STATE OF CALIFORNIA

Edmund G. Brown Jr., Governor

MILITARY DEPARTMENT
OFFICE OF THE ADJUTANT GENERAL
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January 3, 2013

State of California Little Hoover Commission
925 L Street, Suite 805
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Mr. Stuart Drown:

In accordance with your 18 December 2012 letter, I am submitting the following written testimony to provide information for the upcoming 22 January 2013 hearing. Specifically, my submission is meant to provide my observations on the changing needs of the state's veteran population, and potential approaches that state and local agencies can use to more effectively meet these needs. Comments are submitted in direct response to questions posed by the commission in your 18 December 2012 letter.

Question 1: How does the Military Department use behavioral health programs and other services to assist returning National Guard members? How do these programs help ensure the state's readiness for emergencies?

Answer: The California Military Department uses behavioral health programs as part of a multi-program approach to meeting the needs of returning members. Members with Behavioral Health (BH) issues identified while in theater or directly upon return, are addressed through the State Surgeon's office with federally funded support (VA, active duty Military treatment facilities, TRICARE-networked providers) while in the demobilization process or directly following return through Yellow Ribbon events. If they prefer, returning members may use of their own private insurance providers. Should their BH issues not emerge until after Federal benefits lapse (180 days following return) and they are uninsured, VA programs can be an avenue for care. BH staff (4 clinicians and 1 agency coordinator), funded through the Mental Health Services Act, respond to service member needs within their assigned region of California, helping leaders, supervisors, and members connect with support services at all phases of the deployment cycle, or during dwell time. By providing as many avenues of BH support as early as possible, the CNG ensures its members are given more effective care, and are therefore more likely to be retainable and ready when the state needs them for emergency response.

Question 2: How are these programs coordinated? Please include in this discussion a description of the ways the chain of command benefits the organization in its efforts to reach members and create connections between them and personnel.

Answer: All units returning from a deployment have demobilization coordination through the G3 (a centralized Army agency at CNG Military Department). The initial BH screening occurs as units leave active duty status and are "demobilized." The State Surgeon's office is made aware of any returning units and soldiers who are in need of behavioral health support based on a screening instrument, and also based on any incidents that may have occurred during their tour of duty. Treatment can start as early as their outprocessing while still on active duty status through the Federal medical treatment facilities, later in the process through Medical evaluation boards, and even further in the process through the VA. The chain of command is the first line of access to care, when peers, supervisors, leaders identify members who have exhibited BH challenges. The members can also self-report problems they are experiencing, and are encouraged to do so throughout the process of demobilization. During the 30, 60, and 90 day periods following return from deployment, Yellow Ribbon events also create opportunities for units and individual members (as well as family) to evaluate the status of their health and seek any need support or care. These events have mandated attendance. At these events and at scheduled training events for units that are not in the deployment cycle, BH support and ways to recognize members who may be in need of BH services are briefed (during Suicide Prevention Stand Downs, initial entry programs, supervisory training, leadership development, deployment preparation, etc). Between all phases of the deployment cycle, regularly scheduled points in unit training, and through leadership and supervisory courses, the chain of command establishes multiple points of outreach, and connects to individual service members and units Guard-wide. Should an individual soldier experience a BH crisis, a Serious Incident Report and a response is immediately launched from the unit level up the chain of command to CNG Operations (J3). Behavioral Health, Chaplain, and unit resources are accessed, and the case is monitored through resolution.

Question 3: Discuss your experiences as you recently returned from service in Afghanistan. What are the common immediate and longer term needs and experiences for soldiers who return from overseas? How do the National Guard and the state meet these needs, from your experience? What are reforms needed?

Answer: There is a marked difference between a National Guard service member returning from deployment and an active duty member returning to their base. Active component members return to the US and continue to work full time with their units and their peers who deployed with them overseas. Guard members often return, demobilize, and lose the day-to-day support from unit members. Active component members have easy access to military health care facilities, unlike guard members who often live great distances from VA facilities and face legal obstacles if they did not recognize or report injuries or problems immediately after returning from active duty service. Guard members face other points of stress, including a jarring change into a completely different occupation following a lengthy deployment. Sometimes they return to no employment at

all. In my case, I returned to full-time employment—but was concerned about the drastic changes that occurred in my employment when I re-entered the workplace. Changes in workplace hierarchy, individuals who were unfamiliar with my work history and capability, and anxiety about my ability to perform at the level that I did upon leaving my civilian employment, were concerns my active component peers did not have to face upon their return. My experience is a typical one for returning guard/reserve component members. Re-integrating smoothly and effectively to my civilian profession during a period of budget cuts and layoffs was more unnerving to me than rushing into the trauma center during the frequent RPG attacks on my base in Afghanistan. On my first day back to my civilian job, my supervisor chose to formally evaluate my performance with a "no-notice" observation. Having no empathy or understanding of what I had just experienced the previous 7 months in the busiest Military Trauma Center in Afghanistan, my civilian co-workers and supervisors either did not want to know what I had seen and done, or were uncomfortably curious, wanting to know "how horrible was it?" Being able to successfully adjust to civilian life was a continual source of anxiety—especially following the extremely regimented existence I had just left in the combat zone.

How did the National Guard and state meet my needs? Within a month of my return from deployment, a representative from Operation Welcome Home (OWH) called me in response to a form I filled out when I first demobilized from active duty. The series of questions the caller asked me centered on any services or benefits I needed. The same caller contacted me at around 90 days after my return, and again at my 180 day point after returning. This outreach was particularly effective because with each contact I stopped and assessed my individual need at that point in my integration. My military unit, as well, monthly re-enforced the value of my service, and helped me convert my experiences into positive training for unit members who did not deploy. Both the direct calls and the monthly unit support were like lifelines to someone who was trying hard to perform as if I had not left the United States for 7 months and been in a totally different environment. Even as a more prepared medical professional, I had incredible difficulty adjusting those first six months upon my return.

What are reforms needed? If possible, returning service members should be provided a "buffer zone," of time to integrate back in to their former civilian lives. Whether it is through a period of service that is funded like unemployment insurance, or as a part of military demobilization, an extra decompression period would have benefitted my ability to integrate. Continuing the individual contact to each returning California veteran would be of great benefit as well. That concerned citizen from Operation Welcome Home, reaching out to survey my needs, was of immense help and comfort. Those veterans who needed job placement or higher education information benefit from the direct and simple support of a phone call. Also, many guard members who needed health care benefits could have used a program that would have allowed their family health care premiums to be paid for while they were deployed. Changing an entire system of accessing care and then changing back again to the former system or another one, is enormously disruptive and anxiety-ridden for family and service members.

Question 4: What types of issues are faced by women soldiers and veterans? How are they different from those faced by men? What role do these issues play in the overall evolution of the veteran population?

Answer: In all three of my deployments, an issue I faced while being deployed and upon my return was virtually no time to process and deal with my re-integration. I pressured myself to return immediately to the caregiver and mother figure—women in general suppress their personal challenges and instead worry that those around them (children, parents, spouses) are taken care of. I had to ensure that all the domestic arrangements were perfect now that I had returned. Female veterans often ignore problems they face in order to ensure the family is operating normally. Approximately 40 percent of women veterans from OIF/OEF are mothers, and they often experience difficulties converting back from a combat role to a domestic one; but they suppress their challenges and often don't seek help until years later. Women account for 13% of those who fought in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn, according to the VA. Admitting they are in need of help is a challenge as well, because often women feel they have to "prove themselves" as equals in a military environment…Needing support may be construed as a sign of weakness and not being equal to their male counterparts. Although we place these pressures upon ourselves, it can be a real difference with returning female veterans.

Women also have a more difficult time opening up and discussing their combat experiences. Since females are not the typical combat veteran, they often don't feel as comfortable sharing their experiences (and therefore their challenges) with others as male veterans may. Accessing VA care can be uncomfortable also because so few females are in VA facilities. Many women feel alienated in the VA clinics and hospitals. Finally, in order to maintain society's expectation that women are the bond that keeps the family together, women can feel less capable if they need to seek help. They internalize their need to "have it all," being successful in the workplace, the home, in addition to maintaining an appropriate appearance. It is important to a woman's self-esteem to not fall down in any of area (I even had a military female friend mail boxes of "Clairol" to me in Afghanistan). Although we as female veterans often pressure ourselves when we internalize these societal expectations, the stress caused when we can't meet the expectations of performance is real. Female service members want to be perceived as peak performers, equal to our male counterparts in the workplace, yet not as common with our male peers, we feel responsible when our holiday arrangements are not perfect or our turkey is dry. Female veterans may suppress the need for support, and feel overwhelmed when they can't meet their own performance expectations. The VA reported that the most common issues women veterans were treated for in 2009 and 2010 were post traumatic stress disorder, hypertension, and depression. Many women veterans feel a constant need to prove themselves, and avoid seeking help, seeing it as a sign of weakness. The guilt women often feel regarding abandoning their care giver role and deployment for 7 months to a year, can also play a part in their failure to seek help for themselves. They focus on the needs of their "abandoned" family, not seeing themselves of worthy of, or needing support.

The problems faced by returning National Guard service members and women veterans in general mirror the issues faced by the general population in an environment of economic and social challenges. The added stressors of deployment without the full time stable military foundation to return home to (as our active duty counterparts enjoy) increase our vulnerability when compared to the general population.

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