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NATIONAL DEFENSE INDUSTRIAL ASSOCIATION
WARRIOR-FAMILY SYMPOSIUM

MENTAL HEALTH: LINKING WARRIORS AND THEIR FAMILIES, GOVERNMENT AND SOCIETY

Thursday, September 12, 2013

8:35 a.m.

The Ronald Reagan Building and
International Trade Center
Atrium Ballroom
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P R O C E E D I N G S

VADM RYAN: Good morning, ladies and gentlemen. Welcome to the Warrior-Family Symposium. I'm Norb Ryan, President of MOAA, and I'm honored to be joined this morning with our cosponsor for this symposium, Lieutenant General Larry Farrell, President and CEO of the National Defense Industrial Association.

Larry will be up here in a couple minutes. Thank you to all of you for taking time to be with us this morning for our seventh annual Warrior-Family Symposium. Our theme, "Mental Health: Linking Warriors and Their Families, Government and Society," takes a broad look at mental health and the challenges facing our warriors and their family members today.

It's not a new issue, and we must continue to learn from the past and do better in the future for all our servicemembers and their families. This morning we'll look across the generations to see how this issue has impacted on our government, society, and we'll look also ahead to focus on

solutions for the post-war environment.

Ladies and gentlemen, please rise for the Presentation of the Colors and the playing of our National Anthem. Presenting the Colors today is the Army Color Guard led by Staff Sergeant Daniel Perkins, U.S. Army, and the National Anthem will be rendered by "The President's Own," the U.S. Marine Band, led by bandleader Master Gunnery Sergeant William Browne.

Color Guard, present the Colors.

[Presentation of the Colors.]

[Playing of National Anthem.]

VADM RYAN: Please be seated. What a great way to start the day. How about a round of applause for the Army Color Guard and the U.S. Marine Band?

[Applause.]

VADM RYAN: At this time, Commander Steven Smith, U.S. Navy Headquarters FORCECOM, Deputy Chaplain, U.S. Coast Guard, will give the invocation.

CDR SMITH: Being a prior enlisted Marine,

I just have to say "Oorah." With our hearts and minds clear, I would invite you to join me this morning in prayer.

Holy God, it is with great pleasure and honor that I voice this prayer to you on behalf of these assembled. You Holy One are worthy of our praise. To you, we owe everything. And it is in this spirit that I come before you now and ask for not only your presence but also your blessing upon these assembled and this event.

Holy God, many of our forefathers have sacrificed in order for us to know the freedoms that we enjoy, and many will continue to sacrifice in a variety of ways to assure that these freedoms remain intact. May we possess the willingness to encounter the unexpected in order to imagine the unimaginable.

Holy God, we're here to unite and honor, to draw upon the strength of the gifts that you have blessed us with in order to better care for our warriors and their families, their bodies, their minds, their spirits. Help us to become a

stronger united force.

May the gifts and abilities that are reflective in everyone here be blessed in a way that they can enhance their contributions, further their expectations, and accomplish great tasks.

Bless the families of all who have given. May they know and find comfort in a grateful nation. We pray and ask these things in your holy name.

Amen.

VADM RYAN: Thank you, Chaplain.

I just want to take a couple minutes to thank some folks who without their support we wouldn't be able to do this and then recognize some of the folks that are with us this morning.

First of all, thank you to all our sponsors for supporting this year's symposium. We especially want to thank USAA, our Executive Sponsor. We're pleased to have with us Ronnie Wright [ph], Marc Hildebrand, and Gina Jura [ph] representing USAA today. They're at the table right here.

We also want to thank our Patron and Lunch Sponsor, Haven Behavioral War Heroes Hospital, and the representatives are at our next table over. If you all--thank you all very much as well.

Our breakfast this morning for the seventh year in a row was sponsored by the American Physical Therapy Association. We want to thank APTA for their support.

A lot of special guests in the audience today, but none more important than our men and women in uniform. Would all those that are able in uniform to stand and let us give you a round of applause?

[Applause.]

VADM RYAN: September 11 reminds us that it's been this one percent that has kept the other 99 percent of us safe and secure, and so thank you to all of you and your families.

Please hold your applause, but I just want to mention some of the other folks that are here today in case you want to go up and say hello and network with them. Of course, our Chairman of the

Board, General John Tilelli, is here at Table 6.

We also have Major General Barry Bates, the VP for Operations for NDIA. Larry doesn't show up without General Bates here as well.

And then we have some special guests, the spouses of our senior folks in the military: Mrs. Mary Winnefeld, spouse of Admiral James Winnefeld, Vice Chairman of the Joint Chiefs of Staff; Mrs. Anne Campbell, spouse of General John Campbell, USA, Vice Chief of the Army, and he'll be speaking at lunch; Mrs. Debbie Paxton, spouse of General John Paxton, USMC, Assistant Commandant of the Marine Corps, and a panelist at today's symposium.

We have Ms. Ellyn Dunford, spouse of General Joseph Dunford, USMC, Commander International Security Assistance Forces and U.S. Forces Afghanistan.

We have Mrs. Buchanan, spouse of Major General Jeffrey Buchanan, Commanding General Military District Washington, and we have Mrs. Grisoli, Major General Retired, and spouse of Lieutenant General William T. Grisoli, USA,

Director of the Army Staff.

We also have Mrs. Lisa Battaglia, spouse of Sergeant Major Bryan Battaglia, USMC Senior Enlisted Advisor to the Chairman of the Joint Chiefs of Staff; Mrs. Susan Barrett, spouse of Sergeant Major Micheal Barrett, USMC, Sergeant Major of the Marine Corps; Mrs. Theresa Stevens, spouse of the Master Chief Petty Officer of the Navy Michael Stevens; Mrs. McKinley, wife of retired General McKinley.

We have a couple of folks from our Board who are very special because they're on our Health Advisory Committee: Colonel Sharon Richie-Melvan, Commander Pat Kusiack, and Colonel Barb Ramsey, all from the MOAA Board of Directors; and Mike Rogers, currently serving Active Duty, also a member of our Board.

And then finally I don't know if Ms. Rosemary Williams has made it or not, but she's the Deputy Assistant Secretary for Military and Community and Family Policy.

How about a round of applause for everyone

here?

[Applause.]

VADM RYAN: Okay. They've given me a whole bunch of other notes, but in the interest of getting our first speaker on, I will just say a couple of administrative remarks. And one overall theme that we have tried to continue here as we go into our seventh symposium, and that is no nation does as much as our nation does to support its military and its families and its wounded and its caregivers than our nation, but I think we all would agree that it is our job to continue to try and raise the bar in support and get an A plus in every effort that we do. That's why we come together this morning to share best practices, to hear the ideas, to find out how we can do more in the public and private partnership area, and move the ball down the field as we have done for the last six symposiums.

And so we've got an action packed morning for you with a couple of panels and a couple of great speakers. At lunch we're asking you to go

out and get your lunch and then come back in for an interactive panel with the third panel, and that's where you'll use those cards and pens that are on the table to give us your ideas, your suggestions, and your questions for the third panel, and, of course, General Campbell will take questions from the field at lunchtime.

And, please, visit our exhibitors. They can help in this networking and the partnerships that we're trying to promote, and at this time now, I'd like go ahead and introduce my sidekick for this, Lieutenant General Larry Farrell, President of NDIA. Larry.

[Applause.]

LTGEN FARRELL: Well, good morning. Thank you very much for the opportunity to participate in this event. Thanks, Admiral Ryan, for your introduction. NDIA is especially pleased to be able to co-host this event with MOAA. This is the second year that we've done this. It's very rewarding for not only the people that we serve but for our staff. Our staff takes a great pride in

this event.

And we are here today to honor our wounded heroes and their families and to talk about an important topic for today. Working alongside MOAA to plan and execute the event has been a rewarding experience, as I said, for our team, especially given the purpose of this event.

And if you look out there, you see that we are all related in some way or another to these warriors. For NDIA, we have an industry relationship where industry strives mightily to provide the best possible tools for them to execute their mission, but then as you look at our industry and MOAA, about a third to half of the people who serve in this industry wore the uniform themselves, and so we have a special connection to these guys because we were there.

And for people like me--and I'm sure there's a few people in the audience who have family members who are serving--my son serves in the special ops business. So for me this is a family event, you know. It's not just an event

that we do. It's a personal thing for me.

So I can think of no more activity that's more worthwhile or rewarding or that is more deserving of our efforts, and so like Norb, I want to add my sincere thanks to the sponsors and exhibitors whose contributions make this possible, and thanks to all the speakers, panelists, the warriors themselves, the family members that are going to be part of the agenda today.

So I encourage all of you today to participate in the agenda, to engage the speakers and the panelists with questions and comments and feedback and to make their time and your time more productive, and once again I want to thank Norb and MOAA for inviting NDIA to team with them for this symposium. So we all look forward to fully participating in the program today.

So at this time, I'd like to kick it off by bringing our first speaker up. Dr. Robert L. Jesse is the Deputy Under Secretary for Health, Department of Veterans Affairs. In this position, Dr. Jesse leads the Clinical Policies and Programs

for the Veterans Health Administration, which is the nation's largest integrated care system.

Previously, he was the Chief Consultant for Medical Surgical Services in the VA's Office of Patient Care Services, and he is also a Board certified cardiologist, and he serves as the National Program Director for Cardiology in the VA.

He's implemented a lot of reforms in the delivery of specialty and emergency care for our veterans that have significantly improved the quality of care provided across the whole VA health system, and we are really excited to have him here today.

Ladies and gentlemen, please welcome Dr. Robert Jesse.

[Applause.]

DR. JESSE: Good morning. First my thanks to Admiral Ryan and General Farrell for having me here and to General Tilelli and Bates for hosting this symposium and giving the VA a chance to tell a little bit about what we're doing.

I appreciate the introduction. Somehow in

three years in this job, I've yet to get my staff to correct that because they always leave out the most important thing, and that is I still see patients. I keep a clinic down in Richmond because frankly it reminds me of why we do the things we do, and it keeps me focused on what the really important part of this job is, and so I'll extend my thanks to all of you who take care of veterans, all the veterans here in the room, and all the people who support that, including the veteran service organizations that are such valued partners to us.

The other thing I need to do is to figure out how to get staff to prepare talking points that actually fit in the timeframe that I'm given, and they pretty much know that I'm not very good at staying on script anyway. So I'll probably vary quite a bit, but I'll try and stay within time.

I want to say it really is an honor for me to be here, and I'll phrase that in a personal thing. I was born at NAS Whidbey Island. My dad was a Naval Academy grad in 48A, and I think I was

25 years old before I ever lived in one place for more than two years. So I know the life, and I ran into this lovely young lady the first day of college who I am now married to for pushing 40 years whose father also is retired Navy, and our parents retired on the same day although they both lived very different careers.

So I'm in this position not because I happen to, because I really feel deeply about taking care of veterans.

Mental health is frankly one of our highest priorities right now. It's as over the past ten years really come to understand the important priorities of what happens to people when they face battle. It's clear that mental health issues need to be addressed, but we don't just address mental health issues. We don't address PTSD. We take care of patients, of complex human individuals who are struggling.

Often that requires, I think, a concerted effort to reintegrate people back into society. We prepare people very well to go to battle. We are

less good at preparing them to come home, and one of the strongest pieces we have on here is actually I think our vet centers, the reintegration counseling centers, who are there as a bridge of trust in many respects between returning veteran and their communities and the capabilities that we have both in DoD and VA, but often just to have somebody who says I've been there and it gets better, let me help you makes a huge, huge difference, and so I'd like to just acknowledge the importance of that role.

Today, more than ever, more and more veterans are returning to VA for help when they need it. Getting people to recognize that they need help is one of the big challenges. We've actually put out some innovation competitions, not to treat people with PTSD, but actually to try and get people to recognize that, in fact, they need help.

One of the other strong points on that is our Chaplain Service who work very closely with lay chaplaincies because in many parts of this country,

it's the clergy who are the frontline mental health providers, and at least they know when something is wrong in the family, and to have them be able to know where those resources to turn to is crucial.

We have about 1.3 million veterans who are now receiving mental health care in the VA. This number has been rising every year. It will continue to rise probably for at least the next ten years. We think, in part, it's because there truly is I think a strong recognition that the stigma of needing help should not prevent people from getting help.

And more and more the work that this whole country has been doing to make this acceptable and not stigmatize people has been really, really important, and frankly it's because we screen for it. We look for it really carefully. We outreach for it, and we are trying to get people in because we can really help them, and I'll talk a little bit about suicide prevention and the work we're doing in that area, but frankly the best way to prevent suicides is actually to intervene long before it

gets to that, and as a cardiologist, I'll put it, you know, we're very good at treating heart attacks.

We have incredible emergency medicine systems and the like, but frankly we also know that the best thing to do is to prevent a heart attack, and we do that by addressing diet, cholesterol, smoking, hypertension, diabetes, and we need to do the same thing in the mental health arena, addressing the fundamentals, and I think we're learning a lot more about that.

This has been a challenge for our workforce. Ten years ago we had about 13,000 mental health providers; we now have 22,000. In the past year, in part through support of both Congress and the White House, we've brought on board 1,600 new mental health providers, and an appropriate number, three, 400 more people to support them, which is really important actually.

And, in addition, we're in the process now of hiring 800 peer counselors, and this is in a sense to replicate the model of what we have in the

veteran centers, in the vet centers, in the hospitals and clinics, again, to have people who have been there, who have themselves struggled and recovered or are in recovery be able to support their peers.

I think that peer-to-peer mentoring probably is one of the most important things we do. I was going to comment. This was a really good Color Guard that came, very handsome, but I saw a much better-looking one on Tuesday. We have a series of adaptive sports events, and the Color Guard was the all-amputee Color Guard, and I was so impressed, absolutely impressed, and I actually--so I will confess that this was--I had to really work hard because it was actually the TEE Tournament so they made me go out and golf with these guys, and the Sergeant Major from the Color Guard was one of my partners, and, wow, what an incredible group of individuals, and watching how these people support and mentor each other, both mentoring up and mentoring younger guys is just an incredible thing to watch.

And if the VA can do anything, we can be the facilitators of that because I think what they do is as powerful as anything that we can do. Sorry for that digression.

The peer support specialists are really interesting. This is kind of uncharted testimony. There is no degree in being a peer support veteran counselor. So we've had to develop some training. What's really interesting is the retention in this group. As they progress through, we have very little, very little dropout. When we get people working, it's like just a couple of percent that turn over.

Typical turnover in health care is about 20 percent. So the people that are coming into this program are extraordinarily committed to helping their peers.

I talked about suicide. I'll just carry on to that. We really are changing our whole approach to mental health, and we've always taken the approach of treating the immediate problem and not of the fundamentals of prevention, and just as

the lessons we've learned over the past decades in cardiology and other areas, true prevention is getting at the root source of issues, and so we really are trying to change the delivery of health care and particularly mental health care to look at perfect depression care, dealing with issues like sleep, dealing with issues like pain, dealing with issues like substance abuse.

They're all intertwined, and if we don't address them as the fundamentals, we'll not get to the bottom of this, and at the same time, we believe--and we're changing to a very holistic approach to health care, and so that health care is not about physical health care; it's also about mental health and a very much more holistic approach, and that's why we've moved to what we call PACT, the Patient Aligned Care Team model, and this is somewhat like the medical home that you're hearing more in the private sector, and I think the term that DoD uses.

But the frontline of mental health care actually is in the PACT, in the primary care teams.

I was--I'll talk about this in a second, but we're doing these mental health stand-downs--you heard that mentioned earlier--and I went up to the one in White River Junction, Vermont, and their average wait time for a new mental health appointment is 20 minutes--20 minutes. Because if somebody is seen in primary care or comes in requesting help, they have integrated into the primary care environment mental health providers that can see so many, and if they back up beyond 20 minutes, they pull people out from the floors.

It's incredible to see the level of dedication. And I said the only risk here is that nobody is going to believe you. When you say your wait time is less than one day, people are going to think you're fudging the books, but actually talk to the people, and this is the way they're doing it, and I think truly integrating that so that mental health is part of the fundamentals of primary care is an absolute key to success.

I just make a mention of suicide prevention because it's something that's an

extraordinarily important effort. This was stood up as a hotline system. We've had since this came into play in 2007 kind of just a little bit shy of a million calls. There are 30,000 saves of people that were literally in imminent risk of committing suicide that we're able to get help to and bring into recovery.

It's open 24 hours a day, 365 days a year. I think we just are in the process of hiring a couple hundred more people to support that system. It's so strong. And interestingly--these guys are really smart because not everybody picks up the phone. You know, nowadays people use, they text, they tweet, they use the Web, so we've also got a capability for people to come in through chatrooms and other Web-based methodologies if they're having problems. And also--very much encouraging--not just the veteran can call, but anybody who is caring for a veteran, knows a veteran, is concerned about a veteran, to be able to call into that line.

There's a lot in the press about the suicide rate amongst veterans going up, but the

statistic that gets lost is that of those veterans who are in our care, the rate is actually stable or going down, and I use that only as a plea to really help bring people into the care system because if we don't know about them, we can't help them, and then I think this is tremendously important and why the outreach is so important.

So let me talk just a bit about that. As part of a comprehensive plan and in following on some work that we had done with the homeless population, I think the VA has recognized that we cannot solve these problems by ourselves. We have a broad reach. We have at this point 152 hospitals, over 800 clinics, and 300 vet centers, a huge footprint, but we're not everywhere all the time.

And we realize the value of community partnerships. The one thing we can do really well is serve a convening function and by getting all the community partners together because everybody wants to help, and a lot of folks out there, and I'm sure many of you in the room who are wanting to

be part of this, struggle to find the right door to knock on. And so what we're really trying to do is to create the visibility for that so as we go into the communities, every one of our hospitals starting in late June through the end of this month will have a mental health summit.

The point is to bring together community, the non-government agencies, the local governments, state governments, other federal partners, the VSOs, together and really develop plans for how to support the whole community mental health needs, and this is really important because in order to engage the veterans, also you create a capacity across the community that has an even broader scope of support.

So we really appreciate everybody who has come and been part of these. I'm actually flying up to Boston tomorrow to participate in one of them up there. So we're moving in many different pathways in supporting and building the capacity to improve the mental health care for veterans. I will say with great pride that at this point, I

believe that the VA is the best integrated mental health care system in this country, but we're not perfect, and we've got a lot of work to do, and we very much appreciate the support of all of you.

Our DoD partners, we've got some great joint efforts going on so that we ensure that we have consistency as people transition out of active duty into the VA system. We don't jump out of one system and go into another system and send mixed messages, and those have been very valuable experiences as well.

Very interesting work going on in the world of TBI and PTSD. I'll just mention a little bit about PTSD because I think it's hugely important, and it's one of the biggest problems we have, but the good news is that ten years ago, PTSD, the struggle was to make a diagnosis. Today we actually have treatments that really seem to be working. We collectively refer to them as evidence-based cognitive therapies, but my sense is that we are really beginning to get people back on track by using these.

I'm hearing great things. We've trained almost 5,000 mental health providers in these treatment modalities, and people are availing themselves of it and are frankly doing better. VA leads the world, I think, in research into PTSD. We have an incredible center up at White River Junction, Vermont that's working this area, and frankly I think this is hope, that knowing that there is something that can help, there truly is hope, and the real issue is ensure that we have the direct kind of access that we need to have.

So as we move along and are developing our approach to this and then sharing and deploying that with the communities, it's just vitally important that we are able to maintain that level of consistency, but most important is if we say we can help somebody, to actually be able to be there when they need us, and so waits and delays are unacceptable, and as we are dealing with a lot of our issues around scheduling and the like, literally being able to move globally to the model that we see in, as I mentioned, a 20-minute wait

time is really important.

Now, at the front end of that, I will say that our emergency medicine and acute care programs have over the past ten years really been developed in a way that we can support this. There is mental health support in every emergency department in every VA. Anybody who walks in will be evaluated within the first 24 hours, and those who are really in distress and extremis will be taken care of immediately. So if you hear of waits of seven days or 14 days just be aware that people are being seen right away, and those are for follow-up appointments.

But we got to do better. Every time we look and say we're doing better, we do find glitches, and we're working through all these and again appreciate the support that all of you are doing.

Interesting thing about PTSD is some of the work they've been doing using cell phone technology. For instance, there's a thing called the PTSD Coach, which has been out for a couple of

years, won a host of awards. It's been downloaded in over 70 countries so far. Really seems to be a way to connect people and keep them grounded when they need help.

I've mentioned the summits. I think these are really important. We actually--this is I think integrally tied into the homeless problem. As we've been addressing the problem of homeless veterans, and I know you've heard both the Secretary and the President say it's unacceptable for any veteran to spend one night on the street alone, but homelessness is not just an issue of finding somebody a house or a bed to sleep in.

It really is an issue of jobs. It's an issue of mental health; it's an issue of physical health. It's an issue of substance abuse. It's an issue of transportation. It's an issue of community, and as we've been working on this, again, the community partnerships that we're building around this have really helped, and it has also helped to bring a lot of people into mental health treatment, which I think fundamentally has

been one of the biggest successes that we've had.

So what do we need to do? We need to raise awareness. We need to make sure that everybody, every veteran in this country, knows that there is help and help that will help them, and whether it's talking just to a peer to mentor them through some difficult situations, if it's help to just get them integrated to coming back home to a very different life than they've been living for the past year or two years or five years or ten years, is really important, and for those who are really suffering with PTSD and depression and substance abuse and pain, to know that we can help them with those as well.

Pain control is a big issue for veterans, and we've got just incredible efforts going on in that area as well. Also with our DoD partnerships, a large joint piece going on there, and when we can do that, then we can bring all this back together. It's not an issue of stigma; it's not an issue of mental health; it really is an issue of complete wellness and well-being, that we have a holistic

approach to making people live the lives that they want to live.

And I can't underestimate and understate the importance of family, the importance of community in supporting this effort. So I'll close. I know you've got a tight schedule this morning, but I'll close by just thanking you all for being here. I think the fact that this room is as full as it is is an incredible statement of commitment on your all parts to getting engaged and working through these issues with us.

Our door is open, not just to veterans who need our help. That's what we're here for, but also to you, and trying to engage with the broader community in support of this mission is, I think, a very important part of what we do. I've actually stood up an Office--recently--of Community Engagement just so that everybody out there knows there is a door to knock on, and we can make those right connections.

So, again, appreciate you being here. Appreciate your commitment to supporting the

veterans. It's a big problem we're dealing with, but I think together we are truly making progress, and we'll continue to do so. So thank you and thanks for having me here.

[Applause.]

LTGEN FARRELL: Dr. Jesse, thank you very much for that. That was great. Congratulations on the progress you're making. The PTSD Coach and the 20-minute wait, that's all good news, and we thank you for your continued leadership and advocacy for our warriors and veterans. This is really important, but it looks like you guys are making great progress. Thank you very much for that.

Norb, I guess we have a video coming up, and then we'll have a panel, I believe.

[Video presentation.]

VADM RYAN: Okay. We're back for our first fireside chat. We're running a little bit behind. I'm just going to introduce somebody that doesn't need an introduction to those in the local area. Scott Thuman is the anchor of Good Morning Washington and ABC 7 News at Noon.

So you understand he's on a tight schedule. He's asked me not to talk about him--he is an Emmy Award winning reporter--because he cares so much, and he's out here in between his morning gig and his afternoon gig.

Scott, I'll turn it over to you.

MR. THUMAN: Thank you very much. Thanks so much for having me.

Just so you know, I'm not just a TV guy. I want you to understand I come with a little credentials when it comes to understanding what it is that we're here for today. Before I anchored and before I covered politics, I did a lot of military reporting so I spent some time in Iraq. I went over on my own in 2003, just a bullet-proof vest, a helmet and a camera, to do some reporting.

But before that I had done a lot of reporting on the ramping up for the war effort, Fort Stewart, Parris Island, had been out to sea on the USS Kennedy, and then subsequently spent some time at Gitmo, perhaps most importantly at Landstuhl Regional Medical Center where I saw the

other side of what we see on the battlefield.

So I understand why we're here, and I want you to know that you're in good hands. We've got a great panel of people here for you today that are going to share some really insightful information. I think that for those of you who probably think you know a little bit about everything when it comes to the subjects we're going to discuss, even you will learn something today.

And I like the fact that we're going to call this our fireside chat. We're all best friends already. It's a good-looking group we've got for you so we know it's a serious matter, but we'll try and keep it a little bit friendly and fun for you.

So I'm going to introduce everyone on the panel here for you, and then I'm going to let them tell you a little bit about themselves, and then we're going to get right into that discussion. And, of course, we need to keep in mind that the banner says it all. I mean the reason we're here: "Mental Health: Linking Warriors and Their

Families, Government and Society." It's an important mission that can't be overstated because it is a number that continues to grow. We're going to see the need for this sort of treatment and that sort of relationship only intensify over the years.

So I'm glad that you're all here and making the effort to be part of the conversation. So let's begin with my good friend on the far end of the stage here. We've been talking sports all morning, and despite the fact he's a West Coaster, we're going to let it slide today. This is Major Kevin Polosky. He is currently Executive Officer for the Vice Director for Logistics, the Joint Chiefs of Staff, over at the Pentagon.

He's been deployed to Kosovo, Iraq, Kuwait and Afghanistan for a combined total of over 41 months, and he does a lot because not only is he active with his Army career, but he's also the caregiver for his wife Christina, and she suffered several life-threatening ailments, had to be MEDEVACed home from Afghanistan. So he does a little bit of everything, and he's going to share

his story with you in just a moment.

Just to his right, Bonnie Carroll. Bonnie is President and Founder of the Tragedy Assistance Program for Survivors, TAPS, as many of you know it. But she's also got her credentials. She has served in Baghdad. She's worked at the White House as a Liaison for the VA. She founded TAPS following the death of her husband, Brigadier General Tom Carroll, and she is a major in the Air Force Reserve.

Debbie Sprague is joining us as well. She is the bestselling author of A Stranger in My Bed: Eight Steps to Taking Your Life Back from the Contagious Effects of Your Veteran's Post-Traumatic Stress Disorder.

She's an advocate for veterans and their families. She's a Board Certified Life Coach as well, and in 2004, Debbie's husband, a Vietnam veteran, was diagnosed with complications from the exposure to Agent Orange and Post-Traumatic Stress Disorder. She also was diagnosed with PTSD.

And to my immediate left, Lieutenant

General Bernard--"Mick" as many people know him--Trainor, USMC (Ret), a veteran of combat in Korea and Vietnam, former military correspondent, New York Times, and co-author of several books on the military, including Endgame.

So a round of applause for our lovely panel today.

[Applause.]

MR. THUMAN: We're going to make them smile a little bit here. I promise we're going to be easy on you. If you just want to say a little bit about what it is you hope that you can share with the audience today.

MAJ POLOSKY: Certainly. Again, my name is Major Kevin Polosky and, like he said, I am a active duty Army major currently stationed at the Pentagon. I was in Iraq from '04 to '05 running convoys down what was then known as "Route Irish" but Airport Road. I was in Afghanistan for 18 months from 2008 to 2009 with the 101st Airborne Division Air Assault.

And I'm not here about me. I'm here about

my wife. I'm very proud to be the husband of an amazing woman who was injured in Afghanistan in 2009. She suffered from what many people would call "the invisible wounds of war." She has suffered from severe immune deficiency disorder so she was a woman that in 2008 was running half-marathons and in 2009 came back and struggles to get out of bed on many different days. She struggles with depression; she struggles with a lot of things.

I have four children at home, five children all together. And so we have learned how to cope, and I think that's the thing that we have kind of realized in our journey is--and it is a journey--it will continue to be a journey--is it's never going to get great, but it's going to get good. And so we have to be happy with good, and so that's kind of what I hope to share with you guys today, is kind of our journey, where we started, where we're at now, where we hope to go.

So thanks for having me.

MR. THUMAN: Bonnie.

MS. CARROLL: Great. Thank you all so much.

My mother served in the Army Air Corps, and she really inspired me. I joined the Air National Guard while working in the White House, and it was during that time that I was engaged in a humanitarian effort to rescue three Great Whales up in Alaska, and through that effort met my husband.

My mother had died when I was a teenager, and that took my life on a pretty tough path for quite awhile. My husband's military career also began in a similar manner. His father was the first Adjutant General of Alaska and was killed in an aviation accident in the Guard back in '64.

When Tom graduated from high school, he went into the Army. So we really drew on that experience of turning that life around and making a difference.

So when my husband was killed in an Army National Guard crash--something we thought we could never happen to both father and son--I said, well, how are we going to make a difference? How are we

going to pull ourselves up and take these eight families and turn tragedy into hope and healing?

We created the Tragedy Assistance Program for Survivors, and today TAPS is the frontline support resource for all those who get that knock on the door and receive that folded flag. That was back in 1994.

I also continued my military career and had the opportunity to transition to the Air Force Reserve and serve for two years as Chief of Casualty Operations down at Headquarters Air Force Casualty and saw things from another side and got to put personal experience into practice and uniform.

After that assignment, I transitioned in August of 2001 to the Pentagon's Office of National Security and Emergency Preparedness, which was at the time a sleepy little office. Two weeks later, America was attacked, and I was mobilized to active duty.

At that point, I was asked where we could do the most good, and I was assigned to the

Pentagon Family Assistance Center where we cared for over 500 newly bereaved family members just getting the word their loved ones had not survived.

I know a lot of those families are still very active in TAPS today. Lisa Dolan is raising therapy dogs and helping the children. Laurie Laychak is doing therapy work with grief groups. It has become part of our family, and this week as we remember 9/11, I just want to pause to say, you know, the wounded have become the healers. You all are here today because you have lived this life, because you care, and because you continue to make a difference, and I want to acknowledge that and thank each one of you for the support that you give.

MR. THUMAN: Thank you.

Debbie.

MS. SPRAGUE: Thank you.

My background isn't in the military, but I do have something in common, I believe, with everyone in this room, and that is we're all here because we have a love and a concern for our

warriors.

My story with my warrior started in 2000. We were standing in the rain, and when our eyes met for the first time, we fell in love. Eight months later we were married, and we had great dreams for our life together. But just a few years later, in 2003, things began to change, and those dreams ended. My husband started having nightmares. He would be screaming out in Vietnamese in the middle of the night. I would wake up with a fist in my face with him kicking.

He began to be very, very angry, angry outbursts for no apparent reason, and that left my daughter, who was 13 at the time, really walking on eggshells all the time. He began roaming the house at night. He was hypervigilant, his gun at his side all the time, and it made me more afraid of my husband than it did of the possibility of an intruder coming in.

He lost all interest in social activities. He didn't want to go out in crowds or where there was a noise. So that left me going pretty much all

alone or not at all. He lost all interest in our relationship, which left me very sad, depressed, and I was grieving the loss of my husband even though he was sitting right there next to me.

I became very resentful that my life had changed so much, that my dreams had disappeared, and with that resentment came anger, a level of anger that I'd never felt in my life before, but I also felt guilty because I somehow thought this all had been my fault, that if I could just be better, if I could try harder, that he would get better. But unfortunately he didn't get better. My husband had changed and so had I.

He wasn't able to be here today, and he was very sorry that he had a physical injury and wasn't able to make it, but he did want me to share a few words from him. What he wanted you to know is that he was out of control. He had no idea what was happening to him, and he basically turned into a monster, and he hurt everyone around him.

He, as his pain, mental and physical pain, increased, he started abusing alcohol, he started

using, abusing morphine and oxycodone. He was on a road that wasn't going to end well. And he had no idea how to change that direction, but one day he was in a parking lot, and he noticed another Vietnam vet by his ball cap, and he yelled out to him, said "welcome home, brother." And the vet returned "welcome home to you."

And they started chatting, and my husband shared things with him that he could only share with another vet. And that vet said are you getting help from the VA? My husband said no, I don't need help. The vet said I think you do. The next morning he showed up at our front door, virtually took my husband by the hand and took him down to the Veteran Service Office. He was diagnosed with 80 percent PTSD with a variety of health issues from Agent Orange exposure, and he was also rated unemployable.

So he immediately began therapy. He wanted to get well, and, like we heard a few minutes ago, you have to want to get to well, and you have to put the work in, and he did that. But

what no one told us was that when he started therapy, that 30 years of memories were going to start erupting like an angry volcano. So things got worse than ever, and that left me out alone. I had no support. No one around me understood PTSD. No one around me had any idea what was going on inside my home.

So I finally reached out to professional help, and I was diagnosed with PTSD as well, and two different therapists told me just walk away, just divorce him. They told me to walk away from my warrior. But I didn't want to do that. That wasn't what I was looking for. I wanted to know how to help him. I wanted to know how to live in this new world that I had suddenly found myself in.

I was fortunate that because of my faith, I was able to have the strength to stay with my husband and stay in my marriage, and I found support in an organization Family Of a Vet with other spouses that were of great support to me, and I also took on the challenge of learning myself how to deal with the contagious effects of PTSD.

MR. THUMAN: We'll talk more about that. Yeah. And, lastly, but because you're my media brethren, I have to say not least, Mick, if you don't mind.

LtGEN TRAINOR: Yeah. A couple of weeks ago, I came across a book review of a book called The Last of the Doughboys, which described some of the people that had fought in World War I and were now practically all gone from the scene, and this part of it really caught my attention.

It was describing a man, 106 years of age, J. Laurence Moffitt of the Yankee Division. "He does not strain to interpret the memory or assess its impact on him, but simply said his face was all blown off. I leaned down over here to tell him his gas mask was gone. Then I saw that his face was mutilated, and so I left him in the care of the fellows whose job it was to take care of the wounded."

I have to tell you I could, I could identify with that fellow. Let me give you a couple of data points. I served in Korea as a

platoon leader, a platoon of 40 Marines. You don't get in a dirtier war than down at the platoon level with a bunch of Marines.

In my second tour--my first tour in Vietnam, I was with a covert operations group called SOG, and my second tour, I was an infantry battalion commander. But in the second tour, you know, I was a little older, a little more mature, a little hardened, than when I was a young platoon leader.

But let me give you a second data point. I grew up in a working class neighborhood in the Bronx in New York during the Depression, and during the war, World War II, the neighborhood emptied out. All the kids that I used to play with that were a year or so older than me, including my brother, went off to war, and when they were coming back, that's when I was going in the Marine Corps at age 17, sorely disappointed that I didn't get into the action that my neighborhood mates had experienced and seemed perfectly normal when they came back.

I point out my experience and then my background to set the stage for my quote here because I think there may be a generational thing involved. I saw raw combat for a year in Korea as a platoon leader, and I came out of there, and it didn't bother me. Why? Because I'd been brought up in that generation that had experienced hardship and just took it as a matter of course: this is the way it is. You didn't question it. And I think that allowed us to accept some of the horrors that we experienced and, like this fellow says, get up and continue on with the job.

I think in large measure, it was always there and is there, and that that generation, my generation, which I think is different than your generation today--I'm 85--we were able and required to suppress evil things, evil thoughts, evil unhappy actions. I think we suppressed it, and somewhere down inside of me, it's all probably still there, but the cork is pretty tight, and I don't think at this stage of my life, that that cork is going to come out.

Now, that's not to say that I am, I'm in any way degrading the threat that comes to the human being who goes through the horror of warfare, but I'm just saying that I think in my generation, we were able to suppress it better than they can today, and whether that was good or bad, I have no idea.

MR. THUMAN: Great insight. So here's the thing. I think that's what great is everyone on this stage is in agreement and consensus on one thing, and that is that there is always hope. There is always the opportunity for us to improve the situation that we've been dealt, good, bad and ugly; right?

So let's just kind of--I won't necessarily go down the line. I want you all to jump in here if you've got the answers, but I do want to start with you, Kevin, with a quick question because we talked about the challenges that people face. Everyone on the panel has talked about that already just in their own introductions.

You face a daily challenge where it's not

only doing these long days. Kevin, he's up--
thankfully, he's--I'm going to make him watch Good
Morning Washington. Don't worry. But he's up that
early. He gets up. He's hitting the road around
four o'clock to get into work everyday, and you
don't get home till six, yet you're the primary
caregiver for your wife. These are challenges that
a lot of people face.

They don't necessarily know how to get
help. They don't maybe have the courage to ask for
help because of pride. So just is that something
that, you know, you look at now in retrospect, and
you say how could people not want help; how could
they not ask for it? The resources are there to
some degree; right?

MAJ POLOSKY: Absolutely. I definitely
know how people don't want help because I didn't
want help, and I don't even know how I, I kind of
backdoored into it. We went to the VA. Some lady
said, hey, I'm a VA caregiver. You're a caregiver,
and I didn't even know what that was. I never
associated myself as a caregiver. And just through

this process--it was like a two-year long process for us--I now associate myself as a caregiver, and I have met just amazing caregivers through this process.

But help is--yeah, number one, you don't want to--like, for me, for example, it's very hard for me because I have to convince my wife to let me tell her story. So it's easy for me. I can get up and spout my story all day because it's my story, but as a veteran who suffers from depression, I'm not sure I would want someone, you know, going out there and just blasting to the world, hey, these are all my problems.

MR. THUMAN: But is it because you know that it's valuable information for people that you kind of get over that hurdle?

MAJ POLOSKY: Absolutely.

MR. THUMAN: And then she's okay with it as well then?

MAJ POLOSKY: Absolutely. Yeah, because someone has to do it. I mean it's just such a difficult process, and, you know, for us, I really

focus on the depression piece of it. PTSD/TBI, when people think of wounded warriors, they think of the commercial of the person coming back missing a limb, and you can see that person. That person is the image of the wounded warrior.

You can meet my wife, and you would have no idea that she served in the military. You can meet her on a day when she is feeling good, and you would think what's wrong with that person? There is nothing wrong with that person. She's fine. So my whole goal in life--I think I was brought into this thing because I'm the white whale of the caregiver community because I'm male and I'm active duty and I'm a spouse so I hit like every hard-to-find category that they can get.

[Laughter.]

MAJ POLOSKY: But really what I've learned through this is I want to tell people that depression is real. I mean depression is real, and it's not PTSD, and it's not TBI, and it's hard, and it's hard for kids. It's hard for a 12-year-old to watch his mom do that. It's not fair, and people

need to realize that. And I get to watch it everyday, and I have amazing kids, and I have an amazing family, and I have an amazing wife.

But it wasn't always that easy. I mean it wasn't, and so you just have to learn. And so any time that we can share kind of rules that we do or things, you know, that have helped us through our journey, that's what we try to do.

MR. THUMAN: Is it--Mick, you know, you talked about a generational attitude sometimes in that it's kind of ingratiated in your childhood sometimes, especially if you came from the Depression era, whatever it may be. It's hard to understand that sometimes there is something built up inside; right?

Are you--when you look back, and you've done both sides of this, you've done the media side of it, and you've been on the battlefield as a combatant, do you sometimes think that we need to understand that this problem has always existed, but maybe now we're paying enough attention to it, and it's still not enough; we need to pay even more

attention to the issues people are going to face as they continue to come home?

LtGEN TRAINOR: I really don't know because I didn't really think about it coming back from Korea nor from Vietnam. I really didn't think. In Vietnam, we were getting indications. But coming back from Korea, it was like coming back from World War. There was very little talk about, well, there was shell shock and battle fatigue and all that, but it was kind of a minor key.

Now, I will say this, you know, you can't come out of a combat situation without having some reaction. Now my reaction when I came out, when I came back from Korea, I was afraid, very nervous about walking into an open area for two reasons. Number one, I wasn't covered; they could see me. Number two, it's probably mined.

So, but that lasted about, about two weeks, and then it faded away, and I knew that Korea was out of my system when I was driving from New York down to Camp Lejeune to check into my new duty station. And just around the Delaware

Memorial Bridge, I came across a terrible accident where there was a family involved, and you could hear the screaming when they were trying to extricate people from the wreckage. I tell you that shook me up like that, and I said to myself Korea is behind me because I saw worse than that on a daily basis in Korea, and it never affected me.

So I was in a situation now where the armor of "this is the way it is" was off. I was now back in civilization with civilized norms, and what I saw, the horror there, affected me, which ten days earlier wouldn't have bothered me one little bit.

MR. THUMAN: Debbie, you had a book-signing recently, and when you did, people would relate. Tell the story about a gentleman who came up to you recently. This is fascinating.

MS. SPRAGUE: Okay. A man walked up to me, and he said I'm in your book. You wrote about me. And I looked at him because he wasn't familiar. I didn't know him.

[Laughter.]

MS. SPRAGUE: I said okay, and he said I bought your book for my wife, and his wife was standing there, and she said but he hasn't let me read it yet. He said everything you wrote about your husband, I did all those same things. You wrote it about me, and I now know that my wife of 49 years is a saint.

MR. THUMAN: I think it sums out that we all would agree at this point that it's a universal problem. It's a decades long problem; right? So we established that.

So now we need to talk about how we deal with those problems and some of the other insights that the panel can bring to us, and, Bonnie, if you don't mind, because not to get too extreme on the other end, but when people need help, in the most extreme circumstance, not that someone is still with us but is suffering, but when someone is gone, when we've lost someone, that can be the biggest challenge, and a lot of people don't want to reach out for that help either; do they?

MS. CARROLL: No, and, you know, I love

what Kevin said about that connection with other caregivers. With us, it's with other survivors. It's vet to vet. It's other wives.

Way back in the beginning of TAPS, in 1996, General Shalikashvili, the Chairman of the Joint Chiefs, spoke at one of our survivor gatherings. He was so taken by the way our families were connecting with each other, normalizing, validating experiences, providing comfort and support, that he said to all of us, you know, I now understand why there has to be this community of care, said because we can't do for you what you must do for each other.

And he empowered us to gather and to have that access to the newly bereaved, and it's grown tremendously, but it is that peer-based support that is so critical in every one of our areas.

MR. THUMAN: Okay. So let's talk about where there may be some gaps and where we can fill those or how we are proactively avoiding other gaps in the future because this is a big audience here of people who all probably know someone in their

lives who was affected directly by the subject matter. So jump in whoever wants. Where is that gap and how do we fix it?

MAJ POLOSKY: I think for me there's a gap in caregiver identification. We don't know who caregivers are. I mean if I ask you what is a military caregiver, you probably think it's a 24-year-old spouse, female spouse of a male soldier, and that's probably right, but it's also probably wrong. And so, and I hate problem identification without problem solution, but that's what I'm doing.

[Laughter.]

MAJ POLOSKY: So I'm identifying. The problem is we don't know. I mean we have RAND here who is doing a great study right now, and that's the biggest question, is how do you gather data on an unknown population source? So that's why I think we have to reach out and we have to work through the active duty services, through the VA, and get a-hold of these caregivers, and a lot of times, people don't what to tell people they're a

caregiver. It's not fun. You don't want to go out and be like, hey, my spouse or my son or my brother is hurting; I'm taking care of them now.

MR. THUMAN: You're not putting it on your business card.

MAJ POLOSKY: No, absolutely not. So, to me, we have to identify--for the caregiver community, we have to find them, we have to put our arms around them, not just love them, but tell them, hey, there's help, come on, you know, and we're here to do it for you.

MR. THUMAN: Kind of like when a veteran appeared to Debbie's husband in a parking lot and said "welcome home, brother." Where else are we making a difference, though? Where could people who are in this audience who know someone or maybe themselves are dealing with some of the issues we've discussed here so far that they can make strides?

MS. CARROLL: One of the big advances has been with the help lines. Vets for Warriors. It is peer-based. Support our National Military

Survivor Helpline. Steve Robinson is here. He's been a tremendous advocate and has identified the efficacy of that peer-based connection, whether it's better survivors, caregivers, veterans, to really save lives, to prevent suicides, to give comfort. So I think the use of peers has been an extraordinary step forward.

MR. THUMAN: Are people familiar in the audience? Are you familiar with the hotlines that exist? Nodding of heads or shaking of noes. Yeah, we've got some hands up.

So they do exist. They're out there. But perhaps it's not the first thing you look up because you never expect something like this to happen to you, and then if it does, you may not have the clarity of mind to go, okay, where are the resources that have been made available to me; right?

MS. CARROLL: And if I call, will I get someone who says "I was there"?

MR. THUMAN: But those people exist.

MS. CARROLL: Yes.

MR. THUMAN: Where else do you think we're making achievements? Where else have there been breakthroughs? Any ideas from anyone here that you think we've--what we've seen maybe 15 or 20 years ago versus what we have now? When you have seen the transition over decades, is there something that impresses you that you think perhaps people don't take advantage of and they should?

LtGEN TRAINOR: Oh, yeah, there's no question about it. I mean we are miles and years ahead of my day where the thing was if somebody showed some sort of a strange problem, you suck it up, you know. You submerge it.

MR. THUMAN: Walk it off; right?

LtGEN TRAINOR: Which is what we did. That's right. Or the guy turned to the booze. Drugs came a little bit afterwards. So I just think the recognition that this is a real problem and should be brought out in the open, and the best way to me with dealing with it is human contact, human contact of one sort or another.

But the first thing is we've come so far

in establishing the fact that this is a reality that then we can treat it because God knows how many people like this poor 106 guy went through those, most of those, 106 years of his life with a terrible torment that nobody ever knew about.

MR. THUMAN: Is there a stigma out there still, do you think, though?

LtGEN TRAINOR: I think there is.

MR. THUMAN: Yeah.

LtGEN TRAINOR: Certainly within the Marine Corps, there is. And I call out the Marines Corps. I think it's kind of the macho societies.

MR. THUMAN: Sure.

LtGEN TRAINOR: The macho organizations of all the services. I think there is still a stigma that, well, you should be able to suck it up.

MR. THUMAN: And this--not that we've asked for a lot of audience participation, but I heard a lot of yeses in there. So this is something that clearly, just because there are the commercials on TV and because we've been, I guess, a more unified public--for members who aren't part

of the military, for just the average citizen, I know that we feel like we've become more united in this post-9/11 world, that we're more supportive of our military in a lot of ways than obviously we saw after Vietnam or other eras, but clearly there is still a stigma; right?

So how do we get past that? How do we make it okay not only for people who are dealing with issues to face them head on and understand it's okay and be that it's not a weakness, that it's not supposed to be seen as a negative, because is that the stigma we're talking about, that people don't want to ask for help or we're tough and we're strong and we're these, you know, in a really poor summary, we're these fighting machines, and then when something bad happens to us and we break down, we're afraid to ask for help? I'm getting nods there.

How do we overcome that?

MS. CARROLL: Yeah. I had the chance to co-chair the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces, and we went

down to Parris Island, and the Marine Corps has done an extraordinary job of transforming the culture beginning with the recruit training.

Within week two, they had a class on suicide prevention where they started out by saying, you know, there will be times in your military career that you will be in combat, you will be surrounded by the enemy, you will know that you're about to die, what do you when you're surrounded?

And hands, you know, went up, and they said we call in air support, we call in artillery, we call in, you know, we bring it on, you know, call for help. And they immediately then connected that. They said there will be times, there will be times in your life when you are so surrounded by an enemy that you will think there is no way out but to die, and they said what do Marines do? And some hands made the connection, and went up, a little timidly, and they said we call in help, we call for help, and they said good to go.

And they said what does that help look

like? It's your mom, it's your dad, it's your brother, it's the chaplain, it's your first sergeant, it's your battle buddy, it's your friend, you know, hug your dog, it's, you know, get help, reach out, and they normalized and validated help-seeking behavior in week two over crew training.

We did focus groups after that, and we said, you know, would your career be adversely affected if you sought help? And they said no, that's what Marines do. They call in help.

MR. THUMAN: Is that what you see over at the Pentagon, Kevin? Because I mean it's an insular group in many ways. I mean with any industry, it's not enough pointing out just the military, but we all, you know, we're in this bubble where we think we see the forest through the trees, and a lot of times we don't. Do you feel like that people understand in the ranks and in those who are making the decisions that there still needs to be a greater effort to include, to be inclusive of people who need help?

MAJ POLOSKY: Absolutely. So the answer

to that question is yes. I think Chairman Dempsey, and, I think, for us General Odierno, I think you see their faces out there telling people it's okay. It's okay. Go get help. Go get help. So the message is being presented.

How that message is being received, there is still a huge stigma. I mean I will tell you that--like personally would I go seek counseling? I don't know. I mean, and that's just--

MR. THUMAN: You don't know what?

MAJ POLOSKY: I understand what leadership says. I don't know. Do I have a fear that it could be--I mean you take a--you look at the--look at the military today--right--what are we doing? We're cutting back the military; right?

MR. THUMAN: Uh-huh.

MAJ POLOSKY: So we're going to become--if I want to be a life-long, if I want to be a general officer some day, I have to be as competitive as possible. So I used to be competitive in a larger zone. Now I'm competitive in a smaller zone. So are there discriminators? I would hope not. And I

believe, you know, my officers, but it's still, there is still a stigma there. I mean it absolutely is still a stigma there. And spoken from me as a major, you take that down to an E-5 to an E-6 to an E-4 level, oh, there's a giant stigma there. Absolutely.

And I don't know what the answer is. I mean we're doing all the right things, and I will tell you, coming back from, you know, I've spent a lot of time in combat, and I think I'm lucky because I have a spouse who I can share it with, but I can remember being at a friend's house, and we were outside smoking a cigar, and I just looked at him, I said, dude, I'm having some problems, you know, and he said, yeah, I'm having some problems, too, and that was the best help I've ever gotten.

[Laughter.]

MAJ POLOSKY: And I got to talking to that guy, you know, and we looked around like, oh, we're not going to tell anybody we had this conversation, right, you know?

[Laughter.]

MAJ POLOSKY: But I mean it's still at that level, you know, so--and the problem is you have, you have people that kind of went high and write and like to post it on Facebook and their Twitter account, and, you know, on all this stuff that they're dealing with, and, you know, I'm just not comfortable kind of putting myself out there like that. And I think a lot of the people in the military probably aren't.

So to me it's finding that peer, that someone you can relate to, especially if it's close to someone that you're friends with or someone that you're in the same type of peer group with, and just being able to bring it up in conversation.

MR. THUMAN: Yeah, well, and, you know, in real life, outside of anything military, of course, that's helpful. I mean, you know, I'm not going to air my horrible unsavory laundry, but there was a terrible time. My brother and I were both going through something just coincidentally at the exact same time. We hadn't seen each other in awhile, we lived in different states, and we got together. He

flew up here, and we were sitting there at a restaurant and bar having dinner, and he goes, well, this is fun, isn't it?

I said, oh, yeah. This is fun, and that's all it took was to open the conversation because sometimes we just don't want to get on the phone and go, hey, so I'm really hating life right now, and sometimes you just have to both understand that you're not alone, and for those who maybe don't want to go to an organized form of help out there, you know, Debbie, you talked about when your husband was so hypervigilant and wasn't perhaps by any means ready to seek a formal session of help, how do you get someone who doesn't want to accept that there are people out there and groups that are built for this exact purpose?

They don't want to buy into that so how do you handle that? How do you deal with that?

MS. SPRAGUE: You know that's a great question, and it's a hard question. I know that since my husband was diagnosed, he's tried to play it forward with other veterans, but so many of

them, they just don't, they don't want to accept the fact that they are having, having trouble. I've been working with a lot of spouses, and educating spouses. It's so great that today the young spouses are getting educated on PTSD and TBI.

One of the support groups I run, a young gal was talking about her problems, and, you know, she was very knowledgeable about PTSD. A Vietnam spouse was sitting there and tears started just flowing, and she said if I had only known, if I had only known what she knows today, I could have saved my marriage. I'm so sorry that I had to walk away from her husband and her child.

I think having spouses and families understand and be educated, it's going to be a real support to our veterans. When my husband was diagnosed and I looked around, and I would get blank stares when I talked about the fact that he had PTSD or things like there is no such thing, he's just in it for the money, oh, it's a good excuse for bad behavior, and that's why I was totally at a loss because no one I went to could

help me, nobody understood what I was going through.

I lost my son to my cancer when he was ten, and immediately, cancer, I was surrounded by support--friends, family, and total strangers--but when I said the word "PTSD," nobody wanted anything to do with it.

MR. THUMAN: Mick, do you think there are a lot of cynics out there?

LtGEN TRAINOR: Yeah. But let me go back to a point. The human dimension is so important. There are meds that people can take and all that, and sometimes they're overdone, but the human dimension is a constant in dealing with troubles. A guy gets wounded, he goes back to the rear, or he's kind of exhausted, he's pulled out of the line, he wants to go back with the people that he was with. So then people come home who have troubles, but they're isolated.

They're with their family, but the family, you know, they're different, different. Where are my buddies? And their buddies are all over the

country. The business of the human dimension, the buddy system of talking to one another, identifying, knowing the way you normally are, and now I find that you're not that way, then you talk about it.

One of the great things after World War I and World War II was the American Legion and the VFW, and people would join these things, and they were with their substitute buddies from the days-- they don't do that today. So there is that one source. You don't get kids from Iraq and Afghanistan or even from Desert One going in in great numbers like they did after World War I and World War II to these organizations where they can sit there and drink beer, tell lies, but there was a communion of spirits.

There's that human dimension that I think is missing where you have a generation of isolated people. They are not isolated from their families, but they're isolated from their peers, the peers that they have gone through this very dramatic, life-changing situation, and things that could

encourage them to gather together I think, reunions and things of this nature, I think are very, very helpful because the human dimension is the key to any sort of solution, whether the trauma is from an injury or from a mental problem.

MR. THUMAN: And this is a great point because I hadn't realized it until you brought it up, but when I used to work in Jacksonville, I worked for the NBC affiliate down there for years, and we were outside Cecil Field, and NAS Mayport, so we did a ton of military reporting. Whenever we needed to talk to the average veteran, you know, what a horrible way to sum it up, but that's what we would call it, and we would end up going to a VFW or an American Legion Post, and these days you don't.

These days we call an organization. We'd call the Wounded Warriors, and we'd call, you know, the Iraq Veterans. We would find a Web site for a group and call them. People weren't gathered in one spot anymore, and they don't do that. So is there a way for people to share their stories, not

online, but person-to-person, with a beer between them, and sometimes help understand and share solutions, and I saw you--you were nodding your head a lot when Mick was telling that story, Bonnie.

MS. CARROLL: Well, absolutely, and that's what TAPS is about. We now have 40,000, over that, surviving families, who gather around the country in care groups and support groups so we connect folks one-on-one, but it is that peer connection, and whether it is over the phone or over e-mail, it is a connection to just share something so personal, but then normalize and validate that experience. Absolutely.

MAJ POLOSKY: Yeah. I think what he says has valid, a lot of validity. The way we connect now is through Facebook, and being able to sit down and have a beer with someone is very different than posting happy birthday to you because I got a reminder on my timeline.

[Laughter.]

MAJ POLOSKY: I mean seriously. I have

all the people that I serve with in Iraq, I have a Facebook page that I connect with them daily. The last time I saw one of them was probably three years ago, and there's a huge difference in that, and so I think the goods of social media, there's also a lot of negatives, and that is we substitute social media and these fake posts and feelings for being able to sit down next to them and share a meal.

MR. THUMAN: Well, nothing would translate or equal that moment, you said, where you had a cigar with your buddy.

MAJ POLOSKY: Right.

MR. THUMAN: And you just both, without having to really say it, can say I'm struggling, man, and so what is it--the Internet does wonderful things, and it allows us to network in different ways, but how do we get people together again, really together again?

I mean we all, I think we all admit that the Internet has positives and negatives. That may be one of the negatives, and with VFW halls and

American Legion posts closing all around, is there an avenue? Is there an avenue to really get together to ever break through some of that hard exterior that we learn when we're at Parris Island, and we're told that we're these amazing machines? Or is there no answer?

MAJ POLOSKY: The avenue is human effort.

MS. CARROLL: Yeah. In our program, we do have now about 42 events all over the country. We post them way in advance. Thousands of surviving families will travel great distances to be physically together. We just were at Camp Pendleton last weekend, and we had 342 surviving family members who came to Camp Pendleton just to share that, you know--

LtGEN TRAINOR: And it goes well beyond the military. We no longer are a tribal culture. People on their smartphones, they're alone. They're living in their own little cocoon. They don't interface with people except electronically, and you lose an awful lot.

MR. THUMAN: Sure. And that's very true.

Here's what I'm going to do. We're running out of time, but I love the way this conversation is going. I'm going to put you all on the spot here. Give me your Social Security number.

[Laughter.]

MR. THUMAN: And if I could just get your MasterCard. What I want to do is I just want to challenge you to give one piece of advice. That's what I want. I want each of you to give one piece of advice to the crowd here today because I think we've probably all benefitted, I would hope, just from hearing those stories and understanding how we relate to them, and that there are avenues out there because we've identified that there are gaps, but that they're also breakthroughs.

In typical military-government-Pentagon format, you said, you know, you don't come with a problem without a solution; right? So I'll bring you down the line, and just if there is one piece of sage-like wisdom that you would pass on based on your life experiences to this crowd, what would it be? Should I pick on someone else because I

started with you the first time around? Do you want more time to think, Kevin?

MAJ POLOSKY: I know what it is.

MR. THUMAN: You're on it.

MAJ POLOSKY: Yes.

MR. THUMAN: Let's go.

MAJ POLOSKY: Look both ways before you cross the street.

[Laughter.]

MR. THUMAN: Never pet a barking dog.

MAJ POLOSKY: The best piece of advice I could give you is, as a caregiver, so I'll put my caregiver hat on. I was very angry at my wife for being hurt. That's not fair. So after, you know, a roller-coaster ride that has been our life, I had two choices. I could live my life bitter or I could fall in love with the person that I was with, and I re-fell in love with my wife.

So that is the best piece of advice I could give you. You're not going to change them into the person they were so love the person they are.

[Applause.]

MR. THUMAN: That's fantastic. And your wife is here today; isn't she?

MAJ POLOSKY: She's right there.

[Applause.]

MR. THUMAN: You thought this was going to be a stuffy panel.

[Laughter.]

MR. THUMAN: You didn't get a little dirt in your eye, there's something wrong with you. Who's up next?

MS. CARROLL: Well, to do what Kevin has said, and what I hope the TAPS is modeled, and that's to turn tragedy into hope, to be inspired by your life experience, to make a difference for others.

Dr. Alan Wolfelt wrote a model called "companioning," and it's what we can do for each other, and I love his definition. He said it's journeying to the wilderness of the soul with another human being, but it's not about thinking you're responsible for finding the way out. It's

being present.

MR. THUMAN: Yeah. Great.

Debbie.

MS. SPRAGUE: I'd like to offer a challenge.

MR. THUMAN: Okay.

MS. SPRAGUE: Okay. I would like to challenge each of you whether you're a warrior, a spouse, or just someone that cares about our warriors, to go out and find a peer and give them support and encouragement and help, and if we each and everyone of us do that to one person, and we kept playing it forward, I think we'll move a long ways towards getting all of our warriors the help that they need.

MR. THUMAN: Yeah, and that's great because, you know, we talked yesterday being so poignant for us. We talk about 9/11, and we always say, and it's ubiquitous, but for a good reason we always say "never forget," and we truly mean it, but, you know, it was after 9/11, we'd make sure we went up and we shook a hand or when members in the

military in their uniform would come through the airport, we'd clap, and we've let that ebb a little bit, and I think it's great that you say you want to challenge people to reach out on a peer level, whether it's just to support them or let them know that there are other avenues out there for support.

But, yeah, I think that we, I think that we kind of get away from it, and then we wait for an anniversary for 9/11 to come around for us to remember why it's important that we show support for others. So that's a great challenge, and I hope all of us take that up. I know I will. So thank you for that.

Mick.

LtGEN TRAINOR: Well, peer association, to me, is very important, but you have to be careful on that, too, that you don't get six or seven guys that are all feeling sorry for themselves, and that doesn't help at all. So there has to be a positive aspect to it, and I talked about the VFW and the American Legion after the two World Wars, but, granted, reflecting back on when I--just before I

went in the Marines when my neighbors were all coming back, and there was a thing called the 52/20 club that some of you may be aware of--52 weeks--servicemen who had been honorably discharged got 20 bucks for 52 weeks to tie them over till they got a job.

Well, the kids in my neighborhood would all gather, including my brother and myself, at Mannion's Bar and Grill on 164th Street and Ogden Avenue and drink dime beers, and they'd all tell sea stories, you know, war stories, and it was a positive experience for all of them, and then it kind of died out, you know, that you've heard that story before, but they got it out of their system, and they transitioned back into civilian life, and then went on to normal lives.

But the idea of the group of puppies all getting together and wagging their tails, this was so important for their mental health, and I think that is missing in the isolated society that we live in today.

MR. THUMAN: Yeah, we had a rule in

reporting when I used to be a reporter, and we'd get out in the car, you'd get your assignment, and undoubtedly you hated your assignment for every reason you could think of, but we made a rule that you get in the car and you complain to your photographer for five minutes, and after five minutes you got to shut up, and you got to go, okay, how are we going to make this story work? How are we going to be the lead tonight on the news? Because it wasn't valuable after awhile.

So you could, I guess to your point, you can cry in your beer for half a minute, and then it's time to say, hey, remember this and enjoy each other a little bit and take some positive out of it.

Fascinating stuff. I'm really grateful that you all are so open and willing to share your stories. I think that everyone in the audience is as well. I'm glad we had this little fireside chat, as we're calling it. So thank you, Kevin, Bonnie, Debbie, Mick. Thanks for sharing your stories. Thank you all for listening. I really

appreciate it, and I hope that we all come out of here a little bit stronger, a little bit wiser as a result. Have a great day.

[Applause.]

VADM RYAN: Thank you, Scott, Mick, Debbie, Bonnie. Thank you very much. Major, thank you very much. Scott, again.

How about another round of applause for these people?

[Applause.]

VADM RYAN: Well, leaders make a real difference, and you've seen some of the leaders that are making a real difference. We're going to take a short break. We'll be back at 20 after.

[Whereupon, a short break was taken.]

[Video presentation - Soldier Hard, Hip Hop Artist, Songwriter, Veteran, Special Video Message]

[Applause.]

LTGEN FARRELL: Well, we had a great panel just now, and we're about to have another one, thanks to everybody here. This next panel will

look at the impact of mental health on government and civilian communities to include the extent and the consequences of psychological-cognitive injuries on the military and veteran populations, and we heard about that earlier from Dr. Jesse when he talked about the cognitive issue.

We're going to be led today by Alex Quade. Alex was here last year. Thank you for being back. Alex is a freelance war reporter who covers U.S. Special Ops Forces on combat missions, a recipient of numerous prestigious awards for her war reporting, including the Congressional Medal of Honor Society's "Tex McCrary Award for Excellence in Journalism."

Please welcome Alex Quade and her panel.

[Applause.]

MS. QUADE: Thank you. Thank you so much. We're going to be doing a little bit of a roundtable today, but thank you, sir, and thank you all for being here. That's the first step. We have a great discussion ahead so we're going to get right into it, but as a reporter, I was very

encouraged that a couple of weeks ago, our newest Medal of Honor recipient, Staff Sergeant Ty Carter, has made Post-Traumatic Stress awareness his platform, which is one of the mental health issues that we will be talking about today, and as many of you know, Staff Sergeant Ty Carter and his platoon battled at Combat Outpost Keating in Afghanistan.

They faced overpowering odds and lost many men. Following the battle, his First Sergeant Jonathan Hill had said he knew that Carter wasn't fine because he wasn't fine either. Hoping to set an example, the first sergeant told Carter and all of his platoon that he himself had sought counseling and, more importantly, that it had helped.

First Sergeant Hill said, and here's the quote, "One great man told me that if you can't take care of yourself, you can't take care of your soldiers." So if you're a leader and you're not taking care of yourself, you may not be making the right decisions, and you may not be effective on the battlefield. Now that lesson applies to our

whole country, that dealing with mental health issues, that raising awareness, that we as a society, we give our servicemen and women, our veterans and their families the tools to succeed, not only on the battlefield, but also in their transition on the homefront in the years ahead.

As a reporter, I talk with countless veterans, and there's always a point where the talk turns to wounds and battle scars. That talk has been with pain, but it's also with pride, pride of overcoming adversity, of making mission and serving with your buddies.

These battle scars, as you all know, have served as literal physical reminders of the wars that we have fought not only for the veterans, but also for the rest of the country to see and be reminded by. However, the battle scars for mental health and brain injuries are unseen, and that's the critical, critical distinction.

There is almost an embarrassment to talking about it, or even how do we talk about it. It's a battle scar that's been around for a long

time. As we heard in the earlier panel, brain injuries are not new. However, there is a new consciousness and awareness, and that's why we want to have this discussion today.

As a reporter, I've also talked with countless military doctors, and a big risk and concern is that with the wars concluding and fiscal constraints, a big risk and concern is that support and funding for veterans' needs will erode. There is a significant lasting cost or effect of these wars from a mental health perspective, and many make the case that we need to continue these programs that were started for veterans and their families.

As a reporter, just to give you a few back-up facts here, as a reporter, I know that these are very important issues to discuss. We're only just now beginning to understand the scope of this problem that we are dealing with. In the last seven years, the number of VA patients being treated for mental illness spiked 45 percent, reaching about 1.8 million, and the Congressional

Research Service just put a price tag on the mental health costs of the recent wars at about $4.5 billion over the last five years.

This is not a problem that is going to end. It's life-long challenges that our vets and our country are going to continue to face. Over the course of today, we will talk about a number of things, PTS, TBI, depression, and a whole range of diagnosed and undiagnosed medical conditions that our veterans and their families are facing and will continue to face for the rest of their lives, which is why we've gathered people with a variety of backgrounds who are tackling these various important issues.

We don't have all the answers, but this is about bringing the experts together to have an important discussion. You have their bios in front of you, but I'm just going to say a little bit about each important panelist that we have.

Terri Tanielian, over here, is a Senior Research Analyst at the RAND Corporation. Her specialties include military and veteran health

policy, military sexual assault, the psychological effects of combat, resilience and suicide prevention.

Terri is an expert on systems level approaches to addressing mental health needs among veterans and their families.

Over here we have Captain, Navy Captain Richard Stoltz, who is the director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. The goal is to improve the lives of servicemembers, families, and veterans by advancing excellence in psychological health and TBI prevention and care, which also means getting rid of stigma.

Kathryn Power, over to the left, is the Regional Administrator of SAMHSA, the Substance Abuse and Mental Health Services Administration, which is a division of the Department of Health and Human Services.

Kathryn serves as the Initiative Lead on SAMHSA's Strategic Priority for Active Duty Vets and their Families, focusing on collaboration to

meet their mental health needs. She is also a retired Navy Reservist.

And right here, we have Ms. Debbie Paxton, who is a nurse and is the mental health advisor to the Marines Wounded Warrior Regiment, and Debbie will give the local smaller picture perspective of how they're addressing the mental health needs of Marines and their families, and, yes, General Jay Paxton, the Assistant Commandant of the Marine Corps just happened to be lucky enough to be married to Debbie. So she brings a very unique perspective to this discussion.

We have so many issues to talk about today, but to have this fruitful discussion in less than an hour, we're going to talk about the current scope of resources from active duty to the civilian side, and how and where improvements can be made, and how do we mitigate the consequences on our troops and their families?

And in the scope of the current government response, what are we doing well right now and what are the things that we can build upon, where we've

seen some successes? Plus what are the biggest challenges that we still face in trying to understand what a potential solution will look like?

Each panelist is going to give a three-minute little bullet points, and then we are just going to go for it. So hang on. Terri.

MS. TANIELIAN: Well, thank you, Alex, and thank you to MOAA and to NDIA for having this important symposium on this very critical topic and to all of you for coming.

What is the scope of the mental health issues that we're dealing with with returning servicemembers and veterans and their families? Studies have consistently shown that at any point in time anywhere between about 13 to 20 percent of returned servicemembers from Iraq and Afghanistan are currently suffering from Post-Traumatic Stress Disorder. About the same number are suffering from depression, which as we heard earlier is a different disorder that still requires treatment, in addition to some other mental health

consequences that haven't even been quantified yet.

We know at the individual level, they can impact on people severely. Many, many people will live with these disorders for years and live full and functioning, well-functioning lives, but for some, that experience, loss of functioning, and other kind of impacts, they can lead to other consequences which we care about both at the individual level and at the family level.

So as we heard in the first panel, there are impacts on spouses, there are impacts on children, and so as we think about this as a cascade of consequences, that they then ripple to society, that we then see increases in other areas of concern such as suicide, such as homelessness and other risky behaviors, mortality issues.

So there really are--there is a ripple effect if we don't intervene early. We need to ensure that we are treating effectively these post-deployment mental health problems, and the costs of undertreatment as well as untreatment or no treatment are significant. But we also know that

there is hope. We do have a lot of good treatments that have been demonstrated to be effective in bringing symptom reduction and facilitating recovery for these particular conditions.

So we need to ensure that all our returning servicemembers, veterans and their families have access to them. Getting access to them is not so easy. There are multiple systems of care that are designed to address these particular conditions for this population, and those systems have been changing rapidly over the past several years. The proliferation of programs, the investment of funding, have really, really advanced what we know, have expanded our provider base, and have been bringing new training to providers and just generating new programs in the community.

But that's not enough. We still need to do more to ensure that access means access to quality. We need to ensure that we have a pipeline to make sure that the capacity in this country will exist not just today and tomorrow but five years, ten years, 15 years, 25 years, and so we need to

really be thinking about how are we preparing the workforce for being able to identify and treat post-deployment mental health issues among veterans.

And there have been a number of private corporations and nonprofits that have been investing in doing this in the civilian sector to try and supplement and complement what our federal government has been doing. While they've been rapidly expanding their capacity, we've seen lots of programs come about in the civilian and private sector.

We need to kind of think about how can those be woven together to create an effective safety net so that there is no wrong door, so that any door that a veteran and their family seeks will lead them to a path to quality care, and that means partnerships--partnerships with the VA, partnerships with the Department of Defense--and really thinking about we can create those linkages and hold people accountable for ensuring that they're doing the right thing in delivering high

quality intervention.

So I can't speak highly enough as a researcher for the need for evaluation, that this wonderful intent is great, but we need to ensure that what we're doing is effective and efficacious, and to bring about those solutions, particularly in an era where there are constrained resources, and we're all concerned about ensuring that this capacity doesn't dwindle, but the capacity needs to also provide the quality.

MS. QUADE: Thank you so much, Terri.

And now we are going to go over to Captain Richard Stoltz.

CAPT STOLTZ: Well, good morning, everyone. It's a great pleasure to be here, and I really appreciate all that you do. I've been in the military for over 27 years. I'm a clinical psychologist. I spent about half of those years working fulltime doing clinical work, and then I've spent about the other half in various types of executive medicine roles, but even when I was involved with executive medicine, I always found a

way to still do some clinical work.

So I have worked with lots and lots of actually any DoD beneficiary that comes forward with a variety of problems, and I'm very aware of how real this phenomenon is. I'm very aware of how many people suffer from it, including every now and then seeing a Vietnam vet who lived with PTSD over 30 years and never sought treatment and finally when their wife threatens to leave them and they're totally falling apart unless they go into treatment or something like that, they come forward and finally get the help that they need.

And, you know, there's all kind of lessons to be learned from all those patients that are needy, and I would say one is to just how much it validates really the sad and painful reality of what's going on out there, and I think we need to acknowledge that because sometimes these people feel like they should just suck it up or they should just get over it or it's been so long, and for some that attitude simply is not helpful.

So simply validating the reality of the

suffering that so many go through, as well as to see the warning that's out there that we still have so many people from Vietnam that are still suffering.

Now, we just had 2.5 million people or so deploy in the last ten years, and we don't want, you know, 20, 30 years from now those individuals to still have the problems that they're experiencing today, and fortunately we know a lot more now than we did then, and certainly one thing we know beyond a shadow of a doubt is avoidance does not work, that if you have significant symptoms of depression, PTSD, high levels of anxiety that persist, just avoiding them does not work.

We also know that there are many, many treatments that do work, and there's many-- sometimes you don't even need to seek fully professional help. Sometimes just connecting with a group of veterans, the people that can identify what you're experiencing and going through, helps. Connecting family members to other family members.

There are so many ways that people can heal. But avoidance certainly does not work.

So I am extraordinarily hopeful about the future. I see so many efforts on the part of so many people to reach out to active duty servicemembers who have deployed, their families, and to veterans that are now no longer in the service, trying to help, and I see a number of them responding. We still have those that are isolated and aren't dealing with their issues, and we need to continue to work hard to make that happen.

But fully understanding that we're in a resource-constrained environment, I am delighted with how much I see that goes on on the part of so many in our society to reach out in a very genuine and helpful way to others, and I look forward to saying a few more as we go through the rest of our panel here.

Thank you.

MS. QUADE: Thank you so much, sir.

Ms. Kathryn over there.

MS. POWER: Good morning, everyone. Thank

you for inviting me. It's a pleasure to be here.

I'm going to start with a quote from retired Admiral Mike Mullen, who spoke to the graduating class of the U.S. Military Academy. Quote: "I fear they do not know us. I fear they do not comprehend the full weight of the burden we carried or the price we pay when we return from battle. This is important because a people uninformed or a people uninformed about what they are asking the military to endure is a people inevitably unable to fully grasp the scope of the responsibilities our Constitution levies upon them." Unquote.

I think this is a very deliberative phrase that we use to talk about what we think is the issue from a SAMHSA perspective. The Substance Abuse and Mental Health Services Administration is a very small agency inside the Department of Health and Human Services. We see a tremendous divide between the military sector and the civilian sector, and, in fact, no matter how much we encourage partnerships that Terri talked about, we

have a long way to go.

We have a long way to go in terms of understanding broadly why behavioral health is essential to health. Even Americans who are not involved in the military don't fully grasp the fact that behavioral health issues, that is mental health and substance abuse issues, are essential to overall health.

That is one of our driving messages, and we want to incorporate that message in every community in America.

The importance of behavioral health has to be reemphasized all the time, and its essentiality, because we're still fighting with Descartes, who separated the mind and the body in the 17th century and said the psychological and the physical will be separated, and we have struggled for centuries to try to overcome that. We have just now entered an era when we can actually begin to talk about whole health, to talk about wellness, to talk about primary care and behavioral health care.

Now, we have some leadership in VA and DoD

that have looked at that issue, but it is absolutely not where it should be in terms of the development of care.

You walk into any state in the United States, you have 50 different publicly funded mental health and substance abuse systems. That's because they were separated from the public health system in the centuries that we have been caring for people with these conditions.

Now, because of health care reform, we're beginning to take a look at the merging and the integration of primary care and behavioral health care. That is an essential element that needs to happen.

Now, what is a little agency like SAMHSA doing talking to DoD and VA? It's because in 2005, our agencies/our grantees who serve the publicly funded individuals who are uninsured in America with these conditions came to us and said we're starting to see family members who are concerned about their son, their grandson, their brother, their sister, coming back from deployment and

having difficulties.

And, oh, by the way, they either don't want to go to the VA or they are not eligible for VA or they don't want to have anything to do with these other systems, and they're coming into our community agencies. That's why this issue is important.

Now, if the brain is the seat of cognition, emotion, and memory, then it is the actual organ that we need to pay attention to, and we cannot bifurcate it from the physical presence of any other condition. We think that it's important for both the military and the civilian sector to take a public health approach because it's not just the military population; it's their families; it's the communities in which they live.

Everybody in America needs to understand the importance and the prevalence frankly of these conditions. Fifty percent prevalence rate for mental health conditions in America--50 percent. It is a very common condition. And do you think people for centuries have said this is a common

condition? No.

They fear it. They are discriminated against, they are isolated, and that is, in fact, what we do to people in the military and also the people in the civilian sector. We need to have more conversations about this, and we need to have a shared responsibility, and, in fact, we encourage local and state ownership of these populations.

I came from a policy academy in Baltimore where we have six states whose governors appointed teams to help understand what their state looks like in terms of active duty assets, Reserve assets, and remobilized assets and deployed assets, and what are they going to do when those people come home? And by the way, that means sharing information, and, oh, by the way, that means crossing over data, and that means really being a part of the community that is going to help these individuals.

I think that it's important for all of us to be together in this, to create better partnerships across the civilian and military

divide, to learn more about each other, to talk about how culture is different in the military and culture is different on the civilian side, that culture is very different in each specific service.

We have a lot of conversation to have, and I am very happy that SAMHSA is a partner as a part of the Department of Health and Human Services in all of these endeavors.

Thank you.

MS. QUADE: Thank you very much.

[Applause.]

MS. QUADE: Thank you, Kathryn, and one of those conversations and one of those unique perspectives on the service side is Debbie Paxton right next to me.

MRS. PAXTON: Thank you, Alex, and thank you to my fellow panelists for being here and to everyone in the room.

Ladies and gentlemen, we've heard convincing indications today by both military, VA and civilian experts that we'll be facing an increasing need for mental health services by many

of our servicemen and women and their families over the years.

After listening to these big pictures, I greatly appreciate the opportunity to represent the U.S. Marine Corps Wounded Warrior Regiment and our Commanding Officer, Colonel Willy Buhl--who said that--and the highly personalized approach we take to fulfil the mission of providing and facilitating assistance to wounded warriors, their families, throughout all the phases of recovery.

The Wounded Warrior Regiment was actually established in 2007. General Jim Conway was the Commandant then. It became apparent that Marines recovered better when they were brought together in a unit with a common purpose. Marines respond when given a mission that they can attack. So the Wounded Warrior Regiment is the only Marine Corps unit dedicated to caring for wounded, ill and injured servicemembers during their stabilization, rehabilitation and reintegration.

It's not a charitable organization. You're not going to see ads for us on TV unless

you're looking at recruiting ads during football games. For the past six years, our dedicated staff offers assistance to any Marine Corps command for recovering Marines within their unit.

We have a call center which follows 27,000 injured, ill or wounded, combat wounded, Marines throughout their lifespan. It's called the Sergeant Merlin German Call Center. It's a DoD best practice. Sergeant Merlin German succumbed to devastating burns, 98 percent of his body, and so this call center was dedicated to his memory.

This call center not only takes incoming calls but makes thousands of outreach calls to check on the non-medical needs of Marines. When a Marine can no longer or when a Marine's unit can no longer meet his needs, either the complexity or the severity of her injuries are just overwhelming, or that Marine Corps unit has operational commitments that don't allow them to focus on that Marine anymore, the Marine is assigned to one of our two Wounded Warrior battalions. Wounded Warrior Battalion East is at Camp Lejeune, North Carolina,

and Wounded Warrior Battalion West is at Camp Pendleton, California.

Each of these battalions is fully equipped with ADA-compliant barracks, Hope and Recovery Care Centers, and proximity to the community naval hospital.

We currently care for approximately 700 very seriously wounded, ill, or injured Marines who are joined to us. Many of these seriously wounded, ill and injured will remain with us for two years or longer while they stabilize from their often devastating injuries and enter the Disability Evaluation System, now called the IDES because it's been integrated with the VA.

Warrior care is--our form of warrior care is based on establishing a relationship with each Marine as he or she plans their rehabilitation goals. Recovery is supported by four members of the Marine's Recovery Care Team. He has a section leader. He's still a Marine. So there's a Marine Section Leader who is part of that team.

He has a Recovery Care Coordinator, a

civilian generally familiar with Marine Corps culture, either a retired Marine or a Marine spouse, child of a Marine.

Then we have the medical side. So coupled with the non-medical team is the medical side-- medical case manager, primary care provider. Those are the essential components of that Marine's recovery team.

And while he's awaiting the long results of this Disability Evaluation System, he or she and his family continue to refine their recovery goals by completing what we call a Comprehensive Recovery Plan with their Recovery Care Coordinator.

Most of our Marines are going to reintegrate back to their communities. A very small percent because our Commandant has said if you've been combat wounded and you want to return to duty, I'm going to find a job for you. But most will reintegrate back to their communities.

Hopefully I'll have a chance to tell you a little bit more about our Lines of Operation. We're the Marine Corps so we operate along five

Lines of Operation, and because of that, I think we do a pretty good job of coordinating medical, mind, body, spirit and family. This is the Marine Corps that's telling you they're looking at the whole Marine. So I think that we're getting there, and I look forward to talking a little bit more about our Lines of Operation.

Thank you.

[Applause.]

MS. QUADE: Thank you. Thank you, Debbie. Thank you, each of you.

And now we're going to fast and furious. I want to know what do you each see as the biggest challenge that is not being met right now? I'm going to start with Terri, and then Captain Stoltz, and then we're going to bounce around a little bit.

MS. TANIELIAN: Are you sure just one?

MS. QUADE: Just one. The biggest challenge that is not being addressed right now and that needs to be addressed.

MS. TANIELIAN: I think I want to pick up on a theme that I brought up, and Kathryn has

talked about, and the need for this integrated approach at all levels and these partnerships and really overcoming the barriers that have been put in place to kind of create this integrated approach to wrapping our arms around veterans and their families as they come home to our communities.

And these are community issues. They are state level issues. Not all of the problems can be solved here in Washington, and so we do need to think about how we overcome the barriers to these successful integrative partnerships.

MS. QUADE: Captain Stoltz.

CAPT STOLTZ: Boy, it's hard to pick just a few, but I'll focus on this one because if we do everything right and we get us working much better integrated, much more together, better train people to know how to deal with a variety of issues, and we have wonderful programs, but people don't come and take advantage of them, then we're still not reaching them.

So let me just focus a little bit on the stigma issue and the fact that so many people even

that would have easy access to care don't take advantage of that, and this is what I would say that maybe we need to do a better job of. You know, for years the military has done a remarkably good job at this, preparing people for war, and preparing them whether they're going to be on a ship and a fire breaks out, or whether they're in ground combat or whatever it is, training them so well to block out what goes on at times when there's a crisis or so much of what happened in the Middle East wars when IEDs blew up.

And we responded so beautifully. We had servicemembers block that out, do things that saved their own lives, did things that saved their buddies' lives. However, what we didn't tell them is this psychological training and blocking out and staying focused on the mission, while absolutely 100 percent the right thing to do in those situations, when you are back in safe situations, and you get hit with disturbing things like that, you need to find ways, people to be with, places to go, where you can talk about these things that are

going on with you, whether again it's depression or intrusive images or disruptive thoughts or poor sleep or whatever.

And if you don't do that, the problem is not going to get better, and I'm not sure that the wonderful training we tell people about how to psychologically behave in theater is countered with what you need to do when you are in safe places if you have these symptoms. And if we did a better job at that, I think maybe we'd have more people take advantage of many wonderful programs that we already have.

MS. QUADE: Thank you very much.

To kind of tag on to that one and having people be a bit more prepared, Debbie, what do you think can be done better to prepare families and spouses for the returning veteran or these kind of things that might pop up years and years and years later?

MRS. PAXTON: Well, education is key. I think family members are actually thirsting for knowledge about these conditions. Many of them

suffer from depression or ADD or substance abuse. Those are all mental health diagnoses that can occur in family members. So I think teaching people about PTSD, teaching them about depression. Depression is greatly overlooked in the military. It's almost worse to be diagnosed with depression if you're, you know, this hard-charging Marine than to be diagnosed with PTSD or a Traumatic Brain Injury that you can relate back to your combat.

Well, depression can be related back to your combat experience. So I think educating family members, teaching them about the basics of first aid. There is actually, you know, combat operational stress first aid courses that we offer to our family members. So that's how I would answer that question.

MS. QUADE: Thank you very much.

Kathryn, who do you see as the stakeholders right now? We've been talking about coordinating. I mean this is a very complicated challenge to solve, and one of the criticisms of the military right now is that the VA is separate

from the DoD, and there are conflicting needs from the medical side, the government side, the industry side.

Is there a way to coordinate these needs so that the troop isn't conflicted? I'm going to also then ask Terri the same.

MS. POWER: I sort of take that question also as a mix with a challenge because I think there is an institutional lethargy, I guess is the word I want to use, that we have to really overcome that institutional lethargy, and I mean that in the kindest way about bureaucracies. I think there are large institutions that have to learn how to open up their doors and windows, have to learn how to talk to each other, have to learn how to share, and I think some of that is going on.

I think there's a lot of interaction and work between DoD and VA in terms of their integrated mental health strategy. There's a lot of exchange going on between HHS, DoD, and VA about evidence-based practices, and what works in terms of the most relevant practices that are conducted

in the community and conducted in those institutions.

So I think there's--but I think it has to be transformatively thinking, and I think we have to get out of the comfort zone about where we are because these are such large institutions that we have to think in terms of breaking the barriers, and I think the timing is right for this because the rest of the country has to do that on the public health side under the Affordable Care Act so all of those tectonic plates are moving in the public health system.

Let some of those tectonic plates help shape what might be happening in the DoD military system, in the VA system, and within other systems, and I think that transformation itself then, which I see as part of the challenge, needs to be sustained, which to me is the key.

I'm very worried that this population will come to our attention now, and in two years, four years, five years, everyone will be gone. All of us will have moved into other places. All of the

teams we've created in states will be gone or they will have graduated or there will be a different governor, there will be a different Cabinet official. All of that issue around sustainability is a huge systems change challenge, and I think we need to do something about that.

MS. QUADE: Thank you.

Terri.

MS. TANIELIAN: I would echo those comments. I would also kind of highlight the opportunities that I think are afforded to us right now. Given the amount of interest and investment from the private sector and really trying to address these issues and work alongside state and federal government partners to address these issues, we need to kind of come up with these integrated approaches, but think about that sustainability.

And it's not just sustainability of the programs but of the workforce. While we're busy moving around mental health providers from one setting to another setting, we need to think about

the pipeline of those providers who are going to be coming in in the next generation and the future generation so we have a lot of capacity issues that need to be addressed, but it's an enormous opportunity.

We've made huge strides in the past several years in addressing the issues around barriers to care. There is room for improvement, a lot of room for improvement, but we've come a long way, and we need to capitalize on that growth and continue to tackle some of these hard problems, and I think the opportunity is really ripe right now given everything that's going on.

CAPT STOLTZ: And to just chime in with one concrete example, so I'm the director of a DoD executive agency that's in charge of advancing psychological health and Traumatic Brain Injury. My deputy is a VA employee. And I have several members of my staff that work for the VA, and everything that we do, we don't just think about how do we handle the active duty servicemember while they're on active duty. We're already

thinking about what happens when they leave service and having a smooth transition to the VA.

So I totally agree. There's a lot more improvement that can be made, but there are things happening today that are light-years ahead of where we were just a few years ago.

MS. QUADE: Debbie, do you have thoughts on that?

MRS. PAXTON: I was surprised, actually shocked, to read the medical surveillance report of July 2013, which indicated the number one reason that a military member, active duty military member, is hospitalized is for a mental health diagnosis. Number one reason. And it's the number two reason for an encounter with a provider in an outpatient setting.

So it's important for the military and the military treatment facilities to acknowledge that this need exists, and in a time of decreasing budgets and movement toward community, granted we need to work with our communities, but we also need to acknowledge that our military members need

treatment in a military treatment facility, too, because they understand their culture, they understand the command structure that surrounds that Marine or that soldier or that airman, and we need to continue that.

MS. POWER: And I think one of the things that I'm concerned about, Debbie, is that the reinvestment in the active duty military treatment facility issue is an important decision. I mean I had Navy corpsmen treat me all my life. I mean I went to the treatment facility on the active duty base, and that was it. That was my medical life.

We don't have that anymore, and so this whole notion of having shifted to a TRICARE-based system on the active duty side, which are practitioner-based credentialed individuals, and now with the demobilization process and the reinvestment strategy that might have to go on in terms of having active duty capacity for behavioral health I think is a very powerful issue.

MRS. PAXTON: And the VA is busy, too. I mean we heard from the VA.

MS. QUADE: We've talked about medical. We've talked about collaboration. In my role as a reporter, I did a little, a little phone call and talked with General Peter Chiarelli, our former Vice Chief of Staff of the Army, who led, of course, the DoD efforts on PTS, TBI and suicide prevention, and he's right now the CEO of a new organization, nonprofit, called One Mind, which is trying to take a lead role.

And this group that General Chiarelli is involved with and heading, it's trying to get people to adopt the sharing of intellectual property as in medical research, and I know that this is something that people feel very territorial about, and instead of siloing it, his quote to me is we need to share findings so we're not doing redundant work. We need to connect the dots. We need to share data and put together a better database.

He said that they want, as far as his group, they want to try to get to the underlying issue and come up with a new diagnostic for TBI

very specifically, and General Chiarelli said that once we know what's wrong with the--you know, once we have this diagnostic, then we can treat it.

Terri and Kathryn, what role would you think that the private sector would have on something like this, and then on the medical side, this whole idea of sharing as opposed to siloing, and I know that pharmaceutical companies, everybody gets a little? We have information out there, but it doesn't necessarily get shared.

MS. TANIELIAN: Sure. Well, this is, again, I think a topic where we've recently made some important investments, and with the release of the National Research Action Plan for PTSD and TBI, I think those are important kind of strides at the federal government level to really bring together and share and come up with a strategic approach to addressing these issues with information collection and data analysis.

But the private industry is a player. I mean they are investing billions of dollars in services and programs and research, and to the

extent that we need to harness that because it can produce knowledge that is applicable to the federal systems is important, but it's also thinking about kind of the real-life application of some of these approaches and understanding whether they work.

And the billions of dollars that have been invested in this area is, it's heartwarming, but at the same time, there are many of them that are not working, and with some better research and evaluation, they could be improved, or those resources could be targeted towards the best practices where we know things work.

And so I think we need to kind of think about strategies of how can we learn from the independent sector, kind of both the private and nonprofit, and where they are, and understanding kind of their role in generating knowledge.

MS. POWER: I'd defer to Terri and Captain Stoltz in terms of the research question, but I think that the President's Executive Order, that challenge to the three departments, the Department of Veterans Affairs, Department of Defense, and the

Department of Health and Human Services, to look at research was really the impetus for the National Research Action Plan.

That plan, I think, really details for the first time assets across the federal government and other assets that they may, in fact, support across the private sector, but it is the General's intent, I believe, to move forward and to engage and to get the private sector to help participate in that larger look across the database.

And in addition, not only are they trying to look at the neuroscience of some of these conditions, but there's a very specific study as a part of the NRAP looking at suicide and suicide prevention, which I think is an enormous issue relative to this population, and that we need really some very long-term longitudinal views of what that, the etiology of that issue is, and how, in fact, there are contributing factors to the solution of trying to determine how to prevent suicide.

So I think there is momentum in terms of

both the federal opportunities within research, but also the notion that we have very well-known credible people who are out there engaging and soliciting for the private sector to participate in a very unified way.

CAPT STOLTZ: So there is a ton of research going on, some of higher quality than others, but just to give you some examples of what's going on, just even pertaining to the issue of stigma that I talked about earlier. So one of the efforts has been to put the behavioral health providers right in primary care clinics and have them be having open flexible schedules so if somebody comes in with a primary care issue, refers to something that they start to emote about, having the primary care physician right on the spot offer them a chance to go down the hall and talk to somebody more about whatever the issue is.

There are efforts underway to just have somebody assigned to primary care clinics where all they do is pay attention to those people that seem to have a significant psychological overlay to

their complaints and attempt to get them more engaged in treatment because one of the research findings is, is that sometimes people come from treatment, but they leave after just a couple of visits and don't follow through in a way that will allow them to better heal.

There are research things going on where they are calling people on the phone at different intervals just to see how they're doing as a result basis. There are even places that are offering home visits to provide care in the home when people have shown that they have difficulty getting to the facility where they're receiving care. So these are very, very helpful things that are being monitored carefully, and we're making all kind of efforts to have the results of these kinds of initiatives be distributed at a much faster rate than before so we can translate this knowledge we're gaining into practice in a much faster period of time than has historically been the case.

MS. QUADE: Thank you very much.

MRS. PAXTON: I'd like to chime in a bit.

I am actually very proud to hear that many of the things that we are doing in the Wounded Warrior Regiment you just mentioned. We have what we call District Injured Support Coordinators who are mobilized Reservists. They're aligned with our Veterans Integrated Service Networks across the nation.

We can call on them, and they can be on the doorstep of a Marine within 24 hours, and we can connect that Marine who may have been living in mom's basement for the last year and get him to a vet center or to a treatment facility.

75 to 85 percent of the folks who come to us in the Wounded Warrior Regiment--so this is a small population--these are the devastatingly injured--already have a mental health diagnosis. When they come to us, they like breathe a sigh of relief. These people get it. They understand. The stigma is over when they come to us.

So what we work on are more holistic ways, various ways. There are many different types of treatment. One type may not work for one person.

So we try different things. We engage the mind, you know, we engage the body. We have this wonderful Warrior Athletic Rehabilitation Program. Figure out that acronym. WARP. You know who thought that up--a Marine.

[Laughter.]

MRS. PAXTON: So the Warrior Athletic Rehabilitation Program seeks to engage them back into activities that they're used to--athletic activities. It culminates every year in a Department of Defense basically Olympian event in Colorado Springs where all the services and even some of the foreign nations come and compete in this competition, and I'll tell you what--the Marines have won for the last four years, but it was a close and fierce competition last year. So we got our work cut out for us.

So those are things that we're trying desperately already trying to do. We have our call center. We engage our family members. We've got strong family support programs for the Marines in our programs, but this is a small population, you

know, and I think the question remains what's going to happen to the rest of the Marine Corps, to the rest of the services? So I appreciate that.

MS. QUADE: Well, not just to the rest of the Marine Corps and the rest of the services, but for long-term.

MRS. PAXTON: Right. Oh, absolutely.

MS. QUADE: I wanted to go into long-term care. What would be the ideal journey for a serviceman or woman from the front who's dealing with potential mental health issues, and then as the journey goes on and decades and decades ahead, what's the ideal journey? What would be the ideal journey for their family? What does long-term care ideally look like--long-term care?

CAPT STOLTZ: Well, I'll jump in on that. I mean I think we start with care coordination from the very beginning, and, you know, I think you heard earlier, I happened to be here a little bit early and hear some of the great presentations before, and there was some talk about clinical practice guidelines and so forth.

What we're trying to do is expand that and go into clinical pathways. So instead of telling people if a person comes in with this condition, this is how you treat it, we're now talking about this is how you follow a person across the entire continuum of care because some of these diagnoses come together.

So somebody could have PTSD, but they could also have substance abuse problems. Sometimes their depression goes up and down. Sometimes people need some residential care or some intensive outpatient care or even some inpatient care, and then as they transfer from one level of care to another, how does that go?

So we are actually laying that out now, and again combining that with not just DoD places of care but also VA places of care so that we're on the same sheet of music as we follow patients along potentially a longer course of treatment, particularly when you throw TBI on top of some of the psychological disorders.

If it's a purely psychological disorder

that isn't too complicated, frequently that can be healed. Again, it's not that there's one treatment that works right for everyone, as has been previously mentioned, but we know a number of treatments successfully work, but in some of these more complex cases where there are multiple traumas, where there is head injuries on top of the traumas, where substance abuse gets involved, we now have put out there and are increasing the detail and spreading the word about ways to follow a person through the entire continuum of care.

MS. POWER: And one of the things that we've explored and studied and we do demonstration grants about is to take a look at the trajectory of care, and it really should include a component of prevention, and prevention despite the fact that people already may have these conditions, that there is prevention-minded treatment that you can do. There is treatment-minded prevention that you can do.

So the plan really needs to include a prevention component that is blended into this

notion of the continuity of care and then integrated care, always being trauma informed. Extraordinarily important for people to be skilled in terms of determining the effects of trauma which we consider for people with mental health and substance abuse conditions to be almost a universal condition.

And so then that really then trajectory becomes individualized and focused on recovery and resilience, and I think that to me is the ideal trajectory that says you're really looking at a life of discovery and a life of quality that can be recovering and resilient over time, and that is achievable given many of the interventions and given the proper support.

MS. QUADE: Terri.

MS. TANIELIAN: I would absolutely agree, and I think we have to recognize that one size doesn't fit all so you have to think about kind of what that individualized trajectory is going to be. But how do we promise that to the servicemember and their family?

We need to think about the trainings and the orientation of the system, and we've seen some of those changes occur where we're taking mental health and putting it into private care, and we're doing trainings and evidence-based approaches. And so we're starting to make some of those system-level changes to be able to afford that trajectory for each servicemember, veteran and their family.

But that needs to permeate not just in the DoD and the VA but to the civilian sector. There are a number of servicemembers, their family members, and veterans who are not going to seek care in some of the federal systems where they've invested in these trainings. So we need to think about as a nation, as a society, how do we also ensure that our civilian providers are trained in cultural appropriate approaches, trauma informed care, and so that there is that no wrong door.

That they can make appropriate referrals back to the VA as appropriate and as warranted, but that they can ensure that--that we can ensure as a nation that no matter where the family member, the

servicemember or the veterans seek care, they will be, they will have the opportunity for this idea trajectory.

And that's going to take a significant investment in thinking about how we work with private insurance companies and the way that they impanel that their providers and the requirements that they have for the types of training, and how we can actually incentivize and really think about how we can get providers to actually deliver evidence-based approaches in their private settings.

MS. QUADE: Thank you.

I want to kind of wrap up with a closing question for everybody because we're having such a great discussion, but we have to keep it moving. If a family member believes--this is kind of the take-away for everybody--if a family member believes that their loved one is potentially dealing with these issues, whether they were a veteran from 20, 30 years ago, or just coming home now, what should be the family's first step? What

should they do?

I know that I've talked with many Marines in my day, and I often hear something from a family member, well, he or she is angry. I don't want to incite him or her any more, and I'm not going to his or her command because that will just piss them off more. So, Debbie, let me start with you. What should a family member do? And this could be 20 years from now.

MRS. PAXTON: Hopefully, our Wounded Warrior Regiment will still be existing. That is the intent of our Commandant, and we hope to still have our call center and the assets that we use now, our mental health providers, our social workers, our nurses. They can call. They don't have to identify themselves. Eventually we would like to be able to identify the Marine to get one of those DISCs on his doorstep, but as everyone has mentioned, there are a bazillion resources out there. There's call centers. There's contact centers. There is suicide prevention lines.

Marines respond to another Marine. And

that's why we think that peer support is so important.

MS. POWER: I think that the gazillion resources are difficult because people don't know how to go find gazillion resources.

MRS. PAXTON: Right.

MS. POWER: So we have to try to identify the most targeted and most specific, and the first I would say, mentalhealth.gov is a new Web site that has come on board. The President announced it several weeks ago. It is a generic resource where people can find information, and there are some specific tips about how to talk to people about seeking mental health services. 1-800-273-TALK. You press "1," you're immediately connected to Canandaigua, New York with skilled counselors on the phone.

I would encourage, as Debbie has said, a peer is always the right route into the heart and soul of a member of the military, and I would also encourage everyone in the world to take mental health first aid training, a one or two-day

training that's available for anyone in your community. We're pushing it through DoD and VA, and I think it's an excellent way to learn how to approach people with mental health issues and to feel more comfortable out in society being able to interact with people who may have some mental health or emotional issues.

MS. QUADE: Kathryn, that sounds like a final thought, and I want to give everybody a chance to give one take-away for the audience of something if we did not cover here.

Captain Stoltz, is there something that you want people to take away from this discussion today?

CAPT STOLTZ: Oh, I hope you have taken away a fair amount already. I think all of our hearts are in the right place. We're trying to do the right thing. There is so many resources out there.

I guess one thing I would tell you is there's so many young people today in the service, and many of them do respond more to online gadget

kinds of things, and believe it or not, we've developed a number of apps that they can download to their iPhones that have like helpful things in there, all kinds of things to help them with stress.

So in addition to reaching out to so many other resources that are out there, we even have technological tools for those that are tech savvy can easily get access to and download for free, and we've actually had a fairly positive response.

But thank you again for the opportunity.

MS. QUADE: Thank you very much.

Debbie, what do you think that people need to take away from this and your last thought on today's discussion?

MRS. PAXTON: I came back into this work about six years ago. I was not a psychiatric nurse. I was a family nurse practitioner. I taught Lamaze classes. I worked in pediatrics.

But when I started visiting Marines and corpsmen down at the naval hospital in San Diego, I realized that there was this unmet need by these

invisible injuries, and I just had to ask myself, I mean the quote that comes to mind is paraphrasing the Rabbi Hillel, who said, you know, if not me, who? And if not now, when? So that's how I came back into this.

MS. QUADE: Thank you.

Terri.

MS. TANIELIAN: Well, I think, again, there's been a number of important take-aways already mentioned, but I think we need to remember that it's important to continue to work together, and that this problem won't be solved today, and we need to continue our joint collaborative efforts to understand the nature of the problem, identify the potential solution and really work in an effort to get them out to the communities where servicemembers, veterans and their families live, and knock down some of those barriers to care so that help can be provided effectively.

MS. QUADE: Any last thoughts? Okay. You had your chance. We've talked about a lot here today, and we've raised a lot of issues, and you've

all been very attentive. So thank you.

I know you're all looking forward to lunch, but you know we are all at a very critical juncture, and we're winding down these conflicts, and we're transitioning. 2.5 million people served in Afghanistan and Iraq, and we have a huge portion of our population who are dealing not only with this difficult transition back to civilian life, but are also dealing with this condition or a condition that they don't even know how to accurately discuss.

It's key that we do not let this fall out of the public consciousness, and that's why, as I brought up at the beginning, I think it's very encouraging to see someone like a Medal of Honor recipient, brand new Medal of Honor recipient, Ty Carter, that he has made PTS awareness his platform.

My last thoughts because we didn't get a chance to discuss because this was a great discussion, but the last thought I wanted to make sure the impact on the community and something that

I really think that needs to be in the public consciousness is that our military children are struggling, and like generations of military children before them, they will make up and be part of our future military.

The impact of their injuries and psychologically on the military family are enormous. These issues are just now being addressed, as Debbie has also mentioned, and the impact on schools, churches and neighborhoods is significant. It is key, as I said, that we don't let this fall out of the public consciousness, and that we keep this, that everybody keeps talking about this.

So I know that we're going to be having an NFL person talking later today, and that's one of the ways of raising public consciousness, that we need to keep this in the public consciousness.

Thank you to all of our fantastic panelists today--Kathryn Power, Captain Stoltz, Debbie Paxton and Terri Tanielian. I hope again that everybody in this room, that what you heard,

that you share with your communities back home. So thank you again.

[Applause.]

VADM RYAN: Thank you, Alex, and thank you so much to Terri, Debbie, Richard and Kathryn. Great job. We really appreciate it.

We've got one quick reminder before we go ahead and introduce our featured guest speaker before lunch, and that is that you have those cards on your table with the pens. We need your ideas, your questions, for our third panel, and you can drop those in the box out in the lobby as you go to get your lunch.

And the General is holding up one of those cards here. So don't forget to fill out your cards with your ideas, your suggestions, your questions, and then Dr. Brown and the panel will try and address those as we go forward.

Thank you, ladies.

[Applause.]

VADM RYAN: Okay. My pleasure now to introduce our featured guest speaker. General

Campbell is the Vice Chief of Staff of the Army. You've got his bio in the program. You can see he's anxious to talk so you'll read his bio, and you'll see what all of us see, and what certainly our chairman, General Tilelli, has related to me, "a soldier's soldier." He's a servant leader that cares greatly for the troops, the families and our nation, and, General, we're delighted and honored to have you here today.

GEN CAMPBELL: Thanks very much, sir.

[Applause.]

GEN CAMPBELL: Well, thanks very much. You saw me go kiss that beautiful lady over there. That was my wife. So--I'm actually very honored to have the opportunity to come here and talk, and I really wish my schedule allowed me to come here and sit for all the different panels. I heard the last maybe ten minutes of the last panel, some really good information.

I just value an opportunity to get out and talk where I'm not talking about sequestration or budget in the world that we live now although that

will have an impact here maybe as we talk about
programs. I don't think I'm supposed to take Q and
A at the end, but I'll stick around if you have
questions you want to talk about if I don't cover
something here. I do relish the opportunity to
talk about your Army and some things we're doing in
terms of mental health here.

First off, good morning, everybody.
General Tilelli, Vice Admiral Ryan, General
Farrell, thanks really. For all the sponsors here
and all the representatives, for the family
members, caregivers, all of you, thanks for really
taking time out of your very, very busy schedule to
spend the day here, to keep the awareness up, to
talk about this very, very important topic, and
again I wish I could leave the Pentagon more often
and come over here and sit through this. I can't.

I have some folks here that will keep me
updated, and we will certainly take many of the
lessons learned that come of out of this to apply
where we can to our Army, and we'll pass those on.

But I want to thank the Military Officers

Association of America and the National Defense Industrial Association for having me here today, for really holding this conference, the other organizations that are assembled that get together really to help our soldiers and our veterans.

But before I talk about anything, any venue that I have the opportunity to talk about, I always remind people that we are in a fight. Your Army, your Marine Corps, your Air Force, your Navy, Coast Guard, great civilians, we're still a nation at war, and people tend to forget that.

We have over 50,000 soldiers, airmen, Marines, sailors, Coast Guardsmen, civilians in harm's way today. In Afghanistan, we had over 35 soldiers wounded last week. We had 230 in July. We had another 200 in August, and you don't read about that. You don't hear about it. All right. And those wounds will continue for many, many years. So, again, that's really another reason to have symposiums like this to talk about. We continue to be a nation at war. We can never forget the sacrifice of our great men and our women

and for their families that do so much for us.

Yesterday, I had the opportunity to attend the 9/11 memorial ceremony at the Pentagon. The President was there, SECDEF, and the Chairman. Great words. But after 12 years, after that very solemn day in our history, it's really appropriate that we do have time to come together to discuss how we will continue to really collaborate and care for our veterans suffering from these invisible wounds.

What many argue are the signature wounds of Iraq and Afghanistan are really the generation of warriors that we have here today. I heard it in the last panel at the very end talking about Ty Carter, and I think that's really, really neat because I got a really quick video I'd like to really kind of set the tone.

So if you can play the video please.

[Video presentation.]

GEN CAMPBELL: So the theme of this conference is taking action. As you saw there, Staff Sergeant Ty Carter, he's going to take

action. He's going to be a great spokesperson for PTS. He's going to really help our soldiers and other servicemen and women overcome the stigma associated with these invisible wounds, and his powerful impact that he can have to the future of getting this message out that, hey, I'm a Medal of Honor recipient, it's okay. A man of celebrated valor has asked for help so others in similar situations will not fear being considered weak if they took seek the treatment that they need.

Sergeant Carter's message is one of strength and honesty, and we're truly thankful that he's volunteered to serve and continue to serve active in our Army and help in the capacity of reaching out to others so I think that's a really good news story.

Now, the Army leadership is really dedicated to finding ways to overcome really our significant behavioral health challenges. One of these is suicide. I heard that talked about as well. You've all heard the numbers. One in three suicides in the United States is committed by a

separated or retired veteran, 22 potentially a day.

There's 60,000 homeless veterans out there. Certainly not all these are attributed to behavioral health problems, but many of them are, and so the effectiveness of many of our servicemembers who are still serving is negatively impacted by these invisible wounds, and we need to be able to sustain them in their job as they defend our great nation.

These combat proven veterans are a great value to our formations and to our society as a whole, and so we're really counting on them to pass on the lessons learned from the last 12 years of war and really tell the Army story to their hometowns, to the nation, get out there.

We've proven that with proper treatment, our servicemembers can recover from their injuries, and by providing quality care, we can build trust with all of our teammates. We're retaining leaders with combat experience and a steadfast commitment to our force, and they will build the next generation of warriors for our country, and at the

same time, we're sending good citizens back to local communities really to recruit the next generation of our American defenders.

So the veteran is really our greatest recruiting asset. We just recognized the 40th anniversary of the all-volunteer Army back in July timeframe. It's really a concept that has made our Army the best Army in the world, but it really requires constant effort every single day if we want to be able to maintain an all-volunteer Army.

Today, only about 23 percent, two to three out of every ten, can even join one of our services, that are eligible because of the medical and the physical constraints. We continue to succeed in our recruiting in getting the very best in America because we are taking care of our people, and once we stop doing that, we'll lose that all-volunteer force.

So the Army is taking action on behavioral health challenges, and symposiums like today really, really help us build on those partnerships that we value because we cannot do this alone.

Research and education is the foundation of our effort. We are partnered with prestigious academic institutions to include Harvard Medical Center, Cornell, University of Pennsylvania, and the Tel Aviv University in Israel.

We're educating every soldier on identifying the indicators of mental injuries. Sergeant Carter told his platoon sergeant. His platoon sergeant saved his life because his platoon sergeant escorted him to behavioral health. He took him to a center at Fort Carson. He received the right help there, went to Joint Base Lewis-McChord, received additional help there. So educating our soldiers and our leaders across the force will enable early detection and proper treatment to help remove the stigma of these injuries.

In an effort to standardize, integrate, and centralize the tracking of behavioral health and behavioral health patients, we have created what we call the Behavioral Health Service Line, and it's comprised of six really different lines of

effort, and I'd like to briefly cover those six lines of effort.

The first is Embedded Behavioral Health. So Embedded Behavioral Health provides multidisciplinary community behavioral health care to soldiers in close proximity to where they live and to their units, and it stays tight in coordination with their units and their families, and I'll talk a little bit more about that here in a minute.

The second line effort is Behavioral Health Data Portal, and this portal really tracks patient outcomes, satisfaction, and risk factors via a Web application, and it enables improved assessment of program and treatment efficacy. The Behavioral Health Data Portal is currently being implemented at every behavioral health center, every behavioral health clinic in our Medical Command.

Our third line of effort is the Child and Family Behavioral Health Services, and this provides care to spouses and children in the

communities where they live through school-based programs, child and family assistance centers and integration of behavioral health providers in our primary care clinics.

Our fourth line of effort is Family Advocacy Programs, and the FAP provides training and support programs that give our soldiers tools to establish a climate within their families that fosters resilience and trust to eliminate abuse and neglect.

Our fifth line of effort is Tele-Behavioral Health. TBH enables Army Medicine to deliver clinical behavioral health services at a distance via electronic communications, and the Behavioral Health Service Line has deployed about 2,000 of these portable VTC systems worldwide to support our soldiers, to include both back in Iraq and Afghanistan.

In 2002, we provided 37,000 patient-to-patient encounters and provider-to-provider consultations via this VTC system.

And the final line of effort is the

Internal Behavioral Health Consultant, and IBHC integrates behavioral health care into primary care facilities in order to reduce the stigma associated with behavioral health and make it more accessible.

So let me expand a little bit on a few of these. In January 2012, the Army directed the development of Embedded Behavior Health Teams on every Army installation and in all of our active combat brigades, brigade combat teams. We wanted to make this happen no later than FY16.

The Embedded Behavioral Health Model is an early intervention and treatment model that promotes soldier readiness before, during and after deployment. It provides multidisciplinary behavioral health care to soldiers in, again, close proximity to their unit, ideally, inside of the brigade combat team footprint. And it's in close coordination with their leaders so they stay tied into it and their peers.

And each Embedded Behavioral Health Team consists of seven people, normally seven, seven providers--a psychiatrist, three clinical

psychologists, and three licensed clinical social workers.

Utilization of this model, the early results we're getting back statistically shows significant changes in key areas such as improved mission readiness, increased outpatient utilization, and decreased need for acute inpatient psychiatric care.

Combat and operational stress control really remains for the commander to take care of and his responsibility at all levels.

The Embedded Behavior Health Team serves really as that single point of entry into the behavior health care for each of our soldiers and our leaders, and it really, again, helps facilitate early detection and intervention. Soldiers receive expedited interventions, evaluations, and then they can start a community-level treatment really from a single provider, and this really provides continuity of care.

Again, leaders have to be tied into this. They are the single point of contact for questions

that come back, and they become subject matter experts. The behavioral health provider maintains visibility on each of its battalion soldiers and reports trends back to the leadership on a regular basis, and then the working relationship between the provider, the key battalion leaders and the personnel helps really get that message out to erode the stigma commonly associated with behavioral care in the military setting.

So behavioral health providers, they can actually go out there and specifically tailor the options for each of their battalion soldiers based on that continual presence and understanding those soldiers, and today, we have 42 active Embedded Behavioral Health Teams, and 80 percent of those were established inside of our clinics within our brigade combat team footprints. So those are really the six lines of effort that we're really pushing hard on.

While really not part of this symposium, or the main topic, we do have a challenge with Traumatic Brain Injury, and it is closely

associated, I think you'd say, with behavioral health, and I really have dedicated a lot of time to this, and I want to talk about this important topic while I have an opportunity.

We've made great progress, and we have implemented event-driven protocols really to ensure that Army and all DoD personnel that have potentially been involved in concussive type events are properly evaluated and treated and tracked. We've improved protective equipment. We're improving and tracking environmental monitors, putting in helmet sensors, blast gauges.

All of our soldiers in theater wear three blast gauges. Many of our vehicles are starting to get blast gauges built into them so we can get some of that data to help better understand the impact. It really gives us more on the head injuries due to this concussive event.

We're also partnered closely, and I heard it talked in the last piece, with the NFL because there really is a shared culture between a soldier and potentially an athlete like that. The culture

of mental and physical toughness often keeping a soldier or an NFL athlete from seeking or asking for help. Too macho. I can't do that.

So we're participating in a $60 million research and innovation, which was initiated by the NFL. GE is tied into it and Under Armour, and it really is to look at advancing TBI detection and treatment. They're holding numerous local events, to include NFL teams and really Army units and soldiers to go out to help promote concussive awareness, and really do think working with our young soldiers and that young generation coming up, this will make a difference.

To treat PTS and TBI during the height of our conflicts in Afghanistan and Iraq, we created these four deployed Combat and Operational Stress Control Rehabilitation Centers. When I was in Afghanistan in 2010-2011, we called these Resiliency Centers. Now we call them Concussion Care Centers, and in Afghanistan, at the peak, we had about 11 of these facilities that gave our fighting men and women an opportunity to go to a

place to recover over a period of time, and then about 90 plus percent would return to the fight.

They wouldn't have to come all the way back to Landstuhl and Germany, all the way back to Walter Reed, but they can go back out.

By giving our warriors a local sanctuary where they could really heal during that first few days, we saw some very significant long-term effects and results.

Back here statewide, we've partnered with the Intrepid Fallen Heroes Fund. With their generous donations, they built the National Intrepid Center of Excellence, the NICoE, up in Bethesda. We're now expanding that to nine different NICoE satellite centers throughout the country, seven Army, two Marine Corps.

Yesterday, I had the honor to participate in a ribbon-cutting ceremony down at Fort Belvoir where we cut the ribbon on what we're going to call Intrepid Spirit I, and that's a satellite center. It's the first of the satellite locations, and these centers increase access to quality

interdisciplinary care for our soldiers and our family members because a family member absolutely has to be tied into that, and their proximity to where the warriors live allows the patients to leverage the love and support of the families that are tied into this process, the healing process, 24/7. It gives them access to the latest research, and that's very, very important.

The Army's behavioral health efforts are really a part of a greater campaign, and we call it the Ready and Resilient Campaign. That is among one of my top priorities. I know it is for General Odierno and Secretary McHugh as well.

The purpose of the campaign is to establish an enduring cultural change within our Army, starting with our soldiers, but it has to include the families, it has to include our great Department of the Army civilians, that integrates resilience into how we build, strengthen, maintain and assess total fitness, individual performance, and more importantly unit readiness.

Building resiliency for us starts from day

one in the Army and is directly linked to readiness, and our goal again is to create an Army culture that embraces resiliency as a part of our profession and enables us to perform and really to overcome the stigma associated with mental health injuries. So we aim to build a climate of trust, mutual respect, and discipline toward behavioral health and total fitness.

The work being performed by symposiums like all of you are here today is really I think honorable and absolutely essential to the efforts to recover from the last 12 years of persistent conflict and really help build our military, all of our services for the future. The world, I think, as you've seen in the news, but your great men and women in the service deal with every single day, is an extremely unstable and dangerous place. I don't see it getting better.

In the current fiscal environment, the military partnerships with academia, military support organizations, veteran support organizations, partnerships with business and

industry really play a central role in maintaining our readiness as we move forward for whatever our future will bring.

Finding better ways to care for our wounded warriors and veterans has to be an integral part of that mission. We're still at war today. I started off with that. And the recovery from these wars will continue for years and years to come so we can't forget the lessons that we've learned over the last 12 years. We have to continue to work together. We have to continue to build what we owe our great men and women, our veterans.

Really thank you for all that you do, for being here, and I have to end with this because there is a lot of people walking around the halls of the Pentagon with their heads down. All right. They got heavy rucksacks. They're talking sequestration, talking budget, and it's bad. '13 is bad. '14 is bad. '15 is going to get worse. '16 is going to be worse than that. '17, '18, we might start coming out of it.

The bottom line is our nation doesn't

care. When they need us to go someplace, they're not going to say, hey, what about sequestration? They're going to expect your Army to be ready to go. So we got to fight through that. We're going to need all of your help.

But today, you have the greatest Army in the world. It's the best manned, equipped, trained and led Army. We're going to go through this transition period. We're going to have to get smaller, but at the end of this transition, you will continue to have the greatest Army in the world, best manned, equipped, trained and led.

The last thing I'll tell you is that when I see soldiers, leaders, walk around the Pentagon, they got their head down. All right. If you walk out of here and you got your head down because we've got some tough things that we got to wrestle with as a nation, and you're feeling sorry for yourself--all right--go to Walter Reed. All right. Go down to BAMC. Go to the MATC, somewhere between 08 and 1200. Go to talk to Brendan Marrocco. He's a quadruple amputee whose brother gave up his

entire life to be with his brother, gave up an IT career in New York to be with his brother, to spend everyday with him.

All right. Go be around those great Marines, soldiers, all right, and that is infectious. And their attitude, their positive attitude, will get us through anything. So I challenge you to do that.

Thanks for what you're doing here in this symposium. Thanks for what you do everyday for our veterans. Army Strong.

[Applause.]

VADM RYAN: Do you want to take a couple of questions?

GEN CAMPBELL: Sure. I'm the last thing before lunch. All right. I think if you want to go to lunch, you can go to lunch. If you want to ask me a question, I'll stay here. It's up to you. I'm actually going to go have lunch with Greg Gadson, if you know Greg Gadson, back in my office in the Pentagon. So I got something good coming up.

VADM RYAN: Okay. We've got one back there. Yes.

GEN CAMPBELL: Can I walk around with this mic on?

VADM RYAN: Whatever you want.

GEN CAMPBELL: Okay. Thanks.

AUDIENCE PARTICIPANT: I think one of the things about stigma that has been overlooked, and I heard it alluded to a little bit this morning with an active duty major saying that the promotion pool and his competitors gets smaller and smaller as he advances in his career. I don't hear it widely said that your evaluation, your promotion will not be affected if you seek mental health care.

I'm old enough--I'm retired--28 years in the Navy--I'm old enough to remember when the HIV scare hit the military services, and we were prohibited from using that information to be on any kind of a promotion board. And I'm wondering if the same thing can be done with mental health issues here?

GEN CAMPBELL: Yeah. That's a great

question. First off, thank you for that. You know, again, for me, at the level I deal with now, I deal in two things. I deal in prioritization and I deal in risk. I deal in risk to force and risk to mission. When you get right down to it, the Army is about people. All right. And it's about face-to-face interaction and knowing everything you can about your soldier, and I would agree with you, years past, there has been a stigma tied to mental health, tied to HIV, all those types of things.

But what we're really doing in the Army, and the leadership that you have now, both at the noncommissioned officer level--and we really need it at the sergeant level--if our sergeants, our NCOs, don't embrace this culture change, it's not going to sustain. All right. I can say what I want to say as a four-star general. All right. But if we want to sustain it and make a change, it's a cultural thing, and it has to start at the lowest level.

I really do believe as I get out to our posts, camps and stations and talk to the young

soldiers that they believe this, they're taking it on, and so I will tell you in the meetings, the boards I've sat in on, those type of things, there actually is no, no issue with that on promotions.

Now, if you're a person that didn't get promoted and you went through this, you absolutely think that. I got that. Okay. But it's a cultural change. It's going to take time as we move through it. So we're not all the way there. I'm not going to kid you and say we are, but I really do think we're moving in the right direction, and if we're true to our word, you know, you heard Ty Carter say it, it's about--he didn't believe it himself, that he had an issue there, and so if we're true to our word, then we have to make sure that our actions, you know, speak that way.

So I think it's a culture change. I know the Army senior leadership is right where you talked about and should not impact on promotions. Hopefully, that answers where you're going.

VADM RYAN: Time for one more question.

GEN CAMPBELL: All right. A lot of

pressure on you.

MR. ROBINSON: I got a good one for you. As it relates to stigma and culture change in the military, we have a lot of experts here in the room, people who understand trauma-informed care. How can we as a military transfer that information down to the end user, the private, the team leader, the squad leader, so that they understand the occupational exposure of war the same way they understand heat stroke, and when they see it, they know what to do about it, and what is the military doing to try to get that information down to the end user?

GEN CAMPBELL: Great question. Again, I think it's about education, and we're really trying to tie it back into this resiliency piece, and a lot of the issues that we have potentially in the Army are based on outside stressors that our soldiers live and feel every single day, and many of our young kids that come in the military now have those even before they came into the military.

But we have an obligation really to help

them, and I think the way we do that is we educate, and so resiliency training, we have this thing called Master Resiliency Training, we started back in 2008, 2009. We had about 18,000 trained Master Resilient Trainers. Our goal is to get one per every company. Our goal is have one for every 250 civilians in the organizations.

My wife spent two weeks up at the University of Pennsylvania going through it. All the people that I've talked to have said it is a game changer and helps educate them to some of the things you just talked about right there, but that's going to take time to build that up.

We have mobile training teams that go to each post, camp or station to really try to talk through that part of it. One of the comments up here--I think Debbie Paxton talked about it--about the best thing for a Marine is another Marine, and so that peer-to-peer, you know, the same thing with the Army--makes a difference. So if a soldier understands that, gets educated, he can pass it on to his battle buddy.

So it's not going to happen overnight. We shouldn't kid ourselves, but I think that through education, we have to put some resources in there. If everything is a priority, nothing is a priority. So the Chief and our Secretary committed to mental health here and know that it is an issue, and it will be an issue for a long road.

So thanks very much for the questions. Again, I know lunch is waiting for you. I'm very honored to have the ability or the opportunity to come here. Thanks for what you're doing. Don't walk out of here getting all this information and then not doing anything about it--all right--because there's great potential to really help out our soldiers, airmen and Marines, and I'm proud to continue to serve.

Thanks very much.

[Applause.]

LTGEN FARRELL: Thanks, General Campbell. That was great. Appreciate it, sir.

Okay. Just before we leave here, I just wanted to once again thank the sponsors. We've got

USAA here, Marc, Gina and Ronnie, at the front table. Thanks again, guys. We really appreciate USAA.

[Applause.]

LTGEN FARRELL: And then to the lunch sponsor, Haven Behavioral War Heroes Hospital, Vern, Harry, David, Sean, Roberto and Jim are here. Thank you very much for lunch.

[Applause.]

LTGEN FARRELL: And take a look on the back of your program. You'll see all the sponsors, USAA, the Haven Behavioral Hospital, all the way down through our Silver, Bronze, Gold sponsors and our breakfast and registration and media sponsors. And thank them very much. Appreciate that.

[Applause.]

LTGEN FARRELL: Okay. The only thing about lunch is lunch is out there. It's going to be a buffet. You can get it and bring it back in, and we're going to have a panel at lunch where there will be an open discussion, and the focus is going to be on solutions, and so once again these

cards are very important. If you've got an idea or a suggestion, fill it out, and the panel will address it so you can drop these cards right next to the registration desk out there.

If you guys would be back in here by 12:25 where we could start, we'd appreciate it. See you in a little bit. Thank you.

[Whereupon, at 11:57 a.m., the Morning Session concluded and a luncheon break was taken, and at 12:35 p.m., the Afternoon Session was convened.]

A F T E R N O O N   S E S S I O N

[12:35 p.m.]

[Video presentation.]

VADM RYAN: Good afternoon. I hope you're all enjoying your lunch. Continue to please eat. Our next panel is entitled "Innovative Mental Health Solutions Today and Tomorrow." And I know many of you put your suggestions, ideas, and questions in our box. Our panel will try and handle as many of those as possible as the session goes on.

Our leader is Dr. Brown, who serves as the U.S. Army's Director of Psychological Health for the Pacific Region. Dr. Brown is a great American. His bio is in the program. I'm going to let Dr. Brown take things over from here. How about a round of applause for our panel?

[Applause.]

DR. BROWN: First of all, I'd like to thank Admiral Ryan and MOAA and NDIA for putting this together. If you would, keep the applause going.

[Applause.]

DR. BROWN: I've not been up on this stage since 2011, Defense Forum Washington. I think it was a couple weeks after that, sir, I flew to Hawaii to a new gig. So thanks for having me back and putting this panel together.

Innovative practices. We'll get into a couple of things with innovative practices and being out of the box, and I would just like to segue from the video that you just saw with the art therapy and music therapy and a variety of other things. Seeing that brings me back to undergrad, full head of hair--I'll reflect on that for a minute--

[Laughter.]

DR. BROWN: --in a class that I had which was a literature class, which was "Themes in Literature After 1890," and it really addressed themes of women in literature. 1890, the frontier officially closed, and America hit its end, if you don't count Hawaii, hit its end and became more introspective with literature. It was now at the

point where we hit the end of California, we turned back, and we looked inward.

And the literature that was influenced at that time, a bit after, some of the themes were Great Gadsby, F. Scott Fitzgerald; the House of Mirth by Edith Wharton; Dreiser, Sister Carrie; Henry James--Henry James--that's the--yeah, Henry James. I was thinking Harry James--Henry James, Portrait of a Lady. So how does that relate to what we're talking to right here?

I think after ten years of unprecedented funding, what we're looking at right now is there have been tremendous innovations. When I was at Defense Centers of Excellence, I recall we had a study that showed there was over 500 resilience programs, and we were looking at some of the outcomes measures and some of the other approaches to measure success and efficacy.

So that's kind of where we're at right now is we've got sequestration, we've got some challenges coming up as the Vice Chief had mentioned, and now it's time to become even more

innovative with what we have, what resources are available.

I was asked to share briefly innovations that I participated in, and then we'll get into the intros and the innovations of the panel. Two in particular I'd like to highlight. When I showed up in Hawaii, I was asked, hey, in essence, requested by some folks, you know, let's come up with all these different approaches, and I said, well, let's hold off for a minute. Why don't we inventory what we've got first and see what's working and see what has outcomes measures?

And I said let's hold off on this to an extent because at the time we were pushing out this thing called--I was almost going to say Defense Forum Washington--Behavioral Health Summit, the Pacific Regional Behavioral Health Summit. A challenge that we had was our providers need CMEs, CEUs, continuing medical education credits and the sort, and I had said we've got some experts here that are phenomenal at what they do. We might not have it in the budget to send them to the mainland.

What can we do locally?

Senator Inouye liked to say that Hawaii was more than just a tourist destination. We've got a lot of our own experts. So we invited folks from the universities, the hospitals, the whole works, and had our own seminar, our own summit. We had that last year. We had it again this year. This year we partnered with the VA, and when we partnered with the VA, this year it was tremendous.

We had more than 270 people attend. When you look at how much revenue we save versus sending people to the mainland, it came up to about $810,000, not to mention the lost revenue of sending people to the mainland for trainings. They were still available to see patients.

So that's one initiative we had, and I think that's something that we can all do to an extent when required. We still need to come to the mainland from Hawaii, Japan and Korea from time to time for certain things, but that was one innovative practice.

Back to the inventory, I had asked folks,

let's inventory what we've already got. Let's see what's working. Let's reduce some of the redundancies and ensure that we still bridge gaps. From doing that, we invited the Hawaii Psychological Association to show up and, in essence, to help us with our inventory. Knocked their socks off. They said, wow, you folks have got some great stuff.

A problem with many times leading with some of our latest flavors of the month is people ask what were you doing before 9/11, to which we say, well, we're delivering world-class health care, but we don't operate in a vacuum. We still have to come up with innovations.

Hawaii Psychological Association awarded us a "Healthy Workplace" award to which they sent it off to the national level, and we thought, great, thanks a bunch, you know. Let's focus on this Behavioral Health Summit. We later found out, in fact, I think we can cue a video here. We competed at the national level, and I'll tell you the results after we cue up this video.

[Video presentation.]

DR. BROWN: The result: we won the national-level 2013 Psychological Healthy Workplace Award, a first ever for a military installation. So really hats off to the folks out there at Tripler.

Without further ado, I'd like to get into some of the intros of our fellow innovators, and let them introduce themselves and share some highlights. You've seen their bios, and I would like them to share in their own words and supplement what's in their bios.

Starting to my right, Lily.

MS. CASURA: Hi. My name is Lily Casura, and I'm here as an interested other. I'm not military or former military, and I'm not a provider. I started the first Web site back in 2006 about combat veterans and PTSD, and I did it drawing on my background as a journalist but also a successful recovery from chronic fatigue syndrome, which was sort of the PTSD of the 1990s, a lot of similarities, vague symptoms, not really related to

each other, and generally the medical community gives up on you and says you're going to have this forever. There is no real cure, and here's some antidepressants. Hope it helps.

I wasn't satisfied with that, and I used my kind of academic background and journalistic skills to learn my way out of chronic fatigue, and I recovered after five years and then segued back into journalism because I wanted to offer some help to people who weren't finding it through conventional medicine, that there were some alternatives out there.

And then I wrote about natural medicine and the like for about ten or 15 years for a medical journal, for mothernature.com, blah-blah-blah. So I've got a background. My degree is from Harvard with honors, and my training in PTSD is the National Center for PTSD's Clinical Training Program in PTSD, and I've gone through the Center for Mind-Body Medicine, which is based here in D.C., their practitioner level and their advanced level training that's in the Healing the Troops

track.

So the real reason I'm here is my Web site, which I started through a chance meeting online with a Marine officer in Iraq who was in the Sunni Triangle in 2005 before he was injured and had to leave, and up until that point, I really had no skin in the game, which makes me a classic American on this subject.

I found over the years that the people who care the most about these topics are ones who literally have a direct relationship to it, and that's really a shame, but it's an aspect of the all-volunteer force.

So, anyway, I met this Marine officer who was in the Reserves and was over there, and he said I write about this everyday. Is anyone interested in hearing what I have to say? And I said unfortunately no, not really, but stay safe. That was about the level of my interest in November of 2005. But through that conversation, we started a fairly heavy e-mail correspondence, and I got to see live and in real time what it was like to be a

fairly highly placed Marine officer in Iraq with a great academic background who is suffering distinctly from PTSD.

And one of the comments he made at the time when I first knew him is I think I'm over here to leave my demons on the battlefield, and I thought to myself, I don't know much about this, but I have the feeling it works the other way. You come over and you actually pick them up and come back with ones you didn't have.

So what I tried to do was I didn't want to bug him to learn what he was going through. He had a very dangerous job, and I figured I might as well learn about this without bugging him with all the questions so I read every first-person narrative that was coming back from the war to try to understand what he was going through, and I started thinking back on the background I had in integrative medicine and the experts I knew and the tools I knew, healing therapies that would work on certain symptoms because I could see how severe his PTSD was even though he wasn't really ready to

acknowledge it yet, and I thought if he's having this difficult a time, imagine what his 20-year guys are going through who don't have his academic background of his ability to think through this.

So I basically started looking on the Web to see what was out there. I'd already read all the stuff from the '70s and '80s about the Vietnam War and the worthwhile things from that with treating PTSD. I realized there was literally nothing written on the Web, and if there had been, and it had been good, I wouldn't have done my Web site, but since there wasn't, I put, I started putting information out there, and to this day, there are almost a thousand articles that I've written on the various therapies that work and what they work for, and how to triage your own situation, how to not give up hope, what it's like for the caregivers.

It's extremely broad, it's extremely deep, and if I'd ever known back in 2005 that I'd write a thousand articles, I probably wouldn't even have started because that's just too overwhelming, but

that's what I'm here to talk about, is what seems to work for mainly disaffected veterans who do not like the system the way it is or who feel like they're not getting the care that they need.

DR. BROWN: Thank you, Lily.

Greg.

MR. MONTGOMERY: I'm Greg Montgomery. I was actually diagnosed with bipolar disorder in 1996 when I was playing with the Baltimore Ravens, a very traumatic event. First, I'd like to say I have no idea what the horrors of war would feel like, but I do understand psychological pain. I do understand what it feels like wanting to give up and go away, and I feel this inner drive to share my story through my blog, hopefully giving people hope that they can work through these traumas by practicing acceptance, forgiveness and compassion and unconditional love.

As an athlete, I definitely agree that we should integrate some exercise into our recovery model and really engage in peer-to-peer communication. The Pugilistic Offensive Warrior

Tactics program integrates MMA training into an atmosphere of recovery, and I've worked with Jim Estes through the Wounded Warrior Golf Program that engages veterans with other veterans that have been through the similar stresses and turns disabilities into a new ability promoting an accomplishment.

I also worked with a company, the ERIC program, in Colorado. It's an acronym for Everyone Remains in Control, and it promotes productive communication and active listening within the family unit. We have to understand that this diagnosis is a family diagnosis, and we all have to reinvent ourselves and find a way to communicate productively and reinvent the family dynamic forming a support network within the family, identifying triggers, developing tools based on strengths and interests to manage emotions when they come up and making deals within the family and the support system.

For instance, when we're agitated, agree to talk later about subjects, or if they're old topics, agree to let them go and practice

acceptance.

But recently I've really been really looking into the metaphysical approach to creating my own reality and understanding that thoughts are things. They contain energy, and we create a reality with what we think about so we have to be very careful about what we think about and focus on what we are versus what we're not.

My period of enlightenment over the last two years has been extremely difficult. It's been a destructive process, meaning destructing down what I'm not, and I'm finding out who I am and celebrating that, and the reason I'm here is to just share some ideas and share some strength, wisdom and hope with all those that are dealing with these stressful diagnoses.

DR. BROWN: Thanks, Greg.

Jim.

DR. KELLY: Thanks, Dave.

I don't know about the rest of you, but I want to hear a lot more from Lily and Greg after what they've just said and not having really met

either of them before today. And many of you already in the audience know what I do and maybe even been at the National Intrepid Center of Excellence that General Campbell mentioned in his remarks today.

And I came to the innovation theme for this, this panel, through more of the traditional route of medical education as a physician and neurologist, but then also working within the system. So as an academic neurologist working with athletes at all levels, and doing very specific studies on mostly Traumatic Brain Injury cognitive or behavioral changes after a witnessed event such as a concussion in practice or a game, and that led myself and a group of us in the research world to be quite willing volunteers drawn into the military work with those coming back from the Iraq and Afghanistan wars because of the blast-related injuries and a variety of other causes of concussion that led to Defense Department military health system questions about what are we dealing with, what is this invisible wound, what do we need

to know more about?

What's similar to the athlete experience and what's different, and a whole variety of things that we could bring in from the academics, private civilian sector into the military, and I'm now in my fifth year as a DoD civilian and working at this magnificent place at Bethesda, at Walter Reed, again called the National Intrepid Center of Excellence, which was intended to be a place for innovation, to look at those especially with not only the PTSD or depression and anxiety aspects of what happens in a war, but the Traumatic Brain Injury that so many come back with as well.

We are asked actually in this institute model to hit somewhere in between the neurological and the psychiatric, and you know, I fully appreciate what Ms. Power said earlier today about the problem we still have with Descartes and the mind-body split, which I thoroughly do everything I can and have all my career to dismantle and to bridge those two areas.

And yet what we are asked to do at the

NICoE, the acronym for our place, is to hit that middle ground and look at what can help if, in fact, people have both, the known neurological problem and a known psychiatric or psychological condition.

And so I can go into more detail about how that all came about and what it is that we're doing with that as we go. Dave.

DR. BROWN: Well, actually that brings us into a good segue. I was going to mention we were talking back in the green room, and I had mentioned the physicist Hermann von Helmholtz would often speak of saturation, incubation and illumination. I think we've had some saturation with a lot of data, a lot of information. We've allowed that to incubate now for quite awhile, and then you have that eureka moment.

To put practice into this, I recall when I was working on my dissertation, I took a few years and read everything there was, and I was hanging out at the beach for about four months incubating, and my wife said shouldn't you be doing something?

And I had that eureka moment, and I left the beach tanned for about a year, came back kind of looking like a vampire and thought, hey, I'm done.

So with regards to this saturation, incubation, illumination, what I'd like to get into is what are you viewing now from a next steps? We've heard some of your innovations. What do you see as the next steps for us?

DR. KELLY: Well, to segue into that, you already saw some of what happens at our particular institute with Skip Rizzo, who was on the video talking about virtual reality and truly the creation of a virtual Iraq and virtual Afghanistan environment.

The question he's asking, and we are at our institute because the exact same laboratory that we have is partnering with him out on the West Coast, is to look at if, in fact, you're truly immersed in that setting, with the vision on what happens while you're inside a Humvee going down a road in Baghdad, and the chair vibrates when a bomb goes off, and we waft burning rubber smells into

the room, does that help you in a safe setting of a clinic, does it help you get through, get past what it is those demons are, what it is that you brought back from that experience more quickly?

And his research that we're participating with him in is showing that the metabolic changes in certain parts of the brain dealing with stress are reduced in a way that you can actually quantify and see under the conditions of that kind of immersion training, the virtual reality world training, and that's just one of the many examples of the kinds of things that we're engaged in that I think are really quite novel and innovative and bridge into areas of the mind, if you will, in ways that traditional medicine, certainly traditional neurology, hadn't previously.

DR. BROWN: Greg, we were joking in the back, Jim worked with the Bears, I'm from Chicago, it's the law, you have to worship Ditka, and I had said what gives? You didn't play for the Bears. And you had disclosed some steps that you took at a point in your life when you had that opportunity.

Would you mind sharing that?

MR. MONTGOMERY: Yeah. As Ditka says, the past is for losers.

[Laughter.]

MR. MONTGOMERY: And if we can get the past and the future out of our minds and stay in the present moment, I think we can actually be much more productive.

I had an opportunity to try out for the Bears. It was the year I took off. I suffered a-- I didn't get a contract on, and I suffered a concussion when I was playing with the Detroit Lions, and just didn't, didn't have the fire anymore and decided to quit football. I tried out a couple of times. I tried out with the Bears, and it didn't work out.

But, you know, the fire came back. So trying to understand how the brain works and how these rhythms work within our bodies, figuring out a way to steer them is something that I've been studying, that I've been looking into, but as far as manifestation, I'm still Archimedes. I haven't

gotten into the bathtub yet.

I'm anxious to move forward, but I've been dealing with the dark night in my soul for the last two years, and the more I can share my story and the more that I can provide people with the hope that they can get through these tough times, it's therapeutic for me as well.

I was, I have to say that I've experienced symptoms of PTSD, and I think that was due to the fact that when I was first diagnosed, I was medicated, and I was medicated for 16 years until I started doing some studying on the long-term effects and side effects of these very powerful drugs, and I decided I wanted to take a holistic method to it.

I believe that we're powerful beings, and we can actually engage in practices of meditation, exercise, and healthy lifestyles, getting rid of destructive behavior patterns, and make the proper adjustments of recovery and move through it. But after going off the medication, some of this Post-Traumatic Stress came up, Many of the things that

I hadn't dealt with from my childhood, my failures throughout my life, and other stressors, and I got into a manic stage and had to go back on medication, but I weaned off again, and I'm having success with it.

But I just want to emphasize that I truly believe that our thoughts are things. I mean we are all beings of light. We are all energy, and where we direct that energy creates the reality that we're in, and getting rid of those past thoughts and getting rid of those thoughts of the future, we can focus on the present moment and manifest our heaven on earth if we can actually comprehend that.

But the holistic method and metaphysical approach is something that I agree definitely we need to look into.

DR. BROWN: Thanks, Greg.

You mentioned holistic approaches within your next steps. Lily, share with us what you see through your next steps with regards to your Web site, your interactions, your outreach.

MS. CASURA: Okay. I'm contemplating writing a series of books about the veteran experience, more booklets than books because nobody has got a long attention span anymore, but there are so many aspects of this that really haven't been addressed, so many questions that people still have.

A lot of resources still need to be delivered to the community. Everything from how does faith impact this to how does nutrition impact this to what's the woman veteran's experience like? What about male sexual trauma? Men as victims, not as perpetrators. Many, many topics need to be handled, and people are very uninformed about these, or at least these are the ones they're still uninformed about.

They're basically five things that I want to talk about, and I don't know if I'll have a chance to talk about them in-depth. I just want to list off what those are. If I, as the interested other, not really a part of you, but what do I witness and what do I see from the years that I've

spent working with veterans and helping them overcome PTSD and sharing information with them.

I think the first thing is to acknowledge and address the still open wound of Vietnam, and I can't say that strongly enough. I think as a society, before we move on and put all our resources into treating Iraq and Afghanistan vets, we need to go back and apologize for what we didn't do as a society with Vietnam veterans.

I probably feel this more strongly than anything else. They come out of the woodwork. They have been second-class citizens. They have been shunted aside. They are the inferior little brothers and sons of the World War II veterans who we believe did not struggle with PTSD. We call them the "Greatest Generation." The truth is they do struggle with PTSD. They drank heavily. They invested themselves in their workaholism and they produced great things for the country.

But in retirement, those same memories come flooding back, and that's when you struggle with PTSD. Their suicide rate is actually higher

than Iraq and Afghanistan veterans, and yet if you were to quiz ten people on the street, they would all say World War II veterans, there's something about them. They're just higher character people. It's these young ones we need to worry about.

No, not true. We need to become much more informed as a society about PTSD is a consequence of combat. Suicide is a consequence of PTSD. We need to embrace veterans from every generation and what they struggle with, and I don't think it's okay for us as a society to leave the open wound of Vietnam and just move on.

It's like when you're in a relationship with someone, and you do something wrong, and you give them a crummy apology. They sort of forgive you, but they don't really feel right about it. When people say, well, if I hurt your feelings when they know very well you did hurt their feelings.

I think it's time for us as a society to admit who we weren't and who we should have been and bring Vietnam veterans back into the fold. Give them the welcome home they deserve. Don't

keep making them welcome each other home. We know enough as a society to do that.

The number one preventative for PTSD is social support. And when we don't give that, we create public health consequences.

[Applause.]

DR. BROWN: That was your first point.

MS. CASURA: Yeah. That's the main point though.

DR. BROWN: Okay.

MS. CASURA: Do you want me to go over the others quickly or no?

DR. BROWN: We have ten minutes. We have some questions. There are a couple of items I'd like to ensure we incorporate. If you wouldn't mind, hit them quick.

MS. CASURA: Okay. That was the main one.

DR. BROWN: Now that one was beautiful, and I don't want to cut you off.

MS. CASURA: And I even have an idea about how we could do that, by the way, so ask me later. It would be cool.

Okay. The next one is own the problems at the top, meaning four-star general level. Own them with passion and integrity. I think we saw this with General Chiarelli. I think a lot of us understand that the military is so top down that if the top people don't own these issues--PTSD, MST, suicide--it's not going to filter down where it needs to. So that's number two.

Three is let's normalize the situation. We talked about the World War II vets. Let's get rid of the biases and the prejudices about who struggles with this and why. It's very common.

Military sexual trauma, we can't afford to forget it. It affects an equal number of men and women although they serve in different numbers in the force, and what you see with it is different from civilian rape. You see people who do not recover. I like to call it the long-tail of trauma. Decades later they have not shared with the most important person in their life what they've gone through, and there is something about the military environment that makes it tougher for

them to recover. It feels like incest to them, and they talk about command rape being just as difficult to overcome, if not more, than the rape itself. We need to just admit these are problems and deal with them at an ownership level passionately from the top down.

I think we need to preserve institutional knowledge whether it's at the VA or DoD.

DR. BROWN: We've heard throughout the day. Yeah.

MS. CASURA: Yeah. Suicide especially.

And we need to address the financial disincentives for healing. There are ways that veterans can heal from the symptoms of PTSD, but the compensation system is set up to reward disability.

DR. BROWN: And you mentioned something that came to mind when the General in the first panel had mentioned the "cork." That he was able to successfully cork everything down. And I think at times we're guilty of making false equivalency assessment throughout the combat, the wars that we

have with World War I, Korea and Vietnam.

Jim, you and I spoke about this. The cork, so to speak, now for our servicemembers, men and women coming back, I think the bottle is slightly different with TBI, and those individuals didn't have an opportunity to return previously. With the advances of medicine, they're able to.

Would you please elaborate upon that for us?

DR. KELLY: Well, I think what is acknowledged throughout the military health system is that we've never subjected military personnel to what we've subjected ours to in the last 12 years. This is a whole new pattern of repeated deployments.

A variety of problems that they experience even in the training and preparation before redeploying to the war zone and, again, as was emphasized earlier, the all-volunteer Army piece of this, that people have raised their hands and put themselves in harm's way, but they do it time and time and time again, and it's not the pattern that

we've had previously with our military.

And so it's hard to make those equations between World War II or even Vietnam and what it is that's happening now, and I simply, I'm not one of those people who buys into this idea that the younger generation is softer or in some way vulnerable. These people are tough as nails. They are tough as nails, and for them to come back--

[Applause.]

DR. KELLY: --with the problems, under the circumstances, I think what we need to do is innovate, is look in more depth, understand them as people, as individuals, that have been engaged in ways that we simply have no good track record to point to to say this is what that's about, and here's what you do about it.

We're learning as we go. I'm engaged with my team in helping that particular brain problem of concussion and PTSD, but it's a much more pervasive problem than that, as has been pointed out, and there's also a piece of it that I think, at least I hadn't heard since I've been here today, I find the

military and civilian distinctions fairly artificial.

I don't feel like I'm not military just because I'm a bearded academic. I work in a military environment, and I'm honored to do it, and I'm a part of the team, and I'm engaged with it, and I can tell you that the servicemembers that I work with don't seem to care that that's some kind of distinction that we otherwise in society have placed on ourselves.

And I think we have to get past that. We have to look at all of us together engaged in this process in a much more forward-thinking and integrated way, and I'm not just using those words. I mean truly break down the barriers and make it possible for our military to get the care that's available in civilian sector areas and for the military and what we're learning, to be incorporated more quickly into the civilian sector because that's got to happen, too.

DR. BROWN: Speaking of breaking down barriers, I mean you can't beat having a football

guy here for breaking down barriers, and as we transition in our topic here, we're looking at innovative practices now and in the future.

Lead us, if you wouldn't mind, Greg, with ZenPunt. Tell us what ZenPunt is, and I'll then cue into the card.

MR. MONTGOMERY: Well, ZenPunt is just me integrating people envisioning what they want to accomplish on the football field as they go through the process of punting the football, envisioning the perfect punt, and creating your own reality with your mind's eye, and that's something that I agree is applicable to the mental health community as well.

I mean we're very good at treating symptoms, but we're not that great at finding the cause and acknowledging there is pain there, addressing the pain, feeling the pain, and then finding a way to let that go.

I want to promote taking our brain back. I want to promote understanding that our life is perfect; it's serving a purpose. We have to find

the lesson within the trauma, understand that this is our path, and then understand that we're artists. I mean we can rewrite our story depending on what we want to manifest. So that's about it on that tip.

DR. BROWN: Thank you, so much.

Transitioning into the interactive period, I don't know if this is where they dim some of these lights off us and bring it up for the room or not. I'm not trying to direct the technical staff here, mind you, and by the way, I don't officially speak for the Army while here. This is my words so I don't want to go back and find myself unemployed.

We've got some wonderful cards here. One is from a chaplain, and I'd like to give, I believe, it's sir, the opportunity to highlight some of this to which you're referencing. The Warrior Weekend, CREDO, linking veteran services and leaders and communities and faith-based opportunities together.

I'm familiar with CREDO and Warrior Weekend, but the individual who wrote this, would

you mind going to the mic and sharing with us?

Thank you.

CDR SMITH: Need a time limit, sir. Two minutes, five minutes, 30 minutes?

DR. BROWN: Oh, oh, oh. Quick highlight, sir.

CDR SMITH: One minute.

DR. BROWN: A minute, please. Thank you for asking.

CDR SMITH: Well, I agree, we need to get rid of Descartes because we are mind, body and soul, and what we've kind of not mentioned is the hope and the faith piece in that, and thank you, sir, for mentioning part of that.

What is CREDO? Back after the Vietnam era, there was this guy by the name of Don Harris who got together of bunch of warriors who had returned and took them up in the hills of San Diego, and they sat around, they didn't smoke cigars, but they did listen to music.

What they found was a safe place to talk about whatever it is that was on their mind and

take care of one another. It goes back to what Dr. Jonathan Shay wrote in the book Achilles in Vietnam. If you haven't read it, I would recommend you picking that up.

Warriors always have and always will talk to warriors. That's why we found the Greatest Generation when granddad's friends came over, they sat on the back stop. What did they do? They drank a beer and they talked about war stories. We learned things about them that we never knew before.

CREDO, the PGR--it's a terrible name for what it is--I'm calling it the Warrior Weekend--is available only to active duty and their dependents. It used to be available to veterans, anybody with an ID card, and their family members. It's not any longer. I'd like to make it available to those who are--who have veterans' associations, services, corporate America, and then our community-based, faith-based and not faith-based organizations. It's a great avenue to facilitate warriors getting together and taking care of one another.

DR. BROWN: Wonderful. Thank you so much.

We've heard today, by the way, about peer-to-peer, and I've heard some people say, hey, I know there isn't research to support this. I'd like to direct your attention to Defense Centers of Excellence Web site, and they have a white paper on that and some science behind it. So thanks for referencing that again.

I don't want to do this injustice. This is from a Sarah Stierwalt, and this is with regards to spouse caregiving, caregiver training prior to and/or during deployments. Ma'am, would you like to speak to that a bit?

MS. STIERWALT McALOON: Sure.

DR. BROWN: Did you just run out?

MS. STIERWALT McALOON: I'm right here.

DR. BROWN: Okay. Super. Thank you.

MS. STIERWALT McALOON: Sorry. Can you hear me?

DR. BROWN: Yes, ma'am.

MS. STIERWALT McALOON: Okay. In my life experience, I grew up with a mother who's in the

Air Force. She's still serving, she's a lieutenant colonel, and one of the phrases or two-words that got thrown around a lot were "military family."

As a military family, you PCSed together, you go everywhere together, your spouse gets orders along with you to go places, you do things together, but one thing you don't ever hear is "my family is deployed." When my mom deployed to Kuwait in 2006, I had a mission, to take care of my five-year-old little sister. My dad had a mission to take care of the family, and my mom had a mission to take care of our country.

I think it's important that we need to focus on the rest of the family. We need to--

[Applause.]

MS. STIERWALT McALOON: We need to take into consideration that while everyone is out serving our country, the spouse, the children, they're still at home, and I thought that it would be a really great idea to have a briefing for the military family, including the children, to go and learn about what's going on overseas for that

particular mission. Obviously, you can't always say where the soldier will be stationed at overseas, but it's great to hear that and what they're going to be--what's going to be happening when they come home.

DR. BROWN: Wonderful. Thank you.

[Applause.]

DR. BROWN: We're almost up on time with our call to action here, but I do want to call on a Dr. Kimberly Goodwin mentioned, suggested a cultural change within the NCO to lead the way. Dr. Goodwin, are you here to elaborate on this a little?

DR. GOODWIN: I am here. My son is here with me.

DR. BROWN: Wonderful.

[Applause.]

DR. GOODWIN: He's who I wrote about.

MR. GOODWIN: Oh, jeez, I didn't expect this. So my name is Jeremy Goodwin. I spent eight years in the Marine Corps. I just finished last day of active duty about three weeks ago. So--

[Applause.]

MR. GOODWIN: What my mother is referring to is the involvement in the family readiness and the family support for trying to integrate vets into that role--combat vets, the guys that have been there before. I have experienced several different types of deployments. I was in Iraq, Afghanistan, and my last one was to Libya, and I've had varying degrees of family interaction from the readiness officers in the FROs, both at battalion level and then the company level or platoon level in the Marine Corps.

And a lot of them were spouses that stepped up to the plate thankfully, but I think it's vitally important to try and figure out a way to integrate veterans into that role because no other one knows the experience of and is able to articulate to the families obviously within a classified level and just touch on all aspects of everything that deployed servicemembers deal with from the VA to TRICARE to just communication overseas, what to send in care packages and stuff

like that.

I think--and then kind of letting them know what do they expect to deal with when the veteran comes home--I think if there's a way to integrate combat veterans or those that have been in that, gone down that road before, I think it would help with the transition both from the veteran and then from their families so they can merge their lives back together in a more seamless transition.

So I believe in that, and I'm actually helping out. My company is deploying in the spring over to Afghanistan, and I believe strongly in this, and I've volunteered to be that kind of guy to help, and I've had several of the girlfriends, spouses and wives already e-mail me and say, you know, this is awesome. I want to pick your brain, text you every single day and ask you all these questions. So I didn't expect to talk like this, but maybe, you know, service-wide, if we could look to identify a program or something like that, I think that would be very helpful.

DR. BROWN: I'd like to piggyback with what you said and open the aperture a little bit. You had mentioned the term "guys." Today in unconventional warfare, it's guys and gals. Everyone is out there.

MR. GOODWIN: Absolutely.

DR. BROWN: There is no front line.

MR. GOODWIN: Absolutely.

DR. BROWN: And I think it's important that we're as inclusive as we can be with taking steps in that direction.

MR. GOODWIN: Definitely.

DR. BROWN: In the call to action. So unfortunately, we're up on our time, but I thank everyone for contributing and volunteering your ideas and listening to the ideas of the innovators here up on stage. We were, in essence, warned earlier than we've got to keep the momentum going five years, ten years, 15 years out.

I'm reminded of an opportunity to hear at a meeting General Myers, a former Joint Chiefs of Staff, who had warned after Cold War, we had a

little bit of a brain drain, and we don't want to lose this expertise. We don't want to lose these individuals who are at the cutting edge. We need to project out where we're going to go.

So I thank you so much for your time.

[Applause.]

VADM RYAN: Thank you all so much. How about one more round of applause for the group?

[Applause.]

VADM RYAN: Okay. We're going to switch our last two speakers around, and Brian has agreed to go last.

Our next speaker is Senator Sanders, who is the chairman of the Senate Veterans Affairs Committee. Senator Sanders was elected to the Senate in 2006 after serving 16 years in the House. Before that, he was mayor of one of the prominent cities in Vermont, Burlington.

He's known as the "champion for the common man," and as chairman of the Veterans Affairs Committee, he has been a tremendous champion for all of our veterans and their families. Please

help me welcome Senator Sanders.

[Applause.]

SENATOR SANDERS: I feel a little bit guilty coming up here because I was enjoying that previous conversation so much, and I don't know that I have a whole lot more to add, but I did want to thank Vice Admiral Ryan of the MOAA for inviting me to be with you today, and I want to thank all of you for being here and for your interest in this enormously important issue.

Today's focus on mental health is critical, and I commend you for making it a priority. Events like this serve as an important opportunity to raise awareness among members of Congress, the administration and the wider community regarding the issues surrounding behavioral health care and the well-being of our servicemembers, veterans, and their families.

When our servicemen and women are sent into harm's way, their lives are changed forever, and I will on a personal level never forget a meeting, a veterans' meeting that we had in Vermont

I'm guessing 15 years ago, and we had many hundreds of Vermont veterans there, and we had a group of folks sitting around a circle, and there were veterans of World War II and Korea and their wives and girlfriends and so forth, and there were people from Korea and World War II still having nightmares about their experience.

There was a woman who jumped up and participated in the discussion and saying that her husband on one night woke up and tried to strangle her because he thought he was in a very different place in a different world.

So these, what the men and women who go into war go through is something that in many instances is just not forgotten, and our job is to make sure that when our brave men and women come home, that they get the care and the understanding that they need, not only from their families, from their friends and from their coworkers, but also from the entire community, as they transit into a successful civilian life.

The more people know and understand about

mental health, the better prepared we are all to help remove the stigma associated with seeking treatment, and I'm sure that that is an issue that has come up today.

All of us clearly recognize the physical and visible wounds of war, but all too often the invisible wounds of war in service are not fully appreciated, but just a couple of months ago, I was out at Walter Reed Hospital observing the wonderful work that our people there are doing with prosthetics, making sure that our soldiers who have lost their arms and their legs are able to gain as much use of their limbs as possible, and some of the innovations are extraordinary, but the truth of the matter is that no less attention should be given to any veteran who is suffering with mental health issues.

And let us be very clear, and this is a point that I think that has not been made often enough. The wars in Iraq and Afghanistan alone have cost us some 6,600 American lives. But tens of thousands--no, that's wrong--hundreds of

thousands of men and women have returned home from those wars with varying degrees of PTSD and Traumatic Brain Injury--hundreds of thousands.

We have in front of us a huge problem which cannot and must not be swept under the rug. It must be faced as openly and as honestly as we can, and that is what you are beginning to do here today. That's what you're trying to wrestle with, and I applaud you for doing that.

The timing of today's event is particularly appropriate as September is Suicide Prevention Month. This month gives us the opportunity to highlight the importance of mental health care and the consequences of failing to properly treat it, and let us understand, by the way, that suicide and certainly mental health issues are not just a military issue or a veterans issue.

It is a national issue impacting people from all walks of life in every state in this country. Untreated behavioral health problems can be just as dangerous, just as fatal, as untreated

heart disease, and we must be vigilant in our joint efforts to help end veteran suicide.

As chairman of the Senate Veterans Committee, I am committed to this effort and to ensuring that the VA provides timely access to high quality, appropriate mental health care to our veterans and to their loved ones as well.

I believe that VA is making significant progress in its effort in suicide prevention and mental health care, but clearly much, much more needs to be done. The VA has made strides in providing mental health care to veterans. VA is leading the field and, by the way, working closely with their civilian counterparts on PTSD research.

It has also recently completed an unprecedented hiring process to bring 1,600 new mental health professionals into the VA system, and the challenge there is that while we bring in these new professionals and while we want to make sure that the quality of those professionals is as high as possible, we must also make sure that we are doing it in a timely manner and that we bring them

in as quickly as we can.

VA clinicians must also be properly trained to consistently deliver high quality care to each and every veteran, and I believe that the VA has made some important steps forward in this area. VA clinicians are now trained in evidence-based therapies such as cognitive behavioral therapy and prolonged exposure therapy. These therapies are difficult. They can be exhausting for the veteran. They can bring difficult and often frightening situations to the forefront of a veteran's mind.

We must do more to help veterans complete the entire course of therapy. VA must also do a better job tracking both the utilization and completion of these therapies so that we can be certain that veterans get the most out of the care that is afforded them.

While these evidence-based therapies work for a number of veterans, we must also be prepared to think out of the box and provide other forms of behavioral health care. In particular, strong

evidence points to the effectiveness of an integration of what has traditionally been called complementary or alternative health care to the VA tools that they're currently using.

And I am proud to say that the VA has been cutting-edge in a lot of these areas and to tell you that we have just passed out of committee legislation that would significantly increase the ability of the VA to use such therapies as acupuncture, guided meditation, massage therapy, and other therapies, and make them available to more veterans for mental health and for chronic pain care. So I think we're making some progress in that area.

VA must continue to provide care in a variety of settings to meet the individual need of each veteran. In other words, there's an appropriate time and place for each particular concern, and obviously we have 152 medical centers who are doing their work. We have 900 CBOCs, community-based outreach clinics. We have vet centers, and we are using and doing cutting-edge

work in telehealth services, which is extraordinarily important, especially to veterans in rural areas, and each one of those settings plays an important role in appropriate care delivery.

VA medical centers are well equipped to treat the most severe cases that they see, such as PTSD. They are also critical in addressing the mental health care needs of patients admitted to the hospital for physical injuries.

Vet centers I think are underutilized. I don't know that everybody knows about vet centers, but vet centers are there for veterans who served in combat. They are more informal. They are often run outside of the bureaucracy. They're run by veterans themselves. They're often located in a house-like setting where people can come in, you can come in with your wife, your girlfriend, your boyfriend, whatever it may be, and informally discuss some of the issues that are on your mind.

I think there's a lot, they're doing a great job now, and I think there's a lot more

potential for them.

Furthermore, while we always can make improvements, we as a nation, and I'm chairman of another committee which deals with this issue, we have a real crisis in terms of primary health care, and that touches on mental health care as well, because at the end of the day, what we want as a nation is when people are in trouble, physically or mentally, to be able without much problem to find somebody to help them, to be able to walk in the door.

I can tell you that in the state of Vermont, if you, and I think this is true all over this country, if you are suffering from serious mental health issues, and you don't have a whole lot of money, it is hard to find the care that you need, and what the VA has done, which is pretty good--it can be better, and we've got to improve it--but we have now 900 community-based outpatient clinics all over this country, and the door is open to any veteran to walk in that door, and that is a significant step forward.

So it is essential that VA provide all kinds of options for the most severe situations, for mild situations as well, and we've got to do it in rural areas, in urban areas, all over this country, and we must ensure not only that these options remain available, but that veterans know about them.

And of the issues that I am working on right now--we've had a hearing on it--we're working just yesterday--met with the VA fellow in charge of this--is the whole issue of outreach, and that is, by the way, what you were doing today, and the truth of the matter is the VA or any institution, no matter how good the program may be, no matter how good the service may be, it doesn't do anybody any good if the veteran doesn't know what he or she is entitled to.

And the VA is making some progress in that area. Historically, in my view, the VA has not done a good job, and I remember ten years ago, holding meetings all over the state of Vermont, and hundreds and hundreds of veterans were coming out.

They did it with the VA, and they said, oh, we didn't know we were entitled to this, and, in fact, recent surveys have indicated that over half of veterans in America don't know what they are entitled to, but we're making some progress.

If some of you go to the VA Web site right now, you'll find it to be a lot better Web site than it was a year ago. Some of you may have seen on TV some pretty good ads telling veterans about what they're entitled to, what the VA offers, urging them to come in to the system. There are radio ads, and that's just the beginning of a major outreach benefit, major outreach program, to say to the men and women, the 22 million men and women in this country who have put their lives on the line, that the VA is there for them, these are earned benefits, and come into the system. And that's something very important that we're beginning to make some progress on.

Another issue, and I know that you've probably gone over all of these issues throughout the day, is to take a moment--I'd like to take a

moment to acknowledge the role, and I heard that question come up in the last discussion that you had about the role of veterans' family members and caregivers, and I think the woman who asked the question about family is absolutely right. It's not just the soldier, not just the servicemember, who is dealing with the problems. When that person goes to Iraq or Afghanistan or wherever, that person is often leaving a wife or a husband and kids behind, and if we're going to do our job well, we have to understand that this is a family issue and not just the individual soldier as well.

[Applause.]

SENATOR SANDERS: And in Vermont, we have established an outreach program. We've got some money to do that, and we're knocking on doors there talking to the veterans and the wives and the kids because we understand this, in fact, is a family issue, and I pay special attention to the children. If anybody here thinks it is not a traumatic experience for a child to suddenly see his dad or his mom disappear and to be placed in harm's way,

then you would be very wrong. This is a traumatic situation for that child, and that is something we must be very, very mindful of.

So in terms of the caregivers program, some of you may know that a couple of years ago, we passed what I thought was good legislation, and what the legislation says is that we understand that right now in our country, we have many, many disabled vets, and who's taking care of them?

Well, in many cases, it is the wife, the mother, brother, sister, family members who are taking care of them, and those folks are living under great stress as well. So we passed legislation a couple of years ago that would provide modest stipends to those caregivers, give them the training that they need to do their job. Even better, give them the kind of support that in many cases they are lacking.

For financial reasons, that legislation applied only to post-9/11 veterans. We have just gotten out of committee legislation that would expand that program to all veterans and their

families, and I think that's a step forward.

[Applause.]

SENATOR SANDERS: So let me just conclude by once again thanking you for focusing on a very, very difficult issue, which has no simple solutions. These are very tough issues, but they are widespread impacting hundreds of thousands of our veterans. Our job is to make sure--you know, one of the really wonderful things about the military, of which civil society has a lot to learn from, is the military does not leave their soldiers behind on the battlefield.

And what we as a nation have got to understand is that we do not leave our vulnerable people behind in civilian life as well. So we're all in this together. We're trying to tackle a widespread and difficult issue. It's certainly a major issue for the Veterans Committee and for the veterans' community, but it is also a major issue for our society as a whole, and I think our entire country is going to be learning a lot from what we do in terms of the veterans' community.

So thank you all very much for your service to our country. Thank you very much for highlighting this terribly important issue, and let's go forward together. Thank you very much.

[Applause.]

LTGEN FARRELL: Thank you, Senator Sanders. We appreciate your leadership on the Veterans Committee, the Veterans Affairs Committee. We appreciate your passion and your understanding of these issues, and thank you very much for your time today. We know it's a busy time to be a member of Congress right now, and so we thank you for taking time out to be with us.

We're going to turn now--is Brian here--

MR. DELATE: Yes, sir.

LTGEN FARRELL: Hey, okay. Great. We're going to bring on Brian Delate to talk to us. Brian is a veteran of the Vietnam War, 1969 to '70. I was there in '69 so we were close. He served as a decorated noncommissioned officer, and he's done a lot of interesting things since. He wrote and directed an award-winning indie feature, "Soldier's

Heart."

He's had a lot of diverse activities in film, theater, and TV. He's on the big screen working with a lot of actors you know, Al Pacino, Jim Carrey, Jodie Foster, Laura Linney, Ed Harris, Tim Robbins, and others. He's been in the following movies: Wilde Salome; Nice Guy Johnny; The Brave One; Shawshank Redemption and Truman Show, two of my favorites; Buffalo Soldiers, another favorite; Home Before Dark; Sudden Death; and more.

He's right now currently writing and producing Memorial Day, which is a one-man show, with the famed Actors Studio in New York City, and the subject of it is PTSD, and so we all look forward to seeing that.

So here we have a veteran, a writer, an artist. Thank you very much, Brian.

[Applause.]

MR. DELATE: Thank you, sir.

Let me take this in. Thank you, sir. Thank you, General Farrell, Admiral Ryan, Kathy,

Jeanette, Janine, Ana, you guys have been fantastic. This is--this is--I'm really nervous, and I'm going to tell you why, because I'm in the middle of some kind of divine convergence because, yes, I'm a combat veteran from Vietnam, et cetera.

I ignored that for many, many years. Didn't want to think about it. I had the sort of the bad year back that you hear about a lot. That was my story from, in 1970, when I returned home. I found college, and I went into college out of an act of desperation. I didn't know what else to do with my life because I was truly at that time in the middle of suicide, homicide madness.

And college saved me, and then I found theater in the second year of college, and that took me further into having a purpose. One of the things I'm incredibly grateful for, and I was talking about this with Reggie earlier at lunch, was that before the Army, I didn't have any structure. There was no structure, and so the structure that I found in the Army forced me into an excellence I didn't know I even had or it took

me into areas of leadership and responsibility I didn't know I was capable of.

So that, those tools, served me later when I went, when I decided to give college a try because I had had learning problems and reading problems and all that stuff, and once that stuff got straightened out, and I got my focus in school, I started to move forward with my life.

The theme I want to start and end with today, and I'll try and make sense of this before we finish, is nothing is missing. Okay. What do I mean "nothing is missing"? I've been to Vietnam now, this will be my third time, I'm going this Saturday night to Hanoi, to do the play Memorial Day, "When remembering makes you want to forget and being forgotten makes you want to die."

Now, it's expanded. It was a one-man show. Now, it's what we call a two-hander, and I've been working with an incredible actress, Elisa Matula, in New York. When I go to Vietnam to do it, the actress I'll be working with is, her name is Miss Lai Kan [ph]. She is their sort of Meryl

Streep of Vietnam, and she will do her part in Vietnamese. I will do mine in English, and we will have subtitles for both.

Also, my friend Dr. Edward Tick is bringing a group of veterans. We've also invited the students from the University of Hanoi, and also their veterans association will be present with a lot of their membership, and there will be a dialogue to follow that.

We're filming all this, too, so we're a real work in progress with that, and if anybody wants to speak to me afterwards about getting involved in that, please, please, please do.

Anyway, "nothing is missing." The reason I say that is that for many, many, many years, I always secretly felt something was missing, and I always felt that way ever since I got home from the war, and it was a shadow that sort of followed me, and one of the things that I guess, it would show up in the form of where every once in awhile, I think I was outrunning what we call PTS or PTSD.

And I'd think I'd gotten away from it, and

like a shadow, it would be there, and that's when it would make it me think something is missing, and I didn't want to look at--I didn't want to look at the places where I red-lined in terms of fear, behavior. I didn't even--I didn't even do well with taking in my accomplishments. So I always felt that something was missing.

Now, this past January, I went to a book-signing ceremony or a gathering of about two or 300 people at this auditorium in Hanoi, and we were invited to join the cultural ministers and meet this woman. She was, she's a psychic. She's a psychic and I guess a medium, and she's helped over 10,000 families find the remains of loved ones in the South from the war, and she's even helped some American families.

Now, she doesn't do this with a crystal ball. You have to give her information and all this stuff. I just found it to be totally remarkable, and I went to meet her. Because it was a long day, I wanted to get back to the hotel, and I wanted to be kind and polite and thank you very

much, and good luck with your book, et cetera.

And she said through her translator tell him nothing is missing. I said what? Okay.

[Laughter.]

MR. DELATE: Nothing is missing. You know. Thank you. Okay. I got to go now. So I thought about this. Now when I was there, I was in a city called Hoi An, which wasn't far from Chu Lai, which is where I spent some time, and in Hoi An, there was a nice hotel, and the waiter, the busboy, whatever, came by, and he looked at me, and we made eye contact in a very direct way, and it was like--I call them emotional tumors--started down here and basically erupted, and I ran out of the hotel.

My wife was sitting there. I left. I came back about 15, 20 minutes later. Now, I need to take you back to 1969, the reason this happened. In 1969, I came in off of a night-time perimeter patrol duty. I was a sergeant. I had a squad, sometimes two, and we were out. We'd be doing this for a few nights, and we were getting snipered at,

and everybody was tired, and there was a young Vietnamese man who looked at me derisively, and I just lost it, and I proceeded to beat him almost to death, and I kicked his eye out, and I couldn't stop myself.

I was up here watching from above, going what are you doing? What is this? And the guys that I was with, we were all burned out. Nobody tried to stop me. One guy did. So I never ever ever felt good about that, and there's a movie called "The Mission" with Robert De Nero and Aiden Quinn, and Robert De Nero kills his brother, and to punish himself, he drags around this armor on a rope for weeks and weeks and weeks, and finally, it looks like these Indians are going to cut him with a knife, and what they do is they cut the rope to free him, and he cries.

And I found that I did this--it was a purging, and I feel very blessed that this purging took place because then I went back into the dining room of the hotel, and the same waiter came by, very politely, would you like some more tea, sir,

and we made eye contact, and I said yes, thank you, and he gave me more tea, and life went on, and I explained all this to my wife.

I feel like, you know, what, the thing that's so remarkable about this day and the reason I say I feel like I'm part of a divine convergence is I look at this language, and part of my mission is to create what I call or what I've heard writer Paula Caplan call "war literacy," which is a language to bridge veterans with each other, which is a little easier to do, and veterans with the greater community, which is not so easy to do, and even people in the community with each other so they can possibly understand what a combat veteran has gone through.

It's come up today, and I was glad I sat through the day to hear other people because just to realize I'm on the same page as the people I heard here today. One of the most important things I ever did, and I try to encourage other veterans to do, young or old, is to get their story out. I didn't, I didn't think I had a story, you know. I

just didn't--well, I didn't think about it.

And for me, my life changed on 9/11, 12 years ago yesterday. I was downtown because I live in Manhattan. I was downtown, outside with my friend and sister Brigitte, and we were standing there, and I heard the sound first, and it sounded like a rocket, and it was the first plane going about 550 miles an hour. It was on a thousand feet above me, flying like this, and the split second I saw it and heard it, I thought, oh, my God, this plane is in trouble, and the pilot is trying to get it to the water and not crash into people.

And it goes bang, right into the North Tower, and I--this is my reaction at the time--I was furious with God. How, why do I have to witness this? Yeah, you know. Now, little did I know that in the days, weeks, months following, that my story was going to start to emerge whether I liked it or not, and I was going to have to take on my story, and I didn't want to take on my story, but I felt like I was sinking like a rock in my life.

I started becoming more and more dissatisfied with life. I started looking at things askew. I started becoming more judgmental. My wife said to me later, she said after your PTSD came up after 9/11, she said I felt like I woke up one day and I found out that my husband was living in another city and had another family. That's how intrusive it was in her life.

My daughter at the time was seven years old. She came home. They had been shopping, and I was sitting in our living room. This is in Pennsylvania. My daughter came in, and she had this light kind of alarm. She said, dad, you're sitting in the dark. Whoa. Oh, yeah. Let's get some light on here. I went to the VA the next Monday.

The first time I went to the VA--this is how unrecognizable this stuff can be--the first time I went to the VA was in 1978. I started having nightmares and dreams because after the Army and college and I felt accomplished. I was living in New York and starting to make some money, and

it's fun. I'm having a great time. And all of a sudden, here come the dreams, and I thought am I going to crazy? What is this?

The war was blah-blah, you know, I'm having these bizarre nightmares of Picasso images of Vietnamese and Americans and home, and it was nuts. I went to the VA on 23rd Street. I stood in front of the building, and I threw up. I thought, oh, I'm not supposed to do this. I had no guidance. There was nobody to say, oh, you know what, yeah, you are supposed to do this. Get in there.

So I found at the time--I was very fortunate--I found a psychoanalyst who had been a Marine and he was also a college professor, and the two things I knew that were solid in my life were my military experience and the college experience that followed. So I decided to trust this guy, and I say trust because I believe that is a key factor for, mostly for, I'd say for Vietnam veterans, but I think it's true for most veterans with regard to what we're talking about today, is the trust

factor, because part of the PTS, PTSD symptomology for this veteran is the tendency to want to isolate, the tendency to want to be self-reliant.

PTSD or PTS is a collective wound, which means I cannot take care of it myself. I need to have, I have to ask for help. I need allies. I will be crushed under the weight of it. It's a devastating wound. So I've been on a mission now since 2001. I made this little indie film. We took it over to the GI Film Festival in 2008, and we won their best narrative feature award, and we were up against the Hollywood competition, and if you're interested, Janine has copies out in the lobby.

But I didn't go far enough, and that's why I started to get involved in creating a play because I didn't need the funding then. I could go to the people who are my champions at the Actors Studio and say, please, let me work on this, give me some time, let me really delve into this. And Ellen Burstyn, who is a great actress, but she's also a great humanitarian, she said you go as far

and you go as deep as you like.

In fact, in one acting session, I did something with one of my characters, and one of the old guard said to her, what are you doing here, Ellen? This looks like therapy. And she said that's right, it is. She said now it's his job to put it into an art form, and that's what my job was after that.

[Applause.]

MR. DELATE: Thank you. Just for fun, if you want to visit some, if you want to see some entertainment and put the lens of what we're talking about today, take a look at a couple of movies. Take a look at Lawrence of Arabia. Take a look at Lawrence of Arabia with the notion of PTSD and watch what that man goes through. Cool Hand Luke. We got ourselves a Silver Star winner here. Uh. And he's the guy that says we have a failure to communicate or whatever that famous line was from the '60s.

And also Hail the Conquering Hero, which is a comedy really, but there are undertones in

there of what some of those Marines go through in that comedy.

One of the things that I wanted to gravitate to is a couple of quotes. One is from Joseph Campbell, who talked about heroes, and he says a hero is someone who has given his or her life to something bigger than oneself.

And like I say, my story forced itself out of me. The other thing, too, is that I, I don't come to this town that often, but I have had nothing but positive experiences every time I come here, and one of them was not--was positive, but it was painful, which was my daughter, when she was 12, she came home from school one day, and she said, dad, were you in a war? And I said, yeah, just go look at the stuff in my office.

Oh, yeah. So I took her to StoryCorps in New York. We just went there, and I said I want to put something down. I want to record something for my daughter. It will be the Library of Congress, you know. We did that. Two months later, they called me up, and they said can we air this in the

fall? I said, yeah, sure, go ahead, and they did.

This is like five years ago. Well, I brought her down here. I wanted to take her to the Wall. Now I've been to the Wall a few times, and the first time I went, I was actually kind of numb to it. I was like, okay, what's the big deal? I just didn't--I was whatever. I took my daughter, and I'm all prepared to tell her about the Wall, and my experience, and there's a couple of names I want to point out. As we got about a 150 feet away, I started to lock up. I started to--my whole body was here comes another emotional tumor; right.

And we're walking and we're walking, and she's like, dad, are you okay? And I said, yeah, yeah, yeah, yeah, yeah.

[Laughter.]

MR. DELATE: Oh, I didn't know what to do. So we get near the Wall, and there was--the Parks Commission keeps--they keep a couple of Vietnam veterans there to help, and this guy, he saw me. He was 101st, 1968. He saw me. He walked right over. He put his arm around my daughter, and he

said let me tell you about the Wall, let me tell you about some of what your dad might be able to talk about later, and he took over for the next 15 minutes. So, so moving.

Anyway, part of--a couple of things I want to touch on just briefly, and then I'm going to wrap it up with a little bit of a performance--is we talked about today, we've heard a lot about restoration and restoring the soldier, how much goes into preparation and how much needs to be helped in the processing back of finding some kind of new normalcy for our veterans.

When I got involved in this, and I started working on my own recovery, I did some research, and I saw that in the Native American communities, and especially the Plains Indians, one of the things they would do is, in many instances, for--this is for centuries, they would not allow the warriors back into the community--the elders. They would keep them out of the community. They would sit them down. They'd do sweat lodges, all that kind of stuff, and they'd say you need to tell me

your story before you go back into our community or the village.

Well, I don't really have a story. No, you have a story, and you don't go back until you tell me or tell us, and in some instances they had to tell the whole community their story. They also, I can't remember if this is Lakota or Blackfeet, they would bring little children, little children out to where the warriors were, and they'd have them walk with them and hold hands for an hour to two hours a day to start to help them humanize again because the energy that comes up for combat veterans, and it can save their lives, or it can go out of control, is what the Vikings called the berserk energy, and that can be one of the most valuable weapons a soldier can have.

In fact, I was on a retreat a couple years ago with an active duty chaplain who I said to him--I said what are you telling the guys that are going over there now? What kind of spiritual advice do you give soldiers that are going over there to have to possibly kill people?

And he said I remind them that they have a soul. I remind them that the man next to them has a soul. I remind them that the enemy has a soul, and when they have to pull the trigger, that they do it with remorse, but it's part of--it becomes part of their package as a combat soldier.

And that's the thing because one of the things that happened in my experience, and not all of Vietnam, but there were slides off the moral compass that hurt us and hurt everybody, and you have to make up for that. It has to be done.

One of the things I had the privilege to do in April with--I took like these samplers of my show that I'm taking to Vietnam next week. I took 15-minute portions, and I took one to the Psychology Department at Duquesne University. I went to a veterans organization called Counterparts in Las Vegas that was a Vietnamese and Americans who had worked together back then during the war, and while I was at Duquesne, I met a psychologist named Denise Mahone, and her father had been where I was, and we had a remarkable exchange, and one of

the things that she says--and this is called Health Progress. It's a Catholic health magazine, and I have an article in it with Dr. Tick, which there is one copy out there. You can look at it if you want. Take your turn.

Anyway, she says--and this is really important--she says though our culture has come to think of psychology as a science of the mind, "psyche" means soul, and in the work with veterans, acknowledging this root meeting of the word is essential to trusting the depths to which we must try to understand the veteran's experience.

We civilians are vital to the veteran's return, just as the veteran's soul wound opens up to our own capacity for deep witness to the divides within ourselves between the armored and the wounded, action and receptivity, heroism and retreat.

The warrior's story and pain require a deep listening to both the veteran and to the heart of our inner self, a center which comes to encounter itself via the other. This listening

must acknowledge our own violence and destruction that the veteran in turn witnesses and enacts on our behalf.

As the Jesuit thinker, Edward McMahon, wrote: If we aren't in touch with our inner life, we have nothing to do but prepare for war.

So I read that, and the man who brought me there, Dr. Brook, Roger Brook, who was in the South African Paratroopers back in the '80s, he studied the, it's called the Zosa tradition where the soldiers or the warriors confess and telling all that had happened. The community has to tolerate the pain of listening no matter how difficult that may be, and they used some of that process when they were dismantling Apartheid. So it became a peacemaking tool.

I'm going to try and finish up now because I have this--it's James Stewart, who you know from "It's a Wonderful Life" and an incredible career in movies. He served in World War II in the Eighth Air Force, which my father served, and I'm just going to get through this.

With the continued escalation of the war in Europe, Stewart enlisted in the Army Air Corps in 1941 but was not commissioned until January '42. His family had a distinguished record of military service. Both of his grandfathers served in the Civil War and his dad, Alex, saw combat near San Juan Hill in the Spanish American War and served in World War I.

When Jimmy left home to go overseas, his dad was so filled with emotion that he couldn't express his thoughts. Soon Jimmy received the following note from his father. My dear Jim Boy, soon after you read this letter, you will be on your way to the worst sort of danger. Jim, I'm banking on the enclosed copy of the 91st Psalm. The thing that takes the place of fear and worry is the promise of these words. I am staking my faith in these words.

I feel sure that God will lead you through this mad experience. I can say no more. I only continue to pray. Good-bye, my dear. God bless you and keep you. I love you more than I can tell

you. Dad.

And he sent him a copy of the 91st Psalm, and just a couple words from it were: "He that dwelleth in the secret place of the Most High shall abide under the shadow of the Almighty. I will say of the Lord, he is my refuge and my fortress, my God; in him, I will trust."

I'm going to finish with a few words from Shakespeare. It's from the play Henry V. You'll know some of the words. You've heard this before. Some people call it the Band of Brothers Speech. It's better--it's known as the Crispin's Day Speech.

It's based on a battle that took place in 1402, I think, called the Battle of Agincourt and where the French were outnumbering the English four, some say five, to one, and the word going around was that the French were not going to take any prisoners, and so King Henry had to rally his men to not only fight but to win, which turned out as underdogs they won the battle, and Shakespeare wrote it 200 years later, like 1604, something like

that.

I get so nervous. I do this speech up at the veterans parade, opening ceremonies in New York, and every time I get in front of veterans, this is harder than Broadway, believe me. Anyway, so in the play, Henry goes around, and he's starting to measure the fear of his men, and the part I want to share with you is the part about remembrance because remembering is so important, not just telling your story, but remembering.

There are a lot of people here today that I feel are allies in that, and that's why it's such a privilege to be here.

Anyway, in the play, Henry hears his own cousin, his cousin Westmoreland, say: O, if we had but 10,000 men from England here now--something like that.

And Henry says to him: What's he that wishes so? My cousin Westmoreland? No, my good cousin. If we are marked to die, we are enough to do our country loss. And if to win, the fewer men, the greater share of honor.

This day is called the feast of Crispian. He that outlives this day and comes safe home will stand a tip-toe when this day is named, and rouse him at the name of Crispian.

He that shall see this day and live old age will yearly on the vigil feast his neighbors and say tomorrow is the feast of Crispian. Then will he strip is sleeve and show his scars and say these wounds I had on Crispian's day.

Old men forget, but all shall not be forgot for he'll remember with advantages what feats he did that day. Then shall our names familiar in his mouth as household words be in their flowing cups, freshly remembered. This story shall the good man teach his son.

And Crispin Crispian shall ne'er go by, from this day to the ending of the world, but we in it shall be remembered, we few, we happy few, we band of brothers. For he today that sheds his blood with me shall be my brother; be he ne'er so vile, this day shall gentle his condition. And gentlemen in England now abed shall think

themselves accursed they were not here and hold their manhoods cheap whiles any speaks that fought with us upon Saint Crispin's day.

[Applause.]

MR. DELATE: Thank you. Just one more minute. Okay. Thanks. Thank you.

[Applause.]

MR. DELATE: I'm just going to leave you with these words. This is from a priest in New Jersey. It's about homecoming. One never comes home until one prefers a gentle heart to mastery over other lives. One comes home when one learns how to bring a gift and to receive one. When one is home, he or she gives love, makes comfort, hurts for justice. One is homeward bound when one is more tormented by the death of innocents and innocent children than by the frustration of ambition.

One makes a home every time he or she allows a person to feel at home with their self. One is on the right road, not far away, close enough to run the last mile when they realize that

the greatest of all gifts to give another is home, and that the most surprising and wonderful gift to receive is homecoming.

God bless America. Thank you.

[Applause.]

MR. DELATE: Thank you.

LTGEN FARRELL: Brian, that was great.

MR. DELATE: Thank you, sir.

LTGEN FARRELL: Very inspiring, Brian. Thank you so much. How do you top that? My goodness. The Saint Crispin's Day Speech is a personal favorite of mine, and that is a great one, and not that many people have read it or heard it, but it is a great speech.

What a great day. Well, thanks to all of our presenters. You know their names. I don't have to go through them, but the chairmen of our panels, the wounded warriors themselves and their family members and their sharing, it's great. It's a great example of Brian sharing there. We appreciate that and, Greg, as well. I mean who would have known this problem exists in other

places.

And we're filming this, and it's going to be on the Web site so both the MOAA Web site and NDAA Web site will have this. So I encourage you to look for it. Inside the first page of your brochure there is the instructions on where to go to get this.

So a final thank to the exhibitors, the sponsors, for their support, and once we adjourn here in just a few minutes, we've still got exhibitors out there and displays so take your time, enjoy that, meet with some of them. I just wanted to encourage you to reflect on what we've seen today and take it away and do something with it.

We've receive a lot of information, but I think more than that, it's made us think about things, and we've heard some really interesting things. I made a whole page of notes of all the things that I saw that I liked, and I'll just share a couple of them with you.

I was really excited to hear about the Sim

Coach and the immersion training. I'm going to look into that. That really looks fascinating. I've heard of other people doing things like that. Pretty fascinating.

I saw that or I heard that love the person that they are. We heard that from a family member. Be happy with the good. You know you don't get great, but you've got to take what you can get. That made an impression on me. I heard the take care of the family as well as the servicemember, and then there was a lot of talk about and a lot of the presentations kind of focused in on the same thing.

It said if you're going to get through this, you need to find a peer with which or with whom you can have a positive association, somebody that you can relate to, somebody that will allow you to get it out of your system, and avoidance doesn't work, blocking doesn't work, and if you don't have the human dimension of the peers, people are isolated, and they can't make progress.

And as Senator Sanders says, you can't

leave these things untreated. So it's important for us I think to find those relationships where we can move forward. I thought that was very powerful, and we heard it from more than one speaker.

The physical and the mental, not separate. I thought that was very interesting. When I came back from Vietnam in '69, I had two physical incidents unrelated to anything else that happened to me, and I got very sick twice within the first week, and I never figured out why it was, but I think the spring was wound pretty tight, and when the spring came loose, all this other stuff happened.

So--and something else when I was listening to Mick Trainor talk, he said when I came back, he said what I avoided was open spaces and places where they can have land mines, and for me when I came back, I was back in my bed, the second night back, and heard a car backfire outside, and right out of a sleep, I rolled off the bed and tried to get under this bed. It was a platform

bed, and I couldn't get under it.

[Laughter.]

LTGEN FARRELL: Then my wife is looking over the edge and says what are you doing on the floor? I said, well, something about rockets or mortars, but like Mick Trainor, that only happened once or twice, and then it was over and I moved on. But funny things happen, and so it made me think back of all the times and things that I did, too, as well.

So I heard some very powerful things from Greg, and we do a training scenario in NDIA that's focused on cognitive psychology. It's delivered by the Pacific Institute, and it's called Investment in Excellence. They also do something called Discovering the Power in Me, which is focused on wounded warriors, people with PTSD and physical injuries. It's called Discovering the Power in Me, and it's based upon cognitive psychology, and it recognizes that people are very powerful and they have a lot of capacities.

As we've heard, our veterans they're well

trained for war and they're really good fighters, and they're taught how to block bad things out, but when they come back, they can't do that, and they lose, somehow lose touch with that power, and as Greg reminded us, we have to help them discover or rediscover that power that's inside of all of us, and we got to find a way to help them want to get well.

And the training that we went through, I'll just share this last thing with you. It relates to something Greg said too, it's how you think is really important, and kind of the touchstone of this whole training was what you think about as you think, so shall you be.

So I think that kind of puts it to--so we've got to get to these guys, got to help them control their thinking because that's the only way they're going to get out of this.

Anyway, I think we've got a lot of institutions around. It sounds like things are kind of disconnected and the Veterans Administration and the Health and Human Services is

trying to bring it together, but it seems to me if I were to say what we have to do, is we have to find a way to bring it up from the bottom of the communities because there are just too many people out there.

There's 1.3 million veterans out there that need help as we've heard. Institutions can't do that kind of training. It's got to come somehow from the communities. I don't know quite how to do it, but there's a notion there that there's a way to do this in the communities, some kind of a community action.

And as I talked, we talked last night at dinner--and this will be my final point--it's important for sustainability going forward. The war in Afghanistan is going to wind down next year, 2014. There's going to be a tendency, and we've heard the speakers say this, there's going to be a tendency to forget about this, and the nation is going to forget about it, but these people who have these terrible wounds and the people who have PTSD, that is going to be ongoing, they're going to be

dealing with this for their whole life, and the nation is going to forget about the war. So we've got to find a way to sustain this whole thing going forward, Norb.

So anyway, thank you all for being here. Thanks to all the presenters once again, and it was great. I thought last year was good. I thought this year was even better. And thanks to Norb and MOAA for envisioning this thing and being so powerful in your efforts to keep it going. We're real honored at NDIA to partner with you.

Let's have a round of applause for the MOAA guys.

[Applause.]

[Whereupon, at 2:21 p.m., the 2013 Warrior-Family Symposium was adjourned.]