guaranteed a system that *itself* is guaranteed sufficient funding to meet its mandated missions. VA must be sufficiently funded to treat newly returning veterans with acute and emerging mental health issues without displacing older veterans with chronic mental illnesses. Finally, we must also ensure that family members of veterans devastated by the consequences of TBI, PTSD and other injuries have access to appropriate services.

Our testimony calls for strong and continuing oversight on the part of your Subcommittee in a number of critical arenas of VA and DoD responsibility. Mr. Chairman, DAV stands ready to work with this Subcommittee and VA in addressing these issues as we move forward and we appreciate the opportunity to provide this statement.