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WOUNDED WARRIOR PROJECT

Statement of
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On

"Combatting a Crisis: Providing Veterans Access to Life Saving Substance Abuse Disorder Treatment"

April 18, 2023

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the House Committee on Veterans' Affairs Subcommittee on Health – thank you for inviting Wounded Warrior Project (WWP) to submit this written statement for the record of today's hearing on veterans' access to Department of Veterans Affairs (VA) substance use disorder (SUD) treatment.

For 20 years WWP has worked to fulfill our mission to honor and empower wounded warriors. In addition to our advocacy before Congress, we offer more than a dozen direct service programs focused on connection, independence, and wellness in every spectrum of a warrior's life. Our organization has grown alongside the warriors we serve and we remain committed to tailoring our programming to the evolving needs of a post-9/11 generation of warriors that has become increasingly diverse.

In this context, assisting warriors with their mental health challenges has consistently been our largest programming investment over the past several years. In Fiscal Year 2022, WWP spent more than $82 million in mental and brain health programs – an investment consistent with the fact that more than 7 in 10 respondents to our 2022 Annual Warrior Survey self-reported at least one mental health condition.[1] As diagnoses of post-traumatic stress disorder (PTSD), depression, and anxiety have consistently ranked among the top five most self-reported conditions across previous editions of our Annual Warrior Survey, our Mental Health Continuum of Support has developed over the last decade and now allows us to engage each individual based on their unique needs.[2] In Fiscal Year 2022 alone, WWP provided warriors and their family members with nearly 55,000 hours of treatment for mental health conditions, including PTSD, traumatic brain injury, SUD, and other mental health conditions.

[1] WWP's 2022 Annual Warrior Survey can be viewed at https://www.woundedwarriorproject.org/mission/annual-warrior-survey.
[2] More information on WWP's Mental Health Continuum of Support can be found at the end of the document.

Our specific focus on assisting warriors with substance abuse has followed a similar evolutionary path. In 2020, WWP recognized a gap in mental health services for veterans struggling with a substance use disorder and a co-morbid mental health disorder (e.g., PTSD). An increasing volume of veterans connected with our Mental Health Continuum of Support programs were sharing similar stories about their difficulty accessing clinical treatment. Providers were telling veterans that their SUD had to be treated independently before receiving PTSD care, or vice versa. Delays in finding the appropriate care in a timely manner would not only fail to capitalize on the veterans' desire to change their life circumstances, but in some cases cause further damage to their mental and physical health along with declines in family and social relationships. Hearing these stories, WWP committed to investigating further and commissioned the RAND Corporation to conduct a landscape study on the most effective way to treat post-9/11 veterans with co-occurring mental health and substance use disorders.

The resulting report, *Improving Substance Use Care: Addressing Barriers to Expanding Integrated Treatment Options for Post-9/11 Veterans*[3], has helped guide WWP's programming and advocacy before Congress. Data provided in WWP's 2019 Annual Warrior Survey, in combination with findings from the literature on SUDs and mental health disorders in veteran populations, revealed the high level of need for both substance use and mental health care among post-9/11 veterans. Among their key findings, RAND concluded that:

- Veterans screening positive for PTSD or depression are almost 20 percent more likely to screen positive for hazardous alcohol use or a potential SUD;
- Mental health treatment facilities typically specialize in treating one type of disorder or the other;
- Mental health treatment facilities often require veterans to abstain from substance use, but veterans may be using substances to manage their mental health symptoms;
- Veterans who receive substance use treatment alone may be at risk for failing to meet their treatment goals if their mental health symptoms are not addressed; and
- Integrated, evidence-based approaches that address both substance use disorders and mental health disorders concurrently and provide ongoing support for recovery can improve outcomes for this population, but it is critical that veterans are able to access programs and facilities that are equipped to treat the veteran population.

The RAND report includes a number of recommendations for improving options for and access to treatment for veterans with co-occurring SUDs and mental health disorders. One of these recommendations is to decrease barriers to accessing treatment.[4] They write, "given the difficulty of engaging the veteran population, it is essential to reduce barriers to care to help veterans not only initiate care but also to reduce dropout once enrolled."[5] The report also emphasizes the importance of ease of access to services and "limited delays in setting up initial and continuing care appointments."[6]

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[3] ERIC R. PEDERSON ET AL., RAND, IMPROVING SUBSTANCE USE CARE: ADDRESSING BARRIERS TO EXPANDING INTEGRATED TREATMENT OPTIONS FOR POST-9/11 VETERANS (2020).
[4] *Id*. at 150.
[5] *Id*.
[6] *Id*. at 154.

For these reasons, WWP has committed itself to ensuring that veterans who seek help are connected quickly to clinical programs that meet their needs. The Department of Veterans Affairs (VA) is a critical resource and partner for accomplishing those goals, and as discussed below, their collaboration with two key programs has helped lead to more successful outcomes for warriors who have engaged WWP for help. Our work has also spotlighted gaps and efficiencies that inform specific calls to action for this Subcommittee focused on accelerating access to care, addressing provider shortages, enhancing data reporting, and strengthening case management services.

ADDRESSING ACCESS CHALLENGES THROUGH WWP PROGRAMS

Currently when a warrior reaches out to WWP for mental health support, their first step to finding care is a conversation with our Triage team. The Triage team conducts screenings of a warrior's mental health history, provides the warrior with information about our various mental health offerings, and refers the warrior to the most appropriate mental health program within WWP or an external resource. In FY 22, our Triage team received 12,610 referrals to find warriors appropriate treatment, placed 10,634 referrals for mental health support (including 5,630 referrals to external outpatient care providers), and made their first connection with interested warriors an average of 1.04 days later. Warriors assessed as needing SUD treatment were most often either referred to WWP's Warrior Care Network or Complex Case Coordination (C3) program.

Warrior Care Network

Wounded Warrior Project's Warrior Care Network is a two-week intensive outpatient program where warriors are helped to minimize the interference of mental health issues in their everyday lives. WWP partners with four academic medical centers across the country to provide this treatment to help warriors manage their PTSD, TBI, SUDs, and other mental health conditions.

Since publication of WWP-commissioned RAND report on co-occurring SUD and mental health disorders, WWP has invested additional resources to ensure that the Warrior Care Network is providing this integrated treatment for veterans through our academic medical center partners. Warriors who complete the Warrior Care Network program have seen significant improvements in their PTSD and depression symptoms and improved functioning and quality of life. Most significant to today's hearing, treating mental health and SUD concurrently has led to reduced substance use habits. For those being treated as part of Warrior Care Network's SUD program, the pre-treatment average of 6.1 days of substance use per week was reduced to 1.6 days after treatment. After six months, warriors' substance use remained reduced at an average of 4.1 days of substance use per week.

While Warrior Care Network academic medical center partners provide veteran-centric comprehensive care, aggregate data, share best practices, and coordinate care in an unprecedented manner, partnership with VA has helped create a broad continuum of support that has been critical. In 2016, the VA and WWP created a first-of-its-kind partnership, signing a Memorandum of Understanding (MOU) aimed at ensuring continuity of care and successful

discharge planning for Warriors receiving treatment from both WCN and VA. This partnership included providing VA staff to assist part time at each AMC, facilitating coordination of care and integrating the AMC care team.

The MOU and partnership were expanded and enhanced in 2018, establishing four full time VA Liaison positions, embedded at each AMC. The VA Liaisons are responsible for ensuring that medical records are seamlessly shared between VA and WCN, that warriors are fully registered with VA, and that they get follow up care appointments after WCN graduation at the VA. In 2022, the VA renewed the MOU for a third time, continuing to fund one VA Liaison at each AMC site. Each VA liaison facilitates national referrals throughout the VA system as indicated for mental health or other needs. During 2022 alone, VA Liaisons served 708 warriors. Over the FY 18-22 period (beginning when VA Liaisons were assigned):

- 88% of veterans served by Warrior Care Network took advantage of connecting with a VA Liaison.
- 53% of veterans that met with a VA Liaison discharged from Warrior Care Network with a VA appointment scheduled.
- More than 3,000 referrals for VA care were opened. Among the most requested appointments were mental health care, VA benefits, and primary care.
- More than 19,000 hours of collaborative hours between VA Liaisons and academic medical center employees and veterans.

In sum, Warrior Care Network results and collaboration with VA has validated our belief that community-based, veteran-centric, intensive mental health and substance use care can lead to exceptional health improvements and increased engagement between veterans and VA when properly structured and managed.

Complex Case Coordination (C3)

Wounded Warrior Project's C3 team serves warriors with complex challenges that are often multi-faceted and require urgent action. They connect warriors to internal and external resources and treatment options to provide them with immediate assistance. When working with warriors, the C3 team assesses each of their unique needs and works with them to develop an individualized plan. They work to identify the resources that will best meet the warrior's needs and often act as a liaison between VA, the Department of Defense (DoD), and private community resources throughout the course of the warrior's treatment.

All facilities that the C3 team directs warriors to are carefully vetted by a WWP Clinical Psychologist for modality review while the C3 Director conducts on site vetting for a review of their operations. These facilities must participate in the VA Community Care Network or provide a specialty care need. C3 has established a menu of facilities that offer different types and modalities of care including PTSD, SUD, dual diagnosis, MST, grief, serious mental illness, and eating disorders. These facilities vary from inpatient, residential, partial hospitalization, intense outpatient, and treatment with residential capabilities.

The C3 team works a case in three phases. First, they work to stabilize the warrior, conducting an assessment and determining their needs. The second is to maintain the situation while they work to build an action plan, mobilize resources, and advocate for the warrior's needs. The third is the transition, where the team coordinates wrap around services and conducts follow-up. By pursuing these phases with nearly 1,200 warriors to date, the C3 team has developed significant history referring veterans to VA's Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) and provides the most significant perspectives on the access to care challenges facing warriors who pursue that care through VA.

ADDRESSING ACCESS CHALLENGES THROUGH ADVOCACY

As previously stated, WWP's most significant partner in meeting the needs of veterans with SUD and other mental health disorders is VA. Among its most intensive care options are its MH RRTPs, which provide residential treatment services to veterans with mental health issues, SUDs, medical concerns, or those dealing with homelessness or unemployment. There are currently 249 MH RRTPs throughout the country, and they are often an important resource for warriors experiencing co-occurring SUDs and mental health diagnoses. MH RRTPs offer a range of services and evidence-based psychotherapies.

Unfortunately, veteran access to MH RRTPs has been frustrated in several instances by the current access standard landscape. The *VA MISSION Act* (P.L. 115-182 § 104) required VA to establish access standards for community care and VA subsequently established these standards for primary care, mental health, non-institutional extended care, and specialty care. However, VA did not include a specific access standard for residential care, and they do not consider MH RRTPs to fall within their access standards for mental health or specialty care.

Access Standards under VHA Directive 1162.02

Instead, VA uses VHA Directive 1162.02 ("Mental Health Residential Rehabilitation Treatment Program") to define the admission criteria for MH RRTPs and to establish when a veteran is eligible for residential care in the community. The Directive states that all admission decisions must be completed within 7 business days from the referral. Veterans requiring priority admission must be admitted within 72 hours. For all other veterans, they must be admitted as soon as possible after a decision has been made. If they cannot be admitted within 30 calendar days, they must be offered alternative residential treatment or another level of care that meets the veteran's needs and preferences. Alternative residential treatment can be a program in the community, another program within the VISN, or another program in another VISN.

Whenever there is a gap of greater than two weeks for any veteran accepted into a mental health RRTP, providers must maintain clinical contact with the veteran until the time of admission, and address any urgent mental health care needs that arise.[7] Under the Directive, this responsibility should generally fall to the Mental Health Treatment Coordinator (MHTC). The MHTC is responsible for ensuring a veteran's continuity of care while receiving mental health treatment. They are to be the veteran's Point of Contact, clinical resource, and member of the

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[7] *See* VHA Handbook 1160.01 ("Uniform Mental Health Services Handbook").

veteran's assigned outpatient general mental health team, except under certain circumstances. The MHTC is also supposed to be notified when a veteran is not accepted for care, and they are supposed to be included in the discharge and transition planning process.

Unfortunately, VA's admission goals seem aspirational when compared to its most recent admission data. According to a VA briefing provided to veteran service organizations in February 2023, only 38 percent of veterans assessed as needing priority MH RRTP admission in the first quarter of FY 23 were admitted within 72 hours. While 17 percent requested a later date, this leaves many veterans outside of the window required by the Directive. Similarly, data published by the Government Accountability Office in February 2023 showed that, in Fiscal Year 2021, health care systems with mostly rural veterans had an average waiting time above 30 days for MH RRTP programs.[8] Health care systems with some (~27 days) or few rural veterans (~23 days) were only slightly faster.

Wounded Warrior Project's assistance for warriors seeking MH RRTP access, while positive in many instances, has shown similar shortcomings. The lack of a consistently applied access standard has essentially resulted in no true access standard for MH RRTP. Local policy variations have resulted in unpredictable referral decisions. Wait times are not uniformly calculated and can be impacted by inconsistent policies about completion of other, less intensive treatment options. More specifically, some VA facilities will require a veteran to exhaust all outpatient programs before considering them eligible for a MH RRTP program. For patients with co-occurring mental health and substance use disorders, some VA facilities will utilize partial treatments (e.g., SUD care only) while waiting for dual-diagnosis treatment (e.g., treatment for SUD and PTSD) beds to open, satisfying the access standard but not getting the veteran to the appropriate program more promptly. Transparent staffing challenges have limited communication and bed availability. Identifying alternative treatment options that would result in community – or even VA – referrals and faster access to care consistent with Directive access standards are not uniformly accepted. Consequently, some warriors will only pursue care after asking for assistance of a trained and passionate advocate like WWP, or even worse, decided to stop pursuing care altogether.

WWP Access Issues Validated by VA Office of the Inspector General (OIG)

In January 2023, the OIG released a report on noncompliance with community care referrals for MH RRTPs within the VA North Texas Health Care System.[9] The report found a number of instances where the VA North Texas Health Care System failed to follow VHA Directive 1162.02. Throughout most of fiscal years 2020 and 2021, veterans were put on waitlists for two to three months to receive care at the local VA North Texas domiciliary substance use disorder program (DOM SUD) and were not offered referrals for care in the community. Requests by the veterans for community care referrals were inappropriately denied.

The OIG specifically reviewed 15 VA North Texas DOM SUD consults placed for 10 patients as part of their investigation. Seven consults were closed when the patients were

[8] GOV'T ACCOUNTABILITY OFF., VA MENTAL HEALTH: ADDITIONAL ACTION NEEDED TO ASSESS RURAL VETERANS' ACCESS TO INTENSIVE CARE 31 (Feb. 2023).

[9] OFF. OF INSP. GENERAL, U.S. DEP'T OF VET. AFFAIRS, NONCOMPLIANCE WITH COMMUNITY CARE REFERRALS FOR SUBSTANCE ABUSE RESIDENTIAL TREATMENT AT THE VA NORTH TEXAS HEALTH CARE SYSTEM (Jan. 2023).

admitted within 30 days and two were closed when patients declined admission. Unfortunately, the remaining six consults ended after an average wait time of 79 days before the patient was offered a DOM SUD admission or after being removed from the pending bed placement list. Although VA North Texas staff knew the wait time to admission for care was over 30 days, no community care options were offered to these patients.

The OIG report concludes that the VA North Texas chief, Patient Administration Services, misinterpreted VA policy on MH RRTP care and community care referrals and provided inaccurate information to staff and patients. The report goes on to say that "failure to discuss alternative resources or treatment options, including community residential care, may have contributed to patient's increased risk of negative outcomes due to delayed access to DOM SUD services."

This report found other instances of VA North Texas failing to follow VHA policy. The Bonham MH RRTP failed to follow VHA's minimum scheduling requirements to contact veterans four times to schedule a requested service before closing a consult. The OIG wrote that this "failure to adhere to VHA minimum scheduling requirements may hinder efficient patient scheduling and contribute to barriers to accessing DOM SUD services." VA North Texas also failed to follow the VHA requirement that staff assign a mental health treatment coordinator to patients that are either receiving outpatient mental health treatment, have been admitted to an inpatient mental health setting, or those that are waiting to receive a different level of care, such as those waiting for placement at an MH RRTP.

In their response, VA North Texas noted that this time period was during the peak of the COVID-19 pandemic and that VA North Texas had the highest COVID-19 census in the VA system for several months in 2020 and 2021. They also point out that some community care facilities were not accepting admissions during this time. VA North Texas argues that staff were doing the best they could with difficult circumstances and that while VA guidance was misinterpreted, very few patients were ultimately affected. While this may be true in this specific instance, WWP has seen a pattern of these types of issues reported at VA North Texas around the country.

Action in Progress

As WWP has consistently raised the problems with MH RRTP access over several months, we appreciate that Congress has taken important steps to address the mental health and substance use crisis amongst our veteran population in recent years. The *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* (P.L. 116-171 § 201) required VA to develop a clinical provider treatment toolkit and accompanying training materials for comorbid mental health conditions, comorbid mental health and substance use disorders, and comorbid mental health and chronic pain. That toolkit is now publicly available on the VA website.

The *Support the Resiliency of Our Nation's Great (STRONG) Veterans Act* (P.L. 117-328, Div. V § 303) included provisions related to SUD and mental health. Section 503 requires VA to conduct a study on inpatient mental health and substance use care at VA, including if there are sufficient geographic offerings for inpatient mental health care, sufficient bed spaces, and wait times. The study must also include recommendations on new locations for RRTPs and

where new beds can be added. Section 504 also requires a study on treatment at VA for co-occurring mental health and SUDs. The study must include information on the availability of treatment programs, geographic disparities in access to these programs, and average wait times. WWP is eager to see the results of these reports and use them to inform future advocacy.

Moreover, to the extent access issues are created by staffing shortages, WWP is grateful for recent congressional action to improve VA's mental health staffing capabilities. The *STRONG Veterans Act* (P.L. 117-328, Div. V) also includes provisions that will expand the Vet Center workforce (§ 102), create more paid trainee positions in mental health disciplines (§ 103), and offer more scholarship and loan repayment opportunities for those pursuing degrees or training in mental health fields (§ 104).

Recommendations for Future Action

While WWP applauds the work Congress and VA have already undertaken, there is much more work to be done. Based on the data we've outlined and our experiences attempting to place warriors into residential care for co-occurring mental health issues and SUDs, WWP provides the following recommendations:

VA access standards must ensure prompt access to residential mental health and substance use services

The access standards contemplated by the *VA MISSION Act* (P.L. 115-182 § 104) and memorialized in the Code of Federal Regulations (38 C.F.R. § 17.4040) do not, in practice, extend to mental or substance use disorder care provided in a residential setting. VA has maintained adherence to access standards for this type of care through VHA Directive 1162.02, which establishes a priority admission standard of 72 hours and, for all other cases, 30 days before a veteran must be offered (not necessarily provided) alternative residential treatment or another level of care that meets the veteran's needs and preferences at the time of screening.

Due to this approach, veterans seeking mental or substance use disorder care provided in a residential setting are not subject to the access standard protections assigned under law. VA is not required to inform these veterans of their expected wait time. *See* P.L. 117-328, Div. U, § 122. Veterans are not guaranteed the soonest possible starting time before a community referral must be made. *See* P.L. 117-328, Div. U, § 121; 38 U.S.C. § 1703(d)(4). The access standards used are not applicable to community care network providers who receive referrals for these veterans' care. *See* P.L. 117-328, Div. U, § 125; 38 U.S.C. § 1703B(f).

Most importantly, if appropriate community-based providers are identified and available to provide treatment, veterans waiting beyond VHA's policy-backed access standards have no dependable, consistent recourse to be referred for that care. VA has presented data suggesting that only 38% of veterans meeting priority admission criteria were admitted to VA within 72 hours, and that the average wait time before admission among all veterans receiving MH RRTP care was 24 days – just 6 days less than the 30-day access standard and among a population where 53% were admitted within 14 days (information on admissions within 30 days was not provided in the presentation).

At least two approaches show potential to address this problem. First, 38 U.S.C. § 1703(d)(1) can be amended to specifically include access standards for residential mental health or substance-use services.[10] Second, 38 U.S.C. § 1703B can be amended to ensure that residential mental health or substance-use services are included as part of the extended care service access standards that VA must prescribe. Either path would help provide certainty that access standards are not left to VA policy and carry the same opportunities and predictability that are extended to other medical services as part of the *VA MISSION Act*.

Advance policies that promote a stronger mental health and substance use treatment provider base across the United States

In January 2023, the U.S. Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) released the results of its 2021 National Survey on Drug Use and Health (NSDUH), which contains fresh evidence of the extent of mental health and substance use challenges across the country.[11] Results from the survey show that while veterans may be at heightened risk for these health challenges and more likely to experience them, the broader national context must be considered to help adequately address access to care issues that exist and may continue to arise.

Among the findings most pertinent to today's hearing, 29.5 million people aged 12 or older showed alcohol use disorder, 24.0 million showed a drug use disorder, and 5.6 million showed an opioid use disorder.[12] These findings run parallel to findings that nearly 1 in 4 U.S. adults with a mental illness[13] and are particularly striking within the context that more than 150 million Americans live in a federally designated mental health professional shortage area.[14]

One way for Congress to act outside of the VA health system – but nevertheless helping veterans, particularly those in underserved areas – is to pass S. 462, the *Mental Health Professionals Workforce Shortage Loan Repayment Act*.[15] This bill would authorize the federal government to repay up to $250,000 in eligible student loan repayment for mental health professionals who work in mental health shortage areas. As written, this bill requires an annual commitment to full time employment in substance use disorder treatment. Although the *STRONG Veterans Act* enhanced and expanded VA's internal staffing capabilities, we believe that policies to help address a nationwide shortage of medical personnel will bring stronger assurance that mental health and substance use services are available to veterans regardless of whether it is initially pursued at VA.

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[10] *See, e.g.*, S.5348 (117th Congress).
[11] SUBST. ABUSE AND MENTAL HEALTH SVCS., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2021 NATIONAL SURVEY ON DRUG USE AND HEALTH, *available at* https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf.
[12] *Id*. at 32.
[13] *Id*. at 39.
[14] BUREAU OF HEALTH WORKFORCE, HEALTH RES. AND SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREAS STATISTICS, FIRST QUARTER OF FISCAL YEAR 2023 (Jan. 2023) (as of December 31, 2022).
[15] Federal regulations stipulate that, to be considered as having a shortage of providers, a designation must have a population-to-provide ratio that meets or exceeds a certain threshold. Mental health designations may qualify for designation based on the population to psychiatrist ratio, the population to core mental health provider ratio, or the population to both psychiatrist and core mental health provider ratio.

Ensure more consistent reporting on the relationship between SUD and veteran suicide

According to VA's National Veteran Suicide Prevention Annual Report for 2022, the prevalence of alcohol use disorder among "Recent Veteran VHA Users" who died by suicide was 19.6%, cannabis use disorder 8.3%, and opioid use disorder 4.9%.[16] Overall, while suicide rates fell from 2019 through 2020 for those with any mental health or SUD diagnosis, suicide rates rose for those with substance use disorders.[17] Insights like these are helpful for policy-making; the data above is particularly compelling for the subject of today's hearing. Yet even though access to mental health and substance use disorder services is a VHA priority and part of VA's National Strategy for Preventing Suicide, comparable data was not presented in the 2021 report. In 2020 and 2019, mental health and substance use disorder discussion covers periods dating back to 2005[18]; however, no comparable data can be found in the September 2018 report.

While we appreciate the earnest efforts of VA to report on veteran suicide data, WWP supports the laudable goal of more comprehensive and consistent annual reporting. The *Not Just A Number Act* (S. 928) would create several annual reporting requirements for VA, including an examination of trends in suicide rates or deaths among veterans who have a diagnosis of substance use disorder. In addition to creating expectations about consistent reporting on health data and trends, this legislation would go considerably further by looking at trends related to Veterans Benefits Administration usage that have not been addressed in prior annual reporting. In sum, passing this legislation would create more potential for VA and the broader veteran support community to make more informed decisions about where to focus resources to help prevent veteran suicide.

Make case management services more accessible

Wounded Warrior Project's approach to helping warriors find care for co-occurring SUD and mental health disorders has been successful thanks in part to strong case coordination and communication. As discussed previously, VA Liaisons co-located at Warrior Care Network's partner academic medical centers have been an indispensable tool in creating a stronger continuum of care for warrior patients. Between FY 2018 and FY 2022, that collaboration has resulted in over 9,000 cases consultations by VA staff at academic medical centers.

Similarly, our C3 program has also delivered more positive results for veterans on account of close collaboration with VA. Among nearly 1,200 veterans served though C3, 30 percent of those enrolled for care at VA stated the VA is not aware of their current mental health situation. Because C3 works to identify community-based providers that are in the Community Care Network, our advocacy on the veteran's behalf often results in significant communication with local VA mental health leaders once veteran permission is acquired. Subsequent VA-provided referrals for care result in lower out-of-pocket expenses for the veteran than what may

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[16] OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, 2022 NATIONAL SUICIDE PREVENTION ANNUAL REPORT 27 (Sept. 2022).
[17] *Id*.
[18] OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, 2020 NATIONAL SUICIDE PREVENTION ANNUAL REPORT 27-28 (Sept. 2020); OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, 2019 NATIONAL SUICIDE PREVENTION ANNUAL REPORT 12-13 (Sept. 2019).

have been sought independently (or without WWP assistance) and closer coordination of care before and after community-based treatment.

This positive engagement with VA can go even further when considering the typical presentation of a warrior who works with our C3 program. For example, 16 percent of warriors did not have an appointed primary care provider at VA before working with WWP and subsequently established a point of contact for current and ongoing referrals. 78 percent had been unemployed for 6 months or more and could surely benefit from more streamlined support from Veterans Benefits Administration programs like Veteran Readiness and Employment. An equivalent number of veterans also reported unstable housing as a barrier to care. Future care for other conditions would appear more likely as well given that these veterans often present with multiple medical diagnoses (1,149 clinical diagnoses among 422 warriors in a recent sample).

One program that may warrant closer inspection is VA's Mental Health Intensive Case Management program. These programs are required at Veterans Health Administration health care systems serving 1,500 or more veterans identified on the National Psychosis Registry. Designed specifically to optimize the health status, quality of life, and community functioning of veterans diagnosed with serious mental illness who frequently utilize VA mental health inpatient and emergency services, perhaps a complementary program can be made available to veterans with less severe medical diagnoses.

Given how the veterans we serve often present with complex needs, inspiration for improvements to case management can be found in the Federal Recovery Coordination Program (FRCP) that previously assigned recovering Service members with recovery care coordinators responsible for overseeing and assisting the Service member in their course through the entire spectrum of care, management, transition, and rehabilitation services available from the federal government. The program also called for assignment of medical care managers and non-medical care managers who were responsible for, among other tasks, helping resolve problems involving financial, administrative, transitional, and other matters that arose during recovery and transition.

In 2018, the FRCP transformed into the Federal Recovery Consultant Office (FRCO) in response to the Presidential Executive Order, "Comprehensive Plan for Reorganizing the Executive Branch." While this shift may have created some efficiencies, WWP encourages a fresh assessment of whether the FRCO can serve as a similar hub for veterans seeking more assistance with complex cases involving SUD and/or mental health disorders. WWP's experience has shown that veterans are likely to benefit from a heightened level of support often present with co-occurring SUD and mental health disorders.

CONCLUSION

Wounded Warrior Project thanks the Subcommittee on Health and its distinguished members for inviting our organization to submit this statement. We are grateful for your attention and efforts towards addressing this critical issue of substance abuse amongst our nation's veterans. We look forward to continuing to work with you on these issues and are standing by to assist in any way we can towards our shared goals of serving those that have served this country.

MENTAL HEALTH CONTINUUM OF SUPPORT

The Wounded Warrior Project® (WWP) Mental Health Continuum of Support is composed of a series of programs that address mental health care needs of warriors. These programs allow us to engage with warriors based on their unique needs. The continuum is made up of internal resources and programs to assist warriors on their journey to recovery. WWP uses the Connor-Davidson Resilience Scale© (level of resilience), the Rand QoL Scale (psychological well-being), and other validated scales and measurements to determine the appropriate level of care for each warrior.

INCREASED RESILIENCY

INDEPENDENCE PROGRAM

INPATIENT CARE

PROJECT ODYSSEY®

WWP TALK

WARRIORS LIVING THE LOGO

WOUNDED WARRIOR PROJECT®

OUTPATIENT THERAPY

CLINICAL

INCREASED PSYCHOLOGICAL WELL-BEING

WOUNDED WARRIOR PROJECT®

The continuum of support doesn't define an exact, prescriptive path to recovery, rather the individual needs of each warrior to determine the order and frequency of appropriate program engagement. For example, a warrior in acute psychological distress may be referred to a number of clinical intervention programs. Another warrior with less severe mental health issues may participate in only one or two programs. Subsequently, any warrior who has a setback may be re-evaluated and referred back to one or more programs for additional care. The goal is to provide the appropriate amount of care a warrior may need to get to his or her highest possible level of resilience, psychological well-being, and healing.

INPATIENT CARE
Clinical Intervention

Inpatient care is reserved for warriors in severe psychological distress who have exhausted all other resources. WWP may be able to fund inpatient services in order to stabilize warriors so that they can be engaged with other mental health programs in the continuum. The goal is to sustain and facilitate movement in the continuum through other programs.

WARRIOR CARE NETWORK
Clinical Intervention

To accelerate the development of advanced models of mental health care, WWP partners with four world-renowned academic medical centers to form Warrior Care Network®, leveraging our collective commitment and expertise. The Warrior Care Network treatment model delivers a year's worth of mental health care during a two- to three-week intensive outpatient program (IOP). This unique veteran-centric approach increases access to treatment and improves outcomes. Warrior Care Network provides a path to long-term wellness, improving the way warriors are treated today and for generations to come.

PROJECT ODYSSEY
Engagement Intervention

Project Odyssey is a 12-week mental health program that uses adventure-based learning to help warriors manage and overcome their invisible wounds, enhance their resiliency skills, and empower them to live productive and fulfilling lives. Based on their unique needs, warriors can participate in an all-male, all-female, or couples Project Odyssey. The program starts with a five-day mental health workshop, where warriors are challenged to step outside the comfort of their everyday routines. This opens them up to new experiences that help develop their coping and communication skills. After the workshop, participants work together with WWP to stay engaged, achieve their personal goals, and make lifelong positive changes.

★ PROGRAMS WITH MULTIPLE STAGES OF ENGAGEMENT ★

Within the continuum of support there are additional programs/resources that can be engaged at nearly any point in the continuum. These are WWP Talk and outpatient therapy. The Independence Program, which also encompasses multiple stages of engagement, is a unique component of the continuum. The resources provided by the Independence Program allow the most severely wounded warriors the ability to lead a full life at home instead of a long-term facility.

OUTPATIENT THERAPY • *Engagement and Clinical Intervention*

An additional clinical resource available to warriors across the stages of the continuum is outpatient therapy. Here WWP funds external partners to provide individual, family, or couples therapy delivered by a culturally competent therapist in the closest geographic location to the warriors as possible. With multiple funded clinical partners, warriors are able to engage in traditional outpatient sessions or, if in a remote location, engage in virtual therapy.

WWP TALK • *Engagement and Coordination Intervention*

WWP Talk is a telephonic emotional support program that breaks down the barriers of isolation and helps both warriors and family members plan an individualized path toward their personal growth. Participants work one-on-one with a dedicated team member during weekly emotional-support calls. Together, they set tangible goals and develop skills that lead to positive changes, like increased resilience and improved psychological well-being.

INDEPENDENCE PROGRAM
Engagement, Coordination, and Clinical Intervention

The Independence Program provides long-term support to catastrophically wounded warriors living with injuries such as: a moderate to severe brain injury, spinal cord injury, or neurological condition that impacts independence. The program is designed to support warriors who, without high-touch services, would struggle to live day to day due to the severity of their injuries. The Independence Program increases access to community services, provides rehabilitation through alternative therapies, and empowers warriors to achieve goals leading to a more independent life. Because every journey is different, we work as a team with warriors, their family members, and their caregivers to set goals to live a fulfilling life, at home, with their loved ones.

★ LIVING THE LOGO ★

The WWP logo is much more than a trademark — it is what we see as the ultimate goal for all warriors engaged with the continuum of support to achieve. It is the collective goal of the continuum of support (through resources and teammates) to empower warriors to make it to this final phase and live our logo. The logo, one warrior carrying another warrior, represents a peer assisting a fellow veteran — in essence, carrying him through the recovery process until he can walk of his own accord (through heightened resiliency and psychological well-being). Eventually, as resiliency reaches the highest levels in the continuum, warriors are empowered to help carry fellow veterans, essentially becoming force multipliers as they are engaged as peer mentors.