ANDREA SAWYER, Caregiver and Spouse of U.S. Army Sgt. Loyd Sawyer

STATEMENT OF
ANDREA SAWYER
WOUNDED WARRIOR PROJECT
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
U.S. SENATE
JULY 14, 2011
Chairman Murray, Ranking Member Burr, and Members of the Committee:

Thank you for holding this very important hearing and for inviting me to testify. My name is Andrea Sawyer, caregiver and spouse of U.S. Army Sgt. Loyd Sawyer, retired. My testimony will both review my husband's experience in seeking treatment for severe PTSD as well as provide the perspective of the Wounded Warrior Project, with which Loyd and I have been associated, on these important issues.

I believe Loyd's story not only illuminates critical issues, but highlights the need for major changes. Let me share his story.

Loyd was a civilian funeral director and embalmer before joining the Army Mortuary Affairs team. As a mortuary affairs soldier, Loyd did a tour at Dover Port Mortuary where all deceased servicemembers returning from Iraq and Afghanistan re-enter the United States. Loyd worked in the Army uniform shop (where paperwork is processed and final uniforms prepared for deceased servicemembers) and embalmed on the days he was not in the uniform shop. Loyd then served a tour in Iraq, first in Talil and then the Balaad mortuaries where he processed countless deceased civilians and servicemembers. While there, he began exhibiting signs of mental distress including anger, hypervigilance, and insomnia.

Upon his return home, I tried for eleven months to get him help. We encountered delay in getting that help because the base had only one psychiatrist; but the help he ultimately got was ineffective. Finally I found myself in a room with an Army psychiatrist and my husband, and watched Loyd pull a knife out of his pocket and describe his plan of slitting his throat. He was clearly delusional and in great psychiatric distress, and shortly before Christmas in 2007, he was admitted to Portsmouth Naval Medical Center (PNMC). He had multiple episodes of intensive treatment while in service: an initial crisis hospitalization of five weeks (three exclusively inpatient and two intensive outpatient), a separate one week crisis hospitalization for homicidal ideations, eight months in an Army Warrior Transition Unit (WTU), and then appointments three days a week at PNMC two hours away from our home Army base of Fort Lee. Loyd then underwent a medical and physical evaluation (MEB/PEB) process that resulted in a 70% permanent Department of Defense (DOD) retirement from active duty for Post Traumatic Stress Disorder and a secondary diagnosis of major depressive disorder. The accompanying medical paperwork summed up his condition: "The degree of industrial and military impairment is severe. The degree of civilian performance impairment is severe at present, though over time—likely measured in years (emphasis added)—with intensive psychotherapy augmented by

pharmacotherapy to control his anxiety and depressive symptoms—his prognosis MAY improve."

In July 2008 while still on Active Duty, but with retirement paperwork in hand, Loyd enrolled for care at our local VA medical center, the Richmond polytrauma center, better known as Hunter Holmes McGuire VA Medical Center (HHM VAMC). In October, with help from Wounded Warrior Project (WWP), Loyd received a 100% permanent and total disability rating from VA, thus giving him the highest priority status for VA care.

Knowing that Loyd needed extensive help quickly, we tried getting him into the VA PTSD clinic immediately. But the first available appointment required a two-month wait. When he was finally seen, Loyd presented his history, including that he had been seen two to three times weekly at PNMC for the last eight months of active duty, that he remained suicidal, and that he needed intensive therapy. Notwithstanding the severity of his case, we were advised that the only thing available in the PTSD clinic would be a quarterly medication-management appointment and a once-a-month to once-every-six-weeks one-hour therapy appointment. Knowing that Loyd was spiraling into a depression and an unchecked increase in his PTSD symptoms, we elected to use our TRICARE coverage, and began treatment with a local civilian counselor who had trained at the VA's National Center for PTSD. The counselor was able to see Loyd once or twice a week depending on the severity of the symptoms. Throughout the winter of 2008 and the spring of 2009, I became increasingly concerned at the out-of-control depression I was witnessing, and feared that suicide was an imminent possibility. After getting little response from VA mental health, his TRICARE counselor and I discussed sending him to a VA long-term inpatient PTSD program for PTSD. I contacted Loyd's Federal Recovery Coordinator (FRC) for help in finding a program. We did eventually do phone interviews, made a site visit, and enrolled him in a PTSD program at VAMC Martinsburg, WV. I got little to no help from our local VA hospital in finding this program, but Loyd's Federal Recovery Coordinator provided invaluable assistance.

The hospitalization was a nightmare! The program delivered on none of its promises. His doctors there never coordinated with his local VA mental health clinician, his civilian counselor, or his FRC. At one point, his civilian counselor, his FRC, and I were calling the facility daily because we were concerned the medication change they had made was making him physically and verbally aggressive. Even more concerning, he had been taken off that medication while on active duty for the same reasons. Over the course of this ninety-day inpatient program, Loyd had fewer than five individual therapy sessions. Upon completing the program, which I truly believe was just about marking time, he was released and told to follow up with his local VAMC. For my husband, who had already expressed suicidal ideations, there was no care-coordination or communication between any of his treatment providers. He came home and promptly discontinued ALL of his medication because he did not like the way it made him feel. This was a step backward, since for the year and a half prior to the Martinsburg hospitalization, he had been completely compliant with his medication plan.

When I realized that he had stopped taking his medication, I immediately called the Richmond PTSD clinic. I was told that it would be four weeks before they could see him to re-evaluate his medications. I asked the FRC to intervene with the primary care provider (PCM) to try and

speed up the process, but this physician simply told me, I was "wasting his time." Eventually with the help of the FRC, I was able to get him an appointment within a week with a VA psychiatrist in general psychiatry. (Since then, this psychiatrist has managed Loyd's medication, as she very clearly listened to what symptoms needed to be controlled, and, even more importantly, listened to what he needed and wanted as a patient.) At that time, we agreed with her, that for counseling, Loyd was better off continuing with the civilian counselor because he could be seen once/twice a week. By involving Loyd, this VA clinician made it much more likely that he would continue with his pharmacotherapy regimen. She also asked that neuropsych testing be redone and suggested that Loyd try the PTSD ("Young Guns") therapy group that met weekly with a clinician in the Richmond PTSD clinic.

Loyd's repeat neuropysch testing in January 2010 showed that his PTSD symptoms were still severe. On a psychiatric scale test for symptoms of PTSD used frequently by the VA (DAPS), Loyd scored 20 out of 20 on all the indicators except for suicidality for which he scored a 16, meaning he still fell into the extremely high-risk category and was actively suicidal. His authenticity score was a five, which is as high as you can score. So after more than a year in the VA, a ninety-day hospitalization, and weekly therapy, Loyd was not really improving. Feeling rather hopeless, Loyd did decide to try the Young Guns group. He found great solace in this group in being able to relate with others who experienced the same symptoms, but also because he saw people in different stages of recovery who, led by a clinician, were able to analyze their behaviors and suggest multiple positive coping strategies that they each found successful. Unfortunately, four months into the group and without consultation with the patients, medical center staff announced that the VAMC was changing its treatment model and would be disbanding the group by year's end. For those who wished to continue in a group setting, the VA would be turning them over to a yet untested regional division of a new community-based program which had only two employees for a twenty-three county region, neither of whom was trained in counseling. As discussed in more detail below, the resulting year-long saga of trying to keep the group on campus has been unsuccessful, and the 40-member group has withered to an average of 7 to 10.

I believe Loyd's experience raises a strong oversight question for this Committee:

My husband is a veteran with well-documented severe chronic PTSD who gets treatment at one of VA's major VA polytrauma centers. We have all the advantages that should guarantee him good treatment – an excellent, caring Federal Recovery Coordinator; the priority associated with a 100% service-connected disability rating; an OIF case manager; and the assistance of a super VSO. If a veteran with all these advantages cannot access timely, consistent, appropriate veteran-centered care in a system dedicated to the care of veterans, what confidence can this Committee have that a newly enrolled veteran who has recently returned from the war zone will have greater success?

This Committee has rightly identified access as a barrier to quality, comprehensive mental health care. Two other closely-related issues impact that care as well:

Despite the goal of intervening early, VA is failing to reach most returning veterans.

VA reports that nearly 600 thousand, or 49% of all, OEF/OIF veterans have been evaluated and seen as outpatients in its health care facilities, and reports further that approximately one in four showed signs of PTSD. But more than half of all OIF/OEF veterans have not enrolled for VA care. Unique aspects of this war – including the frequency and intensity of exposure to combat experiences; guerilla warfare in urban environments; and the risks of suffering or witnessing violence – are strongly associated with a risk of chronic post-traumatic stress disorder. The lasting mental health toll of the wars in Iraq and Afghanistan are likely to increase over time for those who deploy more than once, do not get needed services, or face increased demands and stressors following deployment. Chronic post-service mental health problems like PTSD are pernicious, disabling, and represent a significant public health problem. Indeed mental health is integral to overall health. So it is vitally important to intervene early to reduce the risk of chronicity.

In 2008, VA instituted an initiative to call the approximately half million OEF/OIF veterans who had not enrolled for VA health care and encourage them to do so. This unprecedented initiative was apt recognition that we must be concerned not just about those returning veterans who come to VA's doors, but about the entire OIF/OEF population. But a single telephone contact is hardly enough of an outreach campaign.

VA has not been successful in retaining veterans in treatment.

Until recently, little had been known about OEF/OIF veterans' actual utilization of VA mental health care. The first comprehensive study of VA mental health services' use in that population found that of nearly 50,000 OEF/OIF veterans with new PTSD diagnoses, fewer than 10 percent appeared to have received recommended mental health treatment for PTSD (clinically defined in this report as attending 9 or more mental health treatment sessions in 15 weeks) at a VA facility; 20 percent of those veterans did not have a single mental health follow up visit in the first year after diagnosis.

These data raise a disturbing concern. They show that enrolling for VA care and being seen for a war-related mental health problem does not assure that a returning veteran will complete a course of treatment or that treatment will necessarily be successful.

Yet VA has set a very low bar for reversing this trend. Consider performance measures reported in VA budget submissions. One such performance measure calls for tracking the percentage of OEF/OIF veterans with a primary diagnosis of PTSD who receive a minimum of 8 psychotherapy sessions within a 14-week period. The FY 2010 performance goal for that measure was only 20%. In other words, having only one in five veterans attend the recommended number of treatment sessions constituted "success." This year's budget submission shows that actual performance fell short of even that very modest goal, with only 11% of PTSD patients receiving that minimum. In contrast, VA is meeting its performance target that 97% of veterans are screened for PTSD. This wide gap between VA's high rate of identifying veterans who have PTSD and its low targets for successful treatment needs to be addressed.

Two VA "Mental Health" Systems

VA operates a vast health care system, and there are many examples of excellence -- just as VA

employs many excellent, dedicated clinicians. It is somewhat misleading, however, to speak of "the VA mental health system," because not only is there wide variability across VA, but in some respects VA can be said to operate two mental health systems. First, VA provides a full range of mental health services through its nationwide network of medical centers and outpatient clinics. That system has increasingly emphasized the provision of "evidence-based-," recovery-oriented care. VA's much smaller Readjustment Counseling program – operating out of community-based Vet Centers across the country – provides individual and group counseling (including family counseling) to assist veterans to readjust from service in a combat theater. In some areas, these two "systems" work closely together; in others, there is relatively little coordination between them.

The differences between these two systems may help explain why greater numbers of veterans do not pursue VA treatment, and why those who do often discontinue.

In our daily, close work with warriors and their families, WWP staff consistently hear of high levels of satisfaction with their Vet Center experience. Warriors struggling with combat stress or PTSD typically laud Vet Center staff, who are often combat veterans themselves and who convey understanding and acceptance of warriors' problems.

In contrast with the relative informality of Vet Centers, young warriors experience VA treatment facilities as unwelcoming, geared to a much older population, and as rigid, difficult settings to navigate. Warriors have characterized clinical staff as too quick to rely on drugs, and as often lacking in understanding of military culture and combat. Medical center and clinic staff sometimes have more experience treating individuals who have PTSD related to an auto accident or domestic abuse than to combat. VA treatment facilities have had little or nothing to offer family members. Unlike Vet Centers that have an outreach mission, VA treatment facilities conduct little or no direct outreach – placing the burden on the veteran to seek treatment.

In essence, the strengths of the Readjustment Counseling program highlight the limitations and weaknesses that afflict the larger system. Too often, that larger system:
- Passively waits for veterans to pursue mental health care, rather than aggressively seeking out warriors one-on-one who may be at-risk;
- Gives insufficient attention to ensuring that those who begin treatment continue and thrive;
- Emphasizes training clinicians in so-called evidence-based therapies but fails to ensure that they have real understanding of, and relate effectively to, OEF/OIF veterans' military culture and combat experiences;
- Fails to provide family members needed mental health services, often resulting in warriors struggling without a healthy support system;
- Largely fails to establish effective linkages and partnerships with the communities where warriors live and work, and where reintegration ultimately must occur.

Perhaps the most disturbing perception warriors have expressed regarding their experiences with VA mental health treatment is that VA officials operate in a way that too often seems aimed at serving the VA rather than the veteran.

Richmond: A Case Study

In describing what it termed its "FY 11-13 Transformational Plan to Improve Veterans' Mental

Health," VA emphasizes its core reliance on providing evidence-based, recovery-oriented, veteran-centric care. But when those three concepts are not in alignment, experience now suggests that the veteran's voice may go unheard. The Richmond VAMC PTSD therapy group, described above, illustrates the point.

The Young Guns group in which Loyd participated petitioned the medical center director to reinstate the group. The petition, signed by 27 members of the group, explained both the importance to the members of the group therapy and expressed their strong view that VA's alternative – for the group to operate as a community-based peer group – was not an effective substitute. While WWP also urged the Medical Center Director to reinstate the group at the medical center, the director's reply stated that "while these…PTSD groups have proven effective in providing environments of social support…, they are not classified as active treatment for PTSD symptoms." The upshot of the Director's ignoring the veterans' strong views and proceeding with the plans was that only 7 members of the Young Guns group attended the initial "community-based" group meeting (which was neither adequately staffed or facilitated). Most have dropped out altogether – having lost trust, feeling "discarded", or in some instances – because it is no longer a "VA group" – they could no longer get approval to take time off from jobs. The all important ability to access the care was no longer available.

Veterans too often confront a gap between well-intentioned VA policy and real-world practice. In this instance, the applicable VA policy (set forth in a handbook setting minimal clinical requirements for mental health care) is clear and on point:

The specifications in this Handbook for enhanced access, evidence-based care, and recovery or rehabilitation must not be interpreted as deemphasizing respect for the needs of those who have been receiving supportive care. No longstanding supportive groups are to be discontinued without consideration of patient preference, planning for further treatment, and the need for an adequate process of termination or transfer. (Emphasis added.)

Throughout our efforts to advocate for these warriors -- writing to the Medical Center Director, meeting with VA Central Office officials, meeting with the Medical Center Director, and finally writing to the Secretary – VA's position at every level remained inflexible. Honoring the veterans' wishes was simply not considered a VA option and while numerous "alternatives" were listed, few took into consideration the sensitivities of these particular patients.

VA did not terminate an ineffective program at Richmond VA. Medical Center officials even acknowledged that it was helping these veterans. VA's cavalier insistence on the appropriateness of this action brings into question the department's ability to adequately address the growing mental health needs of this generation of warriors.

VA Mental Health Care Policy: Still in Transition, Ignoring Gaps

VA has certainly instituted policies aimed at providing timely, effective, and accessible care to veterans struggling with mental illness. But as the above-cited situation at the Richmond VA illustrates, the gap between VA mental-health policy and practice can be wide.

In 2007, VA developed an important detailed policy directive that identified what mental health policies should be available to all enrolled veterans who need them, no matter where they receive

care, and set certain timeliness standards for scheduling treatment. But as VA acknowledged in testifying before this Committee on May 25th, those directives are still not fully implemented. Funding is not the problem, VA testified at the time.
The fact that a policy aimed at setting basic standards of access and timeliness in VA mental health care has yet to be fully implemented – four years after the policy is set – has profound ramifications for warriors struggling with war-related mental health problems, and who face barriers to needed VA treatment. Of VA's many "top priorities," the mental health of this generation of warriors should be of utmost importance as it will directly impact other areas of concern such as physical wellness, success in employment and education, and homelessness.

Geographic barriers are often the most prominent obstacle to health care access, and can have serious repercussions on the veteran's overall health. Research suggests that veterans with mental health needs are generally less willing to travel long distances for needed treatment than veterans with other health problems and that critical aspects of a veteran's mental health treatment (including timeliness of treatment and the intensity of the services the veteran ultimately receives) are affected by how geographically accessible the care is.

VA faces a particular challenge in providing rural veterans access to mental health care. VA has stated that of all veterans who use VA health care, roughly 39% reside in rural areas and an additional 2% reside in highly rural areas; over 92% of enrollees reside within one hour of a VA facility, and 98.5% are within 90 minutes. But many of these VA facilities are small community-based outpatient clinics (CBOC's) that offer very limited or no mental health services. Overall, CBOC's are limited in their capacity to provide specialized or even routine mental health care. Indeed, under current VHA policy, large CBOC's (those serving 5,000 or more unique veterans each year), mid-sized CBOC's (serving between 1,500 and 5,000 unique veterans annually), and smaller CBOC's (serving fewer than 1,500 veterans annually) have the option to meet their mental health provision requirements by referring patients to "geographically accessible" VA medical centers. CBOC's are only required to offer mental health services to rural veterans in the absence of a "geographically accessible" medical center. Notably, current policy does not define what constitutes "geographic inaccessibility." Moreover, in those instances in which small and mid-sized CBOC's do have mental health staff, VA does not require the CBOC to provide any evening or weekend hours to accommodate veterans who work and cannot easily take time off for treatment sessions.

Since long-distance travel to VA facilities represents a formidable barrier to veterans' availing themselves of mental health treatment, it is important that VA provide community-based options for veterans who would otherwise face such barriers. VA policy – as reflected in the uniform services handbook – calls for ensuring the availability of needed mental health services, to include providing such services through contracts, fee-basis non-VA care, or sharing agreements, when VA facilities cannot provide the care directly. But VA officials have informally admitted that, despite the policy, VA facilities have generally made only very limited use of this new authority – often leaving veterans without good options.

Yet there is evidence that this rural access problem could be overcome if there were the will to meet it. In Montana, for example, the VA Montana Healthcare System has been contracting for mental health services since 2001. According to a report by the VA Office of Inspector General

(OIG), more than 2000 Montana veterans were treated under contracts with community mental health centers in FY 2007, and more than 250 were treated under fee-basis arrangements with 27 private therapists. The OIG report also indicates that the VA Montana Healthcare System has sponsored trainings for contract and fee-basis providers in evidence-based treatments.

It is not enough for VA simply to promulgate policies and directives on access-to-care and timeliness. Surely we owe those suffering from war-related mental health conditions real access to timely, effective care, not the hollow promise of a policy that is still not fully implemented four years later.

Finally, a four-year-old policy must itself be open to re-assessment. VA must continue to adapt to the needs of younger veterans whose obligations to employers, school, or young children may compound the challenge of pursuing mental health care. To illustrate, a recent WWP survey found that among veterans who are currently participating in VA medical center and Vet Center support groups, 29% said they are considering no longer attending due to the location of the group being far from their place of work or home. Another 39% of respondents indicated they are considering no longer attending because groups are held at a time that interferes with their work schedule.

Needed: A Veteran-Centered Approach to the Mental Health of OEF/OIF Veterans
PTSD and other war-related mental health problems can be successfully treated – and in many cases, VA clinicians and Vet Center counselors are helping veterans recover. But, as discussed above, VA is not reaching enough of our warriors, and is not giving sufficient priority to keeping veterans in treatment long enough to gain its benefits. What can VA do, beyond fully implementing its policies and commitments? What should it do? WWP asked warriors and caregivers these questions at a summit I attended, as well as consulted with experts. Our recommendations follow:

Outreach: WWP recommends that VA adopt and implement an aggressive outreach campaign through its medical centers, employing OEF/OIF warriors -- who have dealt with combat stress themselves -- to conduct direct, one-on-one peer-outreach. Current approaches simply fail to reach many veterans. For example, post-deployment briefings that encourage veterans to enroll for VA care tend to be ill-timed, or too general and impersonal to address the warriors' issues. An outreach strategy must also take account of many warriors' reluctance to pursue treatment. An approach that reaches out to engage the veteran in his or her community, and provides support, encouragement, and helpful information for navigating that system can be impactful. VA leaders for too long have limited such outreach efforts to Vet Centers. Given what amounts to a public health challenge with regard to warriors at risk of PTSD, there is a profound need for a broad VA effort to conduct one-on-one peer outreach to engage warriors and family in their communities.

Cultural competence education: WWP urges that VA mount major education and training efforts to assure that its mental health clinicians understand the experience of combat and the warrior culture, and can relate effectively to these young veterans. Health care providers, to be effective, must be "culturally competent" – that is, must understand and be responsive to the diverse cultures they serve. WWP often hears from warriors of frustration with VA clinicians and staff who, in contrast to what many have experienced in Vet Centers, did not appear to understand

PTSD, the experience of combat, or the warrior culture. Rather than winning trust and engaging warriors in treatment, clinical staff are often perceived as ignorant of military culture or even as dismissive. Warriors reported frustration with clinicians who in some instances do not appear to understand combat-related PTSD, or who pathologize them or characterized PTSD as a psychological "disorder" rather than an expected reaction to combat. Dramatically improving the cultural competence of clinical AND administrative staff who serve OEF/OIF veterans through training, standard-setting, etc. – and markedly improving patient-education – must be high priorities.

Peer-to-peer support: WWP recommends that VA employ and train peers (combat veterans who have themselves experienced post-traumatic stress) to provide support to warriors undergoing mental health care. (Peer-support must be an adjunct to, not a replacement for, quality clinical care.) In describing highly positive experiences at Vet Centers, warriors emphasized the importance of being helped by peers on the Vet Center staff – combat veterans who themselves have experienced combat stress and who (in their words) "get it." Given the inherent challenges facing a patient in a medical setting and data showing high percentages discontinuing treatment, it is important to have the support of a peer who, as a member of the treatment team, can be both an advocate and support. Public Law 111-163 requires VA within 180 days of enactment to provide peer-outreach and peer-support services to OEF/OIF veterans along with mental health services, and to contract with a national nonprofit mental health organization to train OEF/OIF veterans to provide such services. It is critical that the Department design and establish a national peer-support program, initiate recruitment of OEF/OIF veterans for a system-wide cohort of peer-support-specialists and institute the required training at the earliest possible date.

Provide family mental health services: One of the strongest factors that help warriors in their recovery is the level of support from loved ones. Yet the impact of lengthy, multiple deployments on family may diminish their capacity to provide the depth of support the veteran needs. One survey of Army spouses found that nearly 20 percent had significant symptoms of depression or anxiety. While Vet Centers have provided counseling and group therapy to family members, VA medical facilities have offered little more than "patient education" despite statutory authority to provide mental health services. It took VA nearly two years to implement a legislative requirement to provide marriage and family counseling. Section 304 of Public Law 111-163 directs VA to go further and provide needed mental health services to immediate family of veterans to assist in readjustment, or in the veteran's recovery from injury or illness. This provision – covering the 3-year period beginning on return from deployment – must be rapidly implemented, particularly given its time-limit on this needed help.

Expand the reach and impact of VA Vet Centers: Although many OEF/OIF veterans have been reluctant to pursue mental health treatment at VA medical centers, Vet Centers have had success with outreach and working with this population. Given that one in two OEF/OIF veterans have not enrolled for VA care and many are likely to be experiencing combat-stress problems, WWP recommends that VA increase the number of Vet Center locations, and give priority to locating new centers in close proximity to military facilities. As Congress recognized in Public Law 111-163, Vet Centers – in addition to their work with veterans – can be an important asset in helping active duty, guard, and reserve servicemembers deal with post-traumatic stress. Vet

Centers can serve as an important asset to VA medical centers as well, and we urge greater coordination and referral between the two.

Foster community-reintegration: VA mental health care can play an important role in early identification and treatment of mental health conditions. Yet success in addressing combat-related PTSD is not simply a matter of a veteran's getting professional help, but of learning to navigate the transition from combat to home. In addition to coping with the often disabling symptoms, many OEF/OIF veterans with PTSD, and wounded warriors generally, are likely also struggling to readjust to a "new normal," and to uncertainties about finances, employment, education, career and their place in the community. While some find their way to VA programs, no single VA program necessarily addresses the range of issues these young veterans face, and few, if any, of those programs are embedded in the veteran's community. VA and community each has a distinct role to play. The path of a veteran's transition, and successful community-reintegration, must ultimately occur in that community. For some veterans that success may require a community – the collective efforts of local community partners – businesses, a community college, the faith community, veterans' service organizations, and agencies of local government – all playing a role. Yet there are relatively few communities dedicated, and effectively organized, to help returning veterans and their families reintegrate successfully, and other instances where VA and veterans' communities are not closely aligned. The experience of still other communities, however, suggests that linking critical VA programs with committed community engagement can make a marked difference to warriors' realizing successful reintegration. With relatively few communities organized to support and assist wounded warriors, WWP urges the establishment of a grant program to provide seed money to encourage local entities to mobilize key community sectors to work as partners in support of veterans' reintegration. In short, a grant to a community leadership entity (which, in any given community, might be a non-profit agency, the mayor's office, a community college, etc.) could enable a community partnership with a VA medical center or Vet Center in supporting veterans and their families on their path to community reintegration. There is ample precedent for use of modest grants to stimulate the development of community-based coalitions working in concert with government to provide successful wraparound services.

WWP has offered most of these recommendations to VA officials, and urged them to implement section 304 of Public Law 111-163. The response was little different from the responses WWP received in advocating on behalf of the veterans in Richmond. In essence, the message seems to be, "No thank you, we'll do it our way, and we'll do it when we get to it."

The stakes are high. With a generation of servicemenbers at risk of chronic health problems associated with combat stress, VA and Congress can have few higher priorities, in our view, than to address these issues. With these concerns in mind, WWP is developing draft legislation that incorporates the recommendations we have discussed, and would welcome the opportunity to work with the Committee on instituting these reforms.

Summary

In closing, VA can have few higher goals than to help veterans who bear the psychic scars of combat regain mental health and thrive. While we recognize and acknowledge that VA conducts some quality programs and laudable initiatives, there are regrettably too many disconnects

between those programs and initiatives and the needs Loyd and so many others have. WWP's work with warriors struggling with mental health issues – and with the caregivers who support them -- reminds us daily of the gaps plaguing the system: gaps arising from VA's largely-passive approach to outreach; gaps in access to mental health care in a system still marked by wide variability; gaps in sustaining veterans in mental health care; gaps in clinicians' understanding of military culture and the combat experience; gaps in family support; and gaps in coordination with the benefits system. We look forward to working with this Committee on these important issues and to witness the development of a truly transformative veteran-centered approach to VA mental health care.