

**OVERCOMING PTSD: ASSESSING VA'S EFFORTS TO
PROMOTE WELLNESS AND HEALING**

HEARING

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

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OVERCOMING PTSD: ASSESSING VA'S EFFORTS TO PROMOTE WELLNESS AND HEALING

Wednesday, June 7, 2017

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Committee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. David P. Roe [Chairman of the Committee] presiding.

Present: Representatives Roe, Coffman, Wenstrup, Bost, Poliquin, Bergman, Banks, Walz, Takano, Brownley, Kuster, O'Rourke, Sablan, and Esty.

Also Present: Representative Ryan of Ohio.

OPENING STATEMENT OF DAVID P. ROE, CHAIRMAN

The CHAIRMAN. Good morning. The Committee will come to order.

And before we begin, I would like to ask unanimous consent for our colleague, Representative Tim Ryan from Ohio, to sit on the dais and to participate in today's hearings.

Without objection, so ordered.

With that procedural note out of the way, welcome and thank you all for joining us this morning.

During the Civil War, it was called Soldier's Heart; during World War I, it was called shell shock; during World War II, it was called battle fatigue; today we know it as post-traumatic stress and the last fiscal year alone almost 600,000 veterans sought care for it in the Department of Veterans Affairs.

At today's hearing we are going to discuss whether the current system of VA health care services and benefits effectively promotes wellness and supports veterans with PTSD in seeking treatment.

VA exists to provide veterans with PTSD or any other condition that may be connected to a veteran's time in uniform with the care they need to live healthy, whole lives. Accordingly, the array of benefits and services that VA provides to veterans who have been diagnosed with PTSD is most impressive and expanding.

And I am encouraged by the plethora of treatment programs, both traditional and nontraditional, that VA offers; by the increased number of partnerships with private sector and non-for-profit providers organizations that VA is entering into to better support those with PTSD; and by the innovative research that VA is continually investing in to gain a deeper understanding of how

veterans can overcome PTSD, including one important study that is going on right now to evaluate the use of service dogs for veterans with PTSD. I very much support the research and look forward to reviewing its results when they become available.

I also look forward to holding a separate hearing this Congress to discuss more in depth an issue we will briefly touch on this morning: the benefits of complementary and integrative medicine for veterans, and actions needed to spread both the awareness and the availability of nontraditional techniques that can do a world of good for those struggling. But this morning I want to focus on the perennial problem of PTSD among our Nation's veterans and what more we as a grateful Nation can be doing to support veterans who may be struggling to seek help and to embrace recovery.

Thanks to the quantum leaps in battlefield traumatic medical care, there are fewer casualties as a result of today's conflicts than there have been in previous wars, yet the mental strain that some, certainly not all, but some of our veterans face seem to be taking a heavier toll than it perhaps has ever before.

Since 2010, the number of veterans receiving care for PTSD from the VA health care system has grown by more than 50 percent and despite historic and ever-increasing investments in VA mental health services and supports since the turn of the century, suicide rates among veterans with PTSD are not declining.

Despite all the good, well-intentioned work that has been done, clearly we must do more to reduce the stigma against seeking care to break down institutional barriers that prevent veterans from accessing the services they need, to encourage veterans with PTSD that they can overcome their current challenges and lead full lives, and most importantly to foster connection and healing veteran-to-veteran.

We are joined this morning by a distinguished and diverse group of panelists, three of whom are veterans themselves. What their testimony will tell you is that they need to recalibrate our current system of care for veterans with PTSD and focus our efforts on wellness-based, peer support programs that foster community, connection, and conversation between veterans one-on-one, where they will argue most of the real healing begins, and on making it easier for veterans who know they need help to seek care without having to wait in line or jump through bureaucratic hoops for that first appointment.

If there is one overarching message that I want to get out at this hearing is that PTSD is a treatable condition; it is not a sign of weakness or defeat and it does not have to represent a life of incapacity. For any veteran who may need it, there is hope, there is help, and there is healing available both within the VA health care system and within your home communities. There are other veterans who are ready, willing, and able to walk with you, and with that our focus as policymakers is on trying to make it easier for you.

And I appreciate our witnesses being here to discuss this important topic and in some cases to share their very personal stories with us this morning.

I now want to yield to Ranking Member Walz for any opening comments that he may have.

**OPENING STATEMENT OF TIMOTHY J. WALZ, RANKING
MEMBER**

Mr. WALZ. Well, thank you, Mr. Chairman, and I want to thank you for your leadership in this. You and I have had our entire career in Congress here together on this Committee and you have been a champion of this since the day I got here, addressing the issues in and a holistic approach to our veterans' health care, and for that I am grateful. And your proactive approach to scheduling this hearing and, I agree with you, putting together an all-star panel is greatly appreciated.

I also want to thank you, Mr. Chairman, for the unanimous consent to allow our colleague, the gentleman from Ohio, who is joining us today. Congressman Ryan has been a leader in Congress promoting wellness through mindfulness, social and emotional learning, and encouraging veterans to incorporate healthy practices into their daily lives. I look forward to working with him. He has introduced Veterans Wellness Act of 2017, was an active force behind putting this panel together. So thank you, Mr. Ryan.

To our witnesses, to all of you, thank you for being here today. I look forward to hearing your stories. Many of you have been in my office, you have pushed this issue, you have been in the media, you have been active participants in improving the lives of our veterans, and for that I am grateful.

I can tell you, though, it is always with heavy heart, I vividly remember the testimonies that we have had on this subject before. Family members of Daniel Somers, Clay Hunt and Brian Portwine who were in 2014. These testimonies were difficult to deliver, hard to hear, but integral to the advancement and passage of legislation to address and prevent veteran suicide, the Clay Hunt SAV Act.

The strength of these families to come forward and share their intimate stories of loss is evidence of the care, compassion and community that saturates the veterans population.

I particularly want to recognize in this forum the heroic role military spouse's play. Life is not easy as a military spouse to begin with, but to be called on to get up every day and recommit to the best interests of a spouse struggling with the effects of post-traumatic stress is profoundly heroic and a challenge too often conducted in isolation. So today we want to make sure we honor those heroes in our efforts to save lives. It is this care, compassion and community that must be leveraged by the VA to ensure veterans have access to the support they need while recovering, as the Chairman so rightfully said, with a future of healing, a future of moving forward.

The Clay Hunt SAV Act required the VA to look internally at ways to increase access to mental health care for veterans and externally at ways to increase the community's presence in how this mental health is delivered.

The Clay Hunt SAV Act also mandated the VA begin to collect data on mental health care to aid in future improvements and discussions such as this one. While we wait on the delivery of that data in 2018, we can rely on the VA's reporting of 20 veterans' lives lost to a suicide every day to tell us we have work to do; 20 veterans who did not receive the support they needed in a way that could accept, process and apply.

Before me are four veterans that refused to become a statistic, they refused to become a casualty of war, and after surviving both combat and PTS, these veterans decided to continue fighting on behalf of fellow veterans. I appreciate the time each of you has taken to testify today and I look forward to a discussion that will support further advancements in the treatment of veterans' mental health.

Thank you, Mr. Chairman, and I look forward to your testimony.

The CHAIRMAN. Thank you, Mr. Walz.

Our first panelist is Brendan O'Byrne, a veteran of the United States Army. Welcome.

Mr. Sebastian Junger—I came prepared, I brought the book—a journalist, film maker, and author of many notable works including the recent book, *Tribe: On Homecoming and Belonging*. I recommend you read that.

Zach Iscol, Executive Director of Headstrong Project and a veteran of the United States Marine Corps. Welcome.

Paul Downs, a member of the Boulder Crest Retreat Team and a veteran of the United States Marine Corps, who is testifying on behalf of the David Lynch Foundation's Operation Warrior Wellness initiative. Welcome.

And Dr. Harold Kudler, the Acting Assistant Deputy Under Secretary for Patient Care Services for Veterans Health Administration of the U.S. Department of Veterans Affairs, who is accompanied by Brad Flohr, Senior Advisor at the Veterans Benefits Administration.

Welcome you all also. Thank you for being here this morning.

Mr. O'Byrne, you are recognized for five minutes.

STATEMENT OF BRENDAN O'BYRNE

Mr. O'BYRNE. Hello. Thank you for allowing me to share my story. My name is Brendan O'Byrne. I served in the military from 2002 to 2008.

In May of 2007, I was deployed to the Korengal Valley, Afghanistan, and completed a 15-month tour as a Sergeant and Team Leader with the Airborne Infantry. When my unit and I redeployed back home, I did not expect to have any issues from the deployment, but I was wrong. I began to have various symptoms of PTSD upon returning from combat.

When I was honorably discharged in December 2008, I began to seek help from the VA to deal with the PTSD I had. At the time, I was unemployable, barely able to function in a healthy way, so I applied for disability, PTSD disability.

After a four-year back and forth with the VA, I was given a 70-percent disability rating. Almost immediately, I was told by other veterans and even some workers at the VA that I should fight for my 100 percent. Now, I don't know if they saw something that I didn't, but in my eyes I was not 100-percent disabled, and I told them that. The common response was, "You deserve 100 percent, you earned it."

I take offense to these two statements because I fail to see how I deserve or earned a disability rating. I have PTSD, a treatable disorder. I did not lose a limb or sustain any permanent physical damage. A PTSD disability rating is not a handout, it is a tool.

I used the money as a tool. I didn't have to worry about my rent or bills, I could focus squarely on the PTSD symptoms and fix them. I did the work, working through the crippling anxiety, blinding anger, and a slurry of other symptoms. Because of that hard work, today I know I am no longer 70-percent disabled.

Recently, I have been working on the steps to lower my rating. Surprisingly, I have received a lot of push-back. The push-back has come from well-intentioned VA workers, other veterans, family and friends, all singing the same chorus, "You deserve it, you earned it."

What I have to ask is this: if our goal is not to get the veterans off disability and to become active, contributing members of society, then what is our goal? To me, being an active member of society is the ultimate sign of healing from combat and we all should be striving for it.

On my journey back home I have tried all forms of treatment, from VA counseling to a service dog. My first concentrated effort was through the VA, signing myself into a 45-day in-patient PTSD treatment facility eight months after separating from the Army. While there I learned many of the mechanics of PTSD, like the triggers of PTSD symptoms and ways to deal with them or avoid them.

Every day we would have group counseling sessions. Sometimes I would hear varying stories of trauma from combat in Vietnam jungles to the streets of Iraq, but more than those traumatic stories I heard stories that sounded a lot more like a bad day rather than a traumatic moment.

As weeks went by, I realized a sad truth about a portion of the veterans there, they were scammers seeking a higher rating without a real trauma. This was proven when I overheard one vet say to another that he had to pay his bills and how he was hoping this in-patient was enough for a 100-percent rating. I vowed to never participate in group counseling through the VA again.

When there is money to gain, there will be fraud. The VA is no different, veterans are no different. In the noble efforts to help veterans and clear the backlog of VA claims, we allowed a lot of fraud into the system and it is pushing away the veterans with real trauma and real PTSD.

Since returning home in 2008, I have given speeches all across the country about my struggles with PTSD and talked to thousands of veterans seeking the answers about healing from combat. The trend I have seen among the combat veterans, the most traumatized group, is that they stay away from the VA or at the very least the group counseling settings. They have no patience for the fraudulent veterans scamming the system to get a paycheck and they are definitely not going to open up about their worst days to those who know nothing about them.

The problem is this: when we talk about healing from PTSD, I consider the most effective form of therapy peer-to-peer counseling, especially older vets mixed with younger vets. An easier way to understand the power of peer-to-peer counseling is looking at Alcoholics Anonymous. In AA there are no clinicians, no experts, and no money to gain by going to meetings; the only reward is getting sober.

Being an alcoholic myself, I did not turn to the doctors or psychologists to stop drinking, I turned to AA and the people who understood my plight through their own experiences, and I am close to four years sober now.

Veterans are the same in that we know how to take care of one another, but with the fraudulent PTSD claims and the clinical setting of the VA, it is hard for veterans to really open up about the worst days of their life. Where to go, though, if not the VA?

Last year, I was a co-facilitator of the From Troy to Bagdad Program run and funded by the New Hampshire Humanities. With a group of eight veterans, four Vietnam and four Iraq and Afghanistan, we read and discussed *The Odyssey* by Homer. We met once a week for two hours for 12 weeks. During those 12 weeks, I witnessed something I consider holy: older veterans and younger veterans hashing out the experience of war and homecoming, the old teaching the young and vice versa.

The amount of healing that was accomplished in that room is hard to describe. We talked about God, about death, about life, about the feeling of returning home to a country you no longer recognize as home. We talked about suicide, about anger, about hate; we talked about fate, bravery in combat and at home. And in those 12 weeks I learned more about war and homecoming than I had in all the VA counseling I received in the years of being home.

These are the conversations that bring veterans home and they desperately need to be fostered in the ways that promote the conversations that happen organically.

Around the country, small non-profits designed to serve veterans are springing up. Some of these non-profits have done an immense amount to heal vets. Some that I think are doing really great work are Outbound for Veterans, Heroes and Horses, Team Rubicon, and Team Red, White, and Blue. Though each of these non-profits are vastly different from one another, the one universal is that these groups empower veterans. They show veterans that they are not broken, that they can heal from these experiences, and do great things in the world after war.

When I come back to the question I asked in the beginning, what is our goal for our veterans' futures, programs like the ones I just mentioned are helping reincorporate veterans to be active members of society. I encourage more support for these programs.

[THE PREPARED STATEMENT OF BRENDAN O'BYRNE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. O'Byrne.
Mr. Junger, you are recognized for five minutes.

STATEMENT OF SEBASTIAN JUNGER

Mr. JUNGER. Thank you, Mr. Chairman. Thank you. It is an honor to speak here today.

Although every mission of service is crucial in our military, only about ten percent of soldiers experience sustained combat, and yet by some estimates, twenty five percent suffer from post-traumatic stress disorder or PTSD. Even the lowest estimates of long-term PTSD are higher than the total number of troops in combat.

Humans have evolved over hundreds of thousands of years survive and even thrive despite extreme violence and hardship, and if a quarter of our ancestors were psychologically incapacitated by trauma, the human race would have died out long ago. Many of our vets seem to be suffering from something other than a reaction to trauma.

One possible explanation for their psychological troubles is that, whether they experience combat or not, transitioning from the close, communal life of a platoon to the alienation of modern society is extremely difficult. Twenty five percent of Peace Corps volunteers struggle with depression when they return from service overseas.

Humans evolved to live in small groups where survival depended on being tightly bonded to those around us. We did not evolve to live alone or in single-family units that were independent from the wider community.

Ironically, when you collapse modern society such as during the London Blitz or the attacks of 9/11, there is often an improvement in mental health. Suicide rates in New York City dropped after 9/11. It is thought that the instinctive communalism of a crisis actually buffers people from suicide and depression. As one English official observed during the Blitz, "The chronic neurotics of peacetime are now driving ambulances."

Interestingly, PTSD is virtually unheard of among Afghan and Iraqi fighters, and the Israeli military reportedly has a PTSD rate as low as one percent. All of these societies enjoy both widespread military service and exceedingly tight community bonds. Furthermore, none of these societies incentivize veterans to see themselves as permanently damaged wards of the state.

In an attempt to reach more people, the VA allowed veterans to both self-diagnose PTSD and exempted them from having to cite any traumatizing incident during the war. As a result, the percentage of Global War on Terror vets on PTSD disability seems so high that the VA appears unwilling to release the figure. I have tried for two years to get that figure without success. Even highly placed administrators within the VA eventually gave up after trying to help me.

Obviously, a small number of combat vets will experience long-term trauma reactions and need full disability payments. A larger number of combat vets will need temporary financial support while they undergo counseling and dedicate themselves to rejoining the workforce. But if you want to create hundreds of thousands of depressed alcoholics in our society, give them just enough money to never have to work again and tell them they are too disabled to contribute to society in any meaningful way.

In the civilian population, which does not have access to lifelong PTSD disability, trauma reaction is considered both treatable and temporary. It would be interesting to see how the survivors of the Deepwater Horizon disaster are faring, or the survivors of Hurricane Katrina or the survivors of a town that was hit by a tornado. Surely, the vast majority of these people have resumed productive lives despite having been deeply affected by the trauma they survived. We are not doing veterans a favor by warehousing them in a lifelong entitlement program.

I would like to make one further point. In order for soldiers to avoid something called moral injury, they have to believe they are fighting for a just cause, and that just cause can only reside in a Nation that truly believes in itself as an enduring entity.

When it became fashionable after the election for some of my fellow Democrats to declare that Donald Trump was, quote, “not their president,” they put all of our soldiers at risk of moral injury. And when Donald Trump charged repeatedly that Barack Obama, the Commander in Chief, was not even an American citizen, he surely demoralized many soldiers who were fighting under orders from that White House.

For the sake of our military personnel, if not for the sake of our democracy, such statements should be quickly and forcefully repudiated by the offending political party. If that is no longer realistic, at least this Committee, which is charged with overseeing the welfare of our servicemen and women, should issue a bipartisan statement rejecting such rhetorical attacks on our national unity. That unity is all soldiers have when they face the enemy and you must do everything in your power to make sure it is not taken from them.

Thank you very much.

[THE PREPARED STATEMENT OF SEBASTIAN JUNGER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you for your testimony.

And now, Mr. Iscol, you are recognized for five minutes.

STATEMENT OF ZACH ISCOL

Mr. ISCOL. Thank you.

Thank you all for having me here today. It is an honor to be here before Congress.

Many great things begin in a bar, including my beloved Marine Corps, as did the Headstrong Project. In 2012, I was catching up with my former battalion commander, a guy named Colonel Willy Buhl, about ten years after the second battle of Fallujah. During that fight, we lost 33 Marines in combat, half the battalion, 500 men were wounded, and Colonel Buhl remarked to me that he was worried that we would soon lose more Marines to suicide than we had to enemy action. Today, that count stands at 23 Marines lost to suicide.

For us at Headstrong, this work is deeply personal.

Two days later, I relayed that story to two very successful investors in New York City, very successful finance guys, and one of them remarked to me that he didn’t understand why he could see one of the top psychiatrists in New York City tomorrow morning without private insurance, without a wait time—I’m sorry, regardless of wait time, schedule or insurance, and he asked a simple question, why can’t we do the same for our veterans?

That became the founding mission of Headstrong Project.

Within months, we raised a small amount of money, formed a partnership with Weill Cornell Medicine to treat Iraq and Afghanistan veterans in New York City. Since then, we have provided over 5,500 clinical sessions, grown to almost 200 active clients, and have expanded our treatment program outside of New York City to San

Diego, Houston, Chicago, Washington, D.C., through a network of over 80 world-class private practice providers.

More importantly, we have not had a single suicide.

Prior to our expansion efforts, we intentionally grew slowly to ensure that our model was effective. Among the 47,000 veterans service organizations in our country, there is no shortage of goodwill, but there is also no shortage of half-baked ideas, ineffective awareness campaigns, or fund-raising efforts without a foundation of solid programming. For us, it was critically important that we build a program that actually works.

We will be opening in Denver and Colorado Springs within a month, and received a grant from the New York State Health Foundation to begin providing care to veterans in rural areas of New York State.

Our model is simple, effective, and highly efficient. On average, it costs less than \$5,000 to treat one veteran and \$250,000 to expand to a new market. All treatment is tailored to the needs of the individual and managed by our team at Weill Cornell Medicine. We do not limit the number of sessions and we do not believe that there is a panacea for treating post-traumatic stress.

In New York City, all care is provided at Weill Cornell. In other locations, what we have done is we built a network of top psychiatrists, psychologists, and social workers to provide care. Instead of spending millions to build brick-and-mortar clinics that are often staffed by inexperienced recent graduates, we tap into the capacity of the private market to provide care. These are the same doctors that Members of this Committee would send their loved ones to should, God forbid, they need it. These clinicians must meet a very high standard of experience, training, and qualifications, and they are also vetted, interviewed, and managed by our team at Weill Cornell.

We then pay these clinicians to provide care; in return, we require that they submit their notes to our team at Cornell and that they participate in case conferences to ensure that we have accountability of outcomes. We provide a variety of evidence-based treatments, including EMDR, cognitive behavioral therapy, drug and alcohol treatment, group therapy, and spouse and family support.

When a veteran reaches out to us, we are in touch with them almost immediately. We say on our Web site within 48 hours, it is usually within hours. They then do a call with one of our clinicians, who finds out why they are reaching out to us, what the issue is, and we do not require any paperwork, insurance, and provide care regardless of type of military discharge.

After their phone intake, that client then meets with a psychiatrist M.D. to do an initial session. One or two sessions, we get an initial diagnosis. We ensure that they are a good fit for outpatient care and then we plug them into an individually-tailored treatment program that not only includes evidence-based treatment, but could include substance abuse treatment, group therapy, and non-clinical activities like yoga, rock climbing, kayaking, and other sports and mind-body techniques.

While undergoing the treatment, our team at Cornell closely monitors the veteran's progress to make adjustments to care and

to ensure our client is getting better. This work is not done in a vacuum, but is in coordination with the client and their clinical team.

And while this might seem expensive, it is very efficient and as I said, I said the numbers earlier. In the documents that I submitted, I showed some of the outcomes that we have in terms of improved sleep, reduced hyper-vigilance, reduction in avoidance, reduction in suicide ideation, improved mood, improved at work or at school, reduction in drug and alcohol use, and reduction in the use of medication for symptoms that you can see.

And I would state that those numbers are probably two to three times higher than any other clinical program.

I am also proud to say that our number-one source of referrals is veterans referring other veterans to our program. We have a great relationship with some VA hospitals in cities like San Diego and Houston, less so with others as referral partners.

And most importantly I think, in the special operations community we adhere to five what we call the SOF truths: that humans are more important than hardware, that quality is better than quantity, that special operations forces cannot be mass produced, that competent special operations forces cannot be created after emergencies occur, and that most special operations require non-SOF assistance.

And I believe that these SOF truths are equally important when you are talking about providing credible and effective mental health care to our Nation's veterans and that these truths are the backbone of what makes Headstrong work so effectively. There is no simple app that will solve this problem; instead, it requires talented and dedicated human beings.

I cannot emphasize enough that the quality of the provider's matters immensely and you cannot produce these great clinicians overnight or after a national emergency like the current suicide epidemic.

I would add that this human factor extends to the veterans we treat as well. Our medical director and co-founder, Dr. Ann Beeder, a leading trauma and substance abuse psychiatrist and professor of medicine at Weill Cornell has often remarked that in her 30-year career treating people with mental health issues, veterans represent the best patients she has had the honor of working with. They are goal-oriented, hardworking, and follow the doctor's orders. Remarkably, once they start getting better, they look for ways to continue to serve and give back.

And I will just tell one anecdote. Often a veteran will reach out to us, usually a Seal, a Ranger, or a Marine, and they will want assurances that our program is completely confidential. They will say, you know, I am reaching out, my spouse says that if I don't get help, she is going to leave me, it is the only reason I'm coming here, I want to make sure nobody knows that I'm going to get help. And after a few sessions, that Seal, Ranger, or Marine is starting to sleep through the night, their anxiety and panic attacks go away, they are no longer self-medicating, and after about five or six months, they are much better. And then they won't shut up about the treatment program. They want all of their friends to know

about, they become ambassadors to our program, because treatment works.

And what Mr. O'Byrne said about doing the hard work and that PTSD is treatable, more veterans need to hear those words.

In my own journey, I have learned that one of the biggest barriers to care is that many do not recognize mental health care as real medicine. And I am not talking about drugs or pharmaceuticals, but the hard work that goes into that healing and repairing the effects of combat or moral injury on our brain and nervous systems. Hidden wounds can be healed.

At Headstrong, we firmly believe that if you have the courage to get help and you get the right help, you can recover and get back to the best version of yourself. Our job at Headstrong is to make sure people are getting the right help and our clients will tell you this takes hard work, but is worth all the efforts.

Thank you for your time and for having us here today.

[THE PREPARED STATEMENT OF ZACH ISCOL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you.

Mr. Downs, you are now recognized for five minutes.

STATEMENT OF PAUL DOWNS

Mr. DOWNS. Thank you, Chairman Roe, Ranking Member Walz, and other distinguished Members of the Veterans' Affairs Committee for this opportunity to speak with you today, to tell you my story, and to bear witness for a powerful technique for healing and wellness: transcendental meditation.

My name is Paul Downs and I served 11 years in the United States Marine Corps as an Infantryman and I was deployed a number of times.

When I left the Marines, I realized that I would be closer to my young children, but what I didn't realize was just how much my identity as a Marine meant to me. When I left the Corps, I lost my tribe, I lost my sense of self, and I lost all that I knew to be true. I lost my sense of forward momentum, purpose, and connection.

What caught up with me weren't just the nightmares related to my deployment, it was all the traumas that I carried into the Marine Corps. Like many of my brothers and sisters, my first experience with combat wasn't Karmah or Fallujah, it was the hallways of my own house as a child, a place that should have been safe, but was instead an active war zone. The Marine Corps in actuality saved my life for a time.

When my service was done, I sought help from the VA. I sought guidance and direction and connection, and instead I got apathy, diagnoses, and denials. So I quit trying. Why would I add that level of stress to the struggle that I was already neck deep in?

I suffered from post-traumatic stress and too many outside observers might have seemed like an angry, disgruntled veteran. The fear and sadness was drowning, and after a few months of putting away the uniform I developed a pretty detailed plan for suicide. I was about as close as you could come to becoming a statistic.

I was sitting in my truck, ready to proceed with the plan, and the thought hit me, that to die by my own hand is not my birth-

right. This is not it and this is not to be my end. It can't be and it is not the way of the warrior. Warriors have a deep appreciation for life and are not victims of circumstance.

I called the Executive Director of Boulder Crest Retreat and I said, I need something new in order to live, because if I don't, I am certain to die. That something was the Warrior PATHH program. It is an immersive program where veterans rely on the support, the company, and the experience of our peers. The program was created by combat veterans for combat veterans. And during the program, many modalities allowed me to face my deep struggle and grow to profound strength. I was able to claim a new and positive diagnosis of post-traumatic growth.

The modality that most made this change possible was transcendental meditation. It is a simple-to-learn, easy technique taught by a fellow combat veteran. I took comfort in knowing how evidence-based TM is. And I could cite all the research that demonstrates its promise and its power—340 peer-reviewed studies, National Institute of Health Research showing substantial reductions in heart disease, massive decrease in symptoms of post-traumatic stress, depression and insomnia—but I am not a public health expert, so I would rather just tell you how it helped me.

After just a few weeks of practicing this meditation for 20 minutes, twice a day, I felt less anxious, less angry, more focused, more energized, and more directed. I had found purpose again. I gained a connection to self that I didn't have before; I had severed it in order to survive. And surviving wasn't my birthright anymore, thriving was. I found peace with my past and I realized who I am, and there is no pill for that.

Because of that connection to self, I now find myself as a Warrior PATHH guide at Boulder Crest Retreat. I get to walk with my brothers and sisters on their path from struggle to strength.

There were many activities that we engaged in at the retreat, but many of them don't apply to everyday, post-retreat life. TM is different. I can meditate on an airplane, I can meditate in traffic. I don't close my eyes, but I do use the mantra. And that is why TM is so pivotal; you can take it anywhere and it can be done at any time. And perhaps that is why it has so many other applications, such as classrooms filled with at-risk children or for women and children dealing with the aftereffects of intimate-partner violence.

What I have come to realize is that I needed this training, training to learn how to regulate so I could be as calm, cool, and collected at home as I was on the battlefield. We have to be trained to be present and connected, and it is hard to believe that 20 minutes, twice a day is exactly what we require, but it is. It worked for me, and for thousands of my brothers and sisters. It has given me the opportunity not just to survive, but to thrive, and to live a life that is truly full of purpose, meaning, connection, and service.

And for that I want to thank the David Lynch Foundation and their outstanding Operation Warrior Wellness Division, which makes TM available to veterans overcoming post-traumatic stress and the families who support them. They gave me a gift that changed my life, the lives of my family, and the lives of everyone I come into contact with. I am grateful that they have also been

there for many others. And in 2016 alone veterans and Active duty military from 38 states have learned TM from specially trained teachers and get to experience its impact.

As you reflect on the changes that are needed in the VA, I would ask that you provide more platforms for the voices of others like me, voices that often get lost in our decisions to find solutions, those who have been there and done that on the battlefield and in the depths of despair. The one thing that will never change is that we veterans know what one another need.

Thank you for your time and attention, and for the honor of addressing you today.

[THE PREPARED STATEMENT OF PAUL DOWNS APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Downs. I may have to have you teach me that before my next Town Hall that I do.

[Laughter.]

The CHAIRMAN. Dr. Kudler, you are recognized for five minutes.

STATEMENT OF HAROLD KUDLER, M.D.

Dr. KUDLER. Well, good morning, Chairman Roe, Ranking Member Walz, and Members of the Committee. And thank you for the opportunity to discuss the Department of Veterans Affairs mental health services that promote recovery from post-traumatic stress disorder and support veteran wellness.

I am accompanied by Brad Flohr, Senior Advisor for Compensation Service, Veterans Benefits Administration.

VA is committed to providing timely access to quality, evidence-based mental health care that anticipates and responds to veterans' needs, advances their recovery, and supports reintegration into their communities. In fiscal year 2016, more than 1.6 million veterans received treatment in a VA mental health specialty program. From 2007 to 2017, the number of veterans receiving disability compensation increased 190 percent.

The continuum of PTSD care includes mental health providers based in primary care mental health clinics, behavioral health integration teams, specialized residential rehabilitation treatment programs, and PTSD outpatient clinical teams.

Nationwide, VA operates 131 PTSD clinical teams, each of which has a staff member trained to treat veterans with PTSD and concurrent substance use disorders.

The VA recognizes that PTSD has varied and complex symptom presentations, and they require a nuanced approach. This was the rationale for creating the Center for Compassionate Innovation, which offers options when traditional, evidence-based treatments did not meet veterans' needs. VA's National Center for PTSD is the world's leading resource for PTSD treatment, research, and education. It provides assessment tools and treatment manuals, online training, smartphone apps, on its award-winning Web site, ptsd.va.gov.

An important new research initiative is the Leahy-Friedman National PTSD Brain Bank, the first repository dedicated to understanding how psychological trauma and biological systems interact to create anatomical and functional changes in brain tissue.

Recent VA research finds that 20 veterans die by suicide each day and veterans must receive assistance where and when they need it. To do this, we have developed the largest integrated suicide-prevention program in the country, with over 1100 employees specifically dedicated to suicide prevention and veteran engagement.

VA has also fielded the groundbreaking REACH VET program, which uses a new predictive model to analyze data from millions of veterans' health records to identify those at statistically elevated risk for suicide, as well as other adverse outcomes. This allows VA to provide preemptive, enhanced care to lessen the risks for those before those challenges become crises.

The number of veterans receiving mental health care from VA is growing three times faster than the overall number of VA users. This reflects VA's concerted effort to engage veterans who are new to our system and to enhance access to mental health services for enrolled veterans. It is also a reflection of the elimination of barriers to seeking mental health care by reducing the stigma associated with it.

The VA is committed to working with public and private partners to ensure that no matter where a veteran lives he or she can access quality, timely mental health care.

As of April 2017, there were almost 1100 peer specialists engaging veterans at VAMCs and community-based outpatient clinics. Certified peer specialists are veterans in recovery from mental health conditions who provide understanding, support, and advocacy. Crisis intervention and suicide prevention are skills peer specialists apply from the first moment they meet veterans.

Peers who have recovered from mental health conditions, including many who have survived suicidal ideation and attempts, are living proof to veterans that there is hope for recovery and a quality life.

Vet Centers provide free readjustment counseling for veterans who served in combat and offer a wide range of social and psychological services to veterans, Active duty servicemembers, and their families. This includes individual and group counseling, as well as family and bereavement counseling. In 2015, Vet Centers provided more than 228,000 individuals and families with over 1,664,000 visits.

Vet Centers are non-medical facilities, but they refer veterans to VA outpatient mental health care when that would facilitate successful readjustment to civilian life.

We know that 14 of the 20 veterans who die on average by suicide every day do not receive mental health care within VA and one current barrier to that care is having an other than honorable administrative discharge. Driven by the need to reduce the number suicides and treat mental illness in at-risk populations, VA is expanding provisions for urgent mental health care needs to other than honorably discharged veterans by using existing legal authorities.

Treating PTSD is a top VA priority. We remain focused on providing high-quality care for veterans, because they have earned it and they deserve it, and our Nation trusts us to provide it. We ap-

preciate the support of Congress in doing this and look forward to responding to any questions you may have.

[THE PREPARED STATEMENT OF HAROLD KUDLER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Kudler.

I first of all thank the entire panel. You all were very informative and I appreciate you taking the time to prepare. I am going to hold my questions until the end and I will now yield to Mr. Coffman for five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

Let me ask a question to the VA first, in that what percentage of those who have been assessed as disabled by the Veterans Administration are participating in treatment?

Dr. KUDLER. The way I look at those numbers, it ought to be about half. There are about 930,000 veterans who have been assigned disability for PTSD and we saw 453,000 of them last year.

Mr. COFFMAN. But your number 453,000, that could include a good deal of veterans who have not been—who have complained about symptoms related to post-traumatic stress, but have not been assigned a percentage in terms of disability; is that correct?

Or do you track them according—do you bifurcate those numbers as to those who have been given a percentage of disability, a disability award by the VA, versus those who have not?

Dr. KUDLER. Yeah, I would like to get you a breakdown of that.

Mr. COFFMAN. I would like that breakdown.

Dr. KUDLER. But again, there are 932,000—

Mr. COFFMAN. Right.

Dr. KUDLER [continued]. —who are service-connected with PTSD and we have seen 453,000 of them.

Mr. COFFMAN. I would like to get that breakdown.

And for the veterans representing groups, in your view, number one, is the response from the VA in terms of treating PTSD too drug-centric in terms of the modality of treatment?

And number two, in your view, if given the proper modalities of treatment, is PTSD, can it be brought down to a level where it is no longer debilitating?

Well, let's go right to left, your right.

Mr. O'BYRNE. I do believe the VA is too pill-centric. I mean, I think that our country is too pill-centric. But, you know, when you have a pill that says on the bottle may cause further suicidal thoughts or homicidal thoughts, maybe you shouldn't be going home with those pills for a person that is already suicidal or depressed. I think that that right there should be addressed.

And I do believe that, with time, PTSD is—you know, all symptoms, you are never going to be the same from combat, but the symptoms of PTSD, with time and work, do go away. It just takes time, work, and a concentrated effort in dealing with these things.

Mr. COFFMAN. Thank you.

Mr. DOWNS. First, thank you, Congressman, for the question.

I think that what I would say about the first part of your question is that I can't answer as a clinician, and that there are times where pills are very important and I would never recommend to anybody to quit them cold turkey, that is just a bad idea.

The second half, I think that when you compare the symptoms of post-traumatic stress disorder to the way that we were trained to react in combat, they are almost exactly the same. So when you look at that and you tell us that you are training us to be strong in this wartime environment and these are strengths that we need, and then when we get out you tell us that those exact same strengths are now weaknesses, I think that the first step is to recognize that if they were strengths then, then they are strengths now. And that if we can say, here is how you take these strengths and use them in this area of gray, which when we are combat it is black and white, it is pure, we get it, but when we come back, there is a whole lot of gray that gets introduced. And that if we can use those strengths that we were trained for, in whatever branch of service we are in, in everyday life, how do I use it at home? I think that that is pivotal.

Mr. ISCOL. On the first question, does the VA prescribe too many drugs and pharmaceuticals, I think if you have been to one VA, you have been to one VA, and if you have been to one doctor, you have been to one doctor, and it varies greatly between the different VAs that we work with.

Some of the VAs we work with have a great relationship with our doctors at Weill Cornell Medicine, where the team at Weill Cornell will actually adjust the pharmaceuticals that patients are on and the VA is very open to that, some cases not so much.

In terms of the modalities, I think there are some modalities that work better than others, but they require intensive treatment and supervision, like EMDR, that is one of two approved therapies by the VA Center for Post-Traumatic Stress, the other being cognitive behavioral therapy. And so there are real challenges on training qualified clinicians in EMDR outside of the private market.

And then in terms of PTSD being treatable, as I mentioned in my remarks, on average, most of our clients are asymptomatic within five to six months, we also have some patients that have been in treatment for two-plus years.

And I think one of the important things to understand about treating mental health care is it is not like treating a broken arm. Congressman, if you and I both had a broken arm, 99 percent of the time the treatment is the same, we get a cast. When you are treating mental illness, you are dealing with not just necessarily the combat trauma somebody has experienced, but oftentimes lifelong trauma, different proclivities for substance abuse, a variety of different issues in their personal lives.

And so what we have found works is a patient-centered model and I don't think you can design a one-size-fits-all approach for mental health care.

Mr. COFFMAN. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I appreciate the gentleman yielding.

Mr. Walz, you are recognized for five minutes.

Mr. WALZ. Thank you, Mr. Chairman.

And thank you all for a compelling and thoughtful testimony.

And, Mr. Downs, I am certainly glad you are here to testify. As I said earlier, I have become good friends with Daniel Somers' parents; I wish I had been able to become good friends with him. I am sure your parents are good folks, but I am certainly glad you are

the one that is testifying. And this speaks volumes to your resiliency.

And I think something I have said since I have been here, as a veteran myself, and I think it irritates many of us, veterans are not victims. I heard each of you say that, we are not victims, nor are we damaged. We need in some cases to be repaired, we need to refit, and then get back to whatever we are doing. And I think that attitude itself is so helpful and I think you are bringing a broad spectrum.

Mr. Iscol, again, I appreciate your talk on this. It is not a one-size-fits-all; we need to understand what is there.

I struggle some with our desire to make sure we are evidence-based, but I fall into the camp that if a veteran tells me it works for him, then let's use it. This is for across the spectrum of different treatments.

So if I could ask, Mr. Iscol, you had some interesting things here. How are you able to ensure that folks are getting accurately diagnosed? And then kind of segueing from that, how do you contain costs in this? That should not be our number-one concern, but it is something you are able to do that I think could be applied.

Mr. ISCOL. Yes. If I may call you Sergeant Major?

Mr. WALZ. It is a promotion from this job.

[Laughter.]

Mr. ISCOL. Well, Sergeant Major, I think it is a great question.

The way that we contain costs, and I will start with that, is it really comes down to the team at Weill Cornell. We have three psychiatrists who are world-class psychiatrists, we have a team of about ten clinicians at Cornell who manage the care. And so we then do assessments at four, eight, twelve, and periodically that measure the quality of life of the people that are in our program, measuring their sleep quality, their anxiety, their drug use, whether or not they are getting better in their day-to-day life. And that is not a complicated assessment that we run. And if the care is not working, we modify and change it, and I think that is critically important in managing the costs.

And, I'm sorry, I forgot the other part of your question.

Mr. WALZ. Just the diagnosis on, are we misdiagnosing?

Mr. ISCOL. Yes.

Mr. WALZ. And I think it goes back to Mr. O'Byrne's point on this of diagnosing everyone, are we getting that right? Is that causing complications?

Mr. ISCOL. So I think the diagnosis matters less to us than the goals. When a veteran reaches out to us, the first thing we want to know is why. Is it because of relationship with their spouse, is it because they can't sleep through the night, is it because they are self-medicating, anxiety, a work-related issue? And we really focus on treating that.

And so whether or not it is post-traumatic stress, depression, some sort of other disorder, matters less than understanding what the life goals are.

Mr. WALZ. I appreciate that.

Mr. Junger, thank you again. I appreciate your activism in this. In full disclosure, as a cultural geographer, my first teaching job

was on Pine Ridge. I am drawn to your analogies and the sense of this.

My question to you is, and I think I fall fully into your thinking on this, the reintegration and how we do that, the trouble I have is, is that we have a new phenomenon here where we have a lot of female warriors that, when they come back, they don't get that same sense of integration. They are driving their truck with a veteran plate on it and someone asks them if it is their husband's truck. Those are not anecdotal, those really do happen.

Do you have any research or any of your insights into this, that how do we reintegrate our female warriors into that culture and that communal healing?

Mr. JUNGER. Thank you for the question and I wish I could speak more to it. The unit that I was with in Afghanistan, that is where I met Brendan O'Byrne, was an all-male unit.

My book Tribe really is not about PTSD or soldiers, it is about the consequences of losing community in a modern Nation. And one of the consequences is that people who have suffered trauma, they are not aided in their recovery by the close support of others around them.

The specific gender issue, the issue of the public seeing a woman in a truck with veteran plates and thinking it is her husband's, I mean, that is a public relations campaign, I think. I'm not sure it goes to the sort of deep psychological work that this Committee is going to have to pursue and understand, but I may be wrong. I mean, I haven't really done research on that.

Mr. WALZ. I am just wondering what community they belong to when they come back, that is the one that I struggle with.

Mr. JUNGER. Well, ideally, they belong to the community that they left before they served. And that is the problem is that in a modern society—I am not just picking on America and there's a lot of statistics to back this up—as modernity goes up, as wealth goes up in a society, the suicide rate goes up, the depression rate goes up, the schizophrenia rate goes up. The reason is that many people no longer live in close communities and that is true of female veterans as well, unfortunately.

Mr. WALZ. I appreciate. Thank you.

The CHAIRMAN. I thank the gentleman for yielding.

Dr. Wenstrup, you are recognized.

Mr. WENSTRUP. Thank you, Mr. Chairman.

Thank you all for your insights today, it is tremendously helpful to us.

I was taken by many things, as I think we all have been today. One, the comment about moral injury, and if it is not a just cause and the lack of national unity, and I think that is something that people come home and struggle with. You know, I served under Presidents of both parties and it didn't matter, that is not what it is all about, but when you come home and that same type of feeling is not there, it is hurtful.

But the feeling necessary, that is the one that hit me the most. When I think of my time when I come home as a doctor, spending a year in theater, I saw trauma I have never seen the likes of before. I wasn't used to being attacked three or four times a week, that is not normal. But I did feel necessary. And when I came

home and I was told, well, you have 90 days before you go back to work, I said, I'm going next week. What am I supposed to do, sit around my house? This is damaging to us.

And so I appreciate so much about the talk about community as a core and needing to feel necessary.

So we sit on this Committee, and I'm on Economic Opportunity and on Health, and all the issues we are facing, it seems like in the VA we are being reactive rather than proactive, and the proactive part needs to really come in play while you are still in uniform.

I mean, I would like to ask each of you, would you feel differently if when you hung up that uniform you knew exactly where you were going to be in two weeks, with a job or in school and part of something, part of a community where somebody needs you, would that make the difference compared to getting out and then wondering what is next, as opposed to having it set? I look at the college graduate who gets their degree and already knows where they are going to be working, that is far different than one that gets their degree and doesn't know what lies ahead. And I would love to hear your comments and it plays into what Mr. Junger has written about.

Mr. DOWNS. Thank you, Dr. Wenstrup, it is a good question. And in answer to that, I think about when I got out September of 2014, September 11 actually.

When I got out, I was an E-5 in the Marine Corps, and I had just gotten looked at for E-6. I had been in for 11 years and I was on top of my game, I loved every bit of it. I picked up a 100k contracting job at the exact same place where I was working, I was going to school, I was doing everything. And on the outside you would look at me and you would assume that everything was good and a month after that I had a plan, I had a plan to kill myself.

So I think just having a place to go isn't necessarily good enough. I think that we can go anywhere as long as we know that we can go anywhere; that is not the anywhere that matters, that it is us that makes the difference. So if I am connected in here, if I am satisfied and grateful every morning for waking up, then I can be successful anywhere, and I think that that is key.

Mr. WENSTRUP. So how do we parlay that into the transition out of uniform?

Mr. DOWNS. So I think I'll go back to what I talked about earlier and that is transcendental meditation, and it is just one small practice and it is just one small modality. It gave me the opportunity to create a space within that I had closed off in order to survive.

When I came back from the Marine Corps and essentially when I got out, everything that I had used to kind of fuel my success while in the Marine Corps, the stress, the anxiety, the adrenaline, the three hours of sleep, didn't apply anymore. I had been told that all those things were not good and that I was broken. So when I started transcendental meditation, it allowed those things that I carried into the Marine Corps and that I experienced during war to process out. These thoughts, the traumas, everything started just pouring from me as I continued to practice transcendental meditation.

Mr. WENSTRUP. Thank you.

Any of the others care to comment?

Mr. O'BYRNE. You know, I agree with everything he said, and I also do think that there is a need for some kind of something to be waiting for you at home.

When I left the military in 2008–2009, we were in a recession. I mean, I couldn't get a job cleaning floors at Walmart in the middle of the night. I was just leading men in combat, you know, three, four months before that. I mean, to go from that to that was incredibly damaging.

And, you know, I believe that Ernest Shackleton is one of the best leaders ever and what he said, he had this one guy that was having a hard time when they were stuck on the ice, you know, and they were stuck out there for two years and this one guy was saying he just wanted to lay down and die. And so what he did, what Shackleton did was he took him to the cook, where the cook had a fire burning. And it took a lot of time to keep the fire going, they fed it blubber and stuff like that, so the cook was wore out. So Shackleton said, "Cook, go take a nap and sleep for forever."

And he took the guy who was going to lay down and die and he put him on the fire. And in an hour he came back, and the guy that just was laying down and going to die had his socks hung up next to the fire and that he was in better spirits, he was smiling.

And what Shackleton said was that occupation had brought his thoughts back to the ordinary cares of life. And that is true, that is true of men stuck on ice, that is true of veterans coming home from service. We need to feel part of the society and one of the parts of feeling a part of the society is working for it.

Mr. WENSTRUP. Thank you. Thank you for extending the time, I appreciate it.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

Dr. Kudler, I agree that we need to give veterans access to evidence-based therapies, but I also believe that veterans should have access to complementary and alternative therapies that can help them with PTS. For many of these, the evidence of efficacy is still inconclusive and more research does need to be done.

The President's fiscal year 2018 budget proposes a five-percent cut to VA medical research and an 18-percent cut to the NIH's budget. How would enactment of these cuts affect VA's research into clinical treatments for mental health, including for PTSD?

Dr. KUDLER. The reason we have a VA research program is that nobody else does research on the kinds of issues that the panel is talking about today. Without that VA research program, you are not going to see progress that I think this entire panel is calling for.

Mr. TAKANO. May I just sort of interject just a little bit here? Do you think the private sector at all would be incentivized to do this sort of research?

Dr. KUDLER. We have been meeting with the private sector and we have been having some meetings. The Bush Institute, for instance, had us meet with a group of ten leading pharmacological companies. And they told us, frankly, there isn't a lot of profit in

producing pills for PTSD or looking at new mechanisms to work with.

No, there really isn't a lot of profit in the private sector.

Mr. TAKANO. Including evaluating all of the alternative therapies as well?

Dr. KUDLER. I don't know. I mean, I am not a businessman, but I am not aware there is any profit to be gained in doing that. And yet VA needs to do this and it is part of our mission, so we do it and we depend on those research dollars to do it.

Mr. TAKANO. Can you comment about the NIH budget, the 18-percent cut, how that might impact—

Dr. KUDLER. It is outside my realm.

Mr. TAKANO. Okay.

Dr. KUDLER. If you don't mind, I won't.

Mr. TAKANO. Okay. If it is estimated that \$19 million in VA research appropriations are needed to keep up with inflation and fund current VA research programs, how does VA justify these cuts in the budget when more funding for research and development of effective PTSD treatments and suicide prevention, the VA Secretary's top clinical priority, are needed?

Dr. KUDLER. Well, there are lots of priorities in VA. We get a large allotment, there are very difficult choices that need to be made. Are you going to offer this treatment? For instance, people talk about offering hyper-baric oxygen treatment. Very expensive, equivocal evidence, and yet some people feel it really helps them, but do I not offer medication—and not necessarily even mental health medication, but medication for other problems—because I have spent my money here?

And it is the same question as “Do we do this research?” Do we create this new outpatient clinic in this community that doesn't have one? These are tough questions and they are really too big, I think, to get into within this context.

Mr. TAKANO. I get it.

Mr. Junger, I have heard you speak before in other fora. You described the value to individuals of sharing a mission and that when it ends that sense of loss of purpose can have a profound and long-term effect.

You also draw this example of advanced societies with advanced economies, and what comes to mind is Emile Durkheim, the sociologist, and the concept of anomie, moving from traditional societies to modern ones. And Mr. Downs' comment that it is not just enough to have a place to go to. So, interesting intersections of some of the testimony here today.

I might give you just a little moment to kind of respond to some of the thoughts that I am presenting here.

Mr. JUNGER. Yes. I mean, in terms of Mr. Downs' comment, I think he is absolutely right. I mean, without some kind of inner peace, your circumstances around you can't save you.

But keep in mind, he is referring to having a job, having a place in a society that itself is fractured and alienated.

Mr. TAKANO. That is what I was getting at.

Mr. JUNGER. Yeah.

Mr. TAKANO. I mean, the assumption that the economics by itself, just having a place and making the GI Bill work better and

more smoothly, these are all important things to aim for, but it is not getting at an important aspect here that seems to be causing a lot of suffering.

Mr. JUNGER. Yeah. I mean, in some ways I am pointing out something that is a structural part of our society and it can't be fixed. So, I know that that is frustrating, but we do need to sort of understand it. The need for community is so intense that I have even talked to people who survived cancer, who survived cancer on a cancer ward in a hospital, and would go back to the cancer ward, because that was where they felt like they had community. And these people, these civilians, as they called it, walking around on the streets that hadn't had cancer would never understand their experience.

So when soldiers miss war, and there are many that I have talked to who do and many people have written about it, when cancer survivors miss having cancer, what they are really missing is community, and I think those examples should serve to inform us about what is missing in our wider society.

Mr. TAKANO. I'm sorry, my time is up, but I think we are talking about the everydayness of what we experience versus the intensity of—

Mr. JUNGER. Yes.

Mr. TAKANO [continued]. —what soldiers experience and that is kind of an interesting thing.

Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Bost, you are recognized for five minutes.

Mr. BOST. Thank you, Mr. Chairman. And, gentlemen, thank you for your service, and Mr. Iscol and Mr. Downs, semper fi.

Let me say, if I can, Mr. O'Byrne, can you expand a little bit, because let me tell you, you are the first person I have ever in all the time of having this job, and I have only had it through a term and a half, that says they want to reduce the amount of benefits that they are receiving. Okay? And I understand your argument that it is and I believe that you can be healed, I mean, I do, but how and where do we make that judgment call or where does the VA make that judgment call on individuals? How does that happen?

Mr. O'BYRNE. Well, as I started the research, it is the same process of getting benefits, which is I will go in front of a psychiatrist/psychologist and go through the same process of saying, here are my symptoms and, you know, how have I improved, how have I not improved, what is my current living status like? So it is all in the same process really.

Mr. BOST. So as you went through the process of when you first got your writing, do you feel like the VA handled that correctly or incorrectly at the time?

Mr. O'BYRNE. It is hard to say correct or incorrect. You know, I was pretty broken at that time and so I missed a couple of the CMP exams, and I felt at the time it was unfair, but I am not sure if I feel the same way now. It is sort of the process that you have to go through, you have to be vetted.

And what I talked about with some of the fraud, that has to happen, right? Because there are veterans that, you know, they are

going to abuse the system, if they can; they are going to get a paycheck, if they can. So I think that the system has to be set up in a certain way that you have to go through these steps. I didn't think it was fair at the time, but it is sort of necessary, yeah.

Mr. BOST. Okay. And, you know, that was a concern I have with your expressing and your situation, but I don't know—yeah, fraud and abuse occurs, but I don't know how we stop it. Do you see what I'm saying? Because I don't want—maybe—

Mr. ISCOL. Yeah, if I may. So at Headstrong we don't require any proof of military service, we don't require any paperwork at all, and if there are people taking advantage of us our philosophy is, that's okay, because we have a bigger mission.

At the end of the day, the other benefit we have, as one of our clients has told us, is we don't provide anything but health care, so we don't have that issue of benefits.

Mr. BOST. Thank you.

Another question I have for Dr. Kudler, what do we use through the VA to show either success or failure as we treat post-traumatic stress syndrome patients, in comparison and can we do in comparison to the private sector? Because I know the studies and all of those that have been done, as a matter of fact a very successful one in my district is called "This Able Vet," and it works very, very successful and it actually has three university studies that proved how it works successfully.

What do we do through the VA to know that we are successful in the programs we are putting forward?

Dr. KUDLER. Our specialty PTSD clinics on a regular basis will review a very thorough PTSD clinical interview called the CAPS interview, which is sort of the standard in research and also it is more intense than most clinicians use to assess if our PTSD clinics working.

But what we are trying to do, that is only the—the specialty clinics, those 131, only cover a small number of the veterans who actually have PTSD at different levels—we are trying to develop a new program called Measurement-Based Care. And actually, unfortunately, there are some legislative and IT concerns that get in the way of that. What we want to do is have veterans give us direct input of their symptoms on smartphone apps and in computers. You know how you have the white coat syndrome when you come to the doctor's office and your blood pressure goes up? Then they say, hey, you have high blood pressure. No, I'm just afraid of you, Doctor. What you want to do is get people at rest at different times of the day when they are in their normal lives and say how are they doing. We want to enter that data, but right now there are security concerns with the computer information. You are going to get past our firewall. What viruses are going to follow?

We need to solve that problem and I believe there are technological solutions to that, but we may need your help as a congressional body in getting permission and legislation to collect data directly from veterans. When we have that, then every patient can say to their doctor how am I doing, and not just in PTSD, but in other problems too, and they can compare that and it goes right into the electronic record.

That is what we are trying to build, we have been working on it for the last four years.

Mr. BOST. Wonderful. Thank you.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Ms. Brownley, are you recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

And thank you to the panelists for being here. It has been very enlightening.

And, Mr. Junger, Dr. Wenstrup gave me your book and I read it over the weekend.

Mr. JUNGER. Thank you.

Ms. BROWNLEY. I think in some ways your book, points out or tells us what I think we already sort of intuitively know, but what your book does so well is to give us that framework to answer the question of why. And I really did enjoy the read and I encourage other Congressional Members to read your book.

I wanted to also ask Mr. Downs, your testimony was very compelling, you talked about transcendental meditation, you also said in your testimony about the validation, clinical validation of the success of the program, you said something to the effect of many public health agencies have validated this. Is that correct, did you say that in your testimony?

Or just do you think TM has been validated as a sound therapy for mental health?

Mr. DOWNS. I do think that transcendental meditation is a sound practice and it is something that has to be done every day. And I can tell you from personal experience that after leaving Boulder Crest Retreat and the Warrior PATHH, about six months into it I felt on top of the world, and I decided that I didn't need TM anymore and I stopped. And I was okay for a couple weeks and then I fell.

And the good news is you fall forward—you don't fall backwards, you fall forward, but I did fall. And at that point I kind of realized that I think I created an illusion of option, I created an illusion of choice that I didn't really need it anymore, but in order to continue to thrive you do have to practice. Because every day that I wake up and I open the door, life is going to punch me in the face one way or another.

And the question then becomes, well, how do you struggle well? Because struggle is just inherent to being human. So how do I struggle well? And I think that my realization was that TM was the thing that helped me struggle well.

Ms. BROWNLEY. Thank you for that.

Dr. Kudler, I wanted to ask you, I think I agree with Mr. Walz's comments, if it works for veterans, we should be doing it, but I think in terms of complementary and alternative therapies the most common barrier to the use is the lack—at least what the VA says, is the lack of sufficient evidence to support their efficacies. And as I look through the VA/DoD Clinical Practice Guidelines, you know, for every therapy it is, you know, research focusing on the efficacy of acupuncture is still relatively limited, not discussed in the VA/DoD Clinical Practice Guidelines, that is said for many of

these therapies. Evidence of AAT, animal-assisted therapy, is ongoing, but at this point lacks support.

So, you know, Mr. Takano was talking about the research and the impacts of lack of research that may occur here. I guess the question for me is, why aren't we using evidence-based practices that have already been established outside of the VA and say, okay, we see the efficacy here, it has been proven by university studies, whoever it is, and bring more efficacy back into the VA, understanding that these alternative therapies do indeed work outside of the VA, they will work—I mean, isolation and other kinds of things that in Mr. Junger's book as consistent not only with veterans, but cancer patients, as he said, and others, why aren't we pulling this together so that we are really meeting the needs of veterans right now, today, as opposed to more of these long-range efforts that you are talking about, which I think are valid, but we need resolved today. We cannot risk losing another veteran, we have to bring this forward.

So I do not understand why we are not utilizing what the research is telling us outside of the VA to implement more of these programs.

Dr. KUDLER. Well, in sum total, I agree with you.

The balance of being a doctor, especially in the age, people call it the age of evidence-based care, is that, well, you wouldn't do anything there wasn't evidence for, that is not scientific, but doctors aren't scientists and doctors try to help patients. It is something I like about being a doctor. You have got that person in front of you, your job is to help them, not to come up with the right answer on the test. The test is that person, and that person is going to be different and there will be different ways to engage and help each one. I think we have been hearing that from the panel.

Over 90 percent of all VA medical centers have at least one kind of complementary and integrative health. VA has a center on complementary and integrative health. We are moving forward in a number of ways. For over 30 years, VAs have had sweat lodges, most of them west of the Mississippi, because culturally appropriate tribal customs are helpful to veterans with PTSD.

We have expanded in just about every direction: yoga, meditation. Just this morning there was a report on a VA study that we did on meditation with the University of Rochester, we asked them to evaluate our demonstration project and they found it very helpful.

So we are moving forward and we need to do more.

Ms. BROWNLEY. Well, I thank you for that. My time is up. I just want to say, though, if we had a handbook that said yes to these things, I think more doctors would be able to apply them.

I yield back.

The CHAIRMAN. Thank you for yielding.

General Bergman, you are recognized.

Mr. BERGMAN. Thank you, Mr. Chairman.

To you warriors, you all know the term, steel sharpens steel, and when you are in the uniform fight, you know where the steel is. I would suggest to you that when you leave the uniform fight, you have to find the new steel to keep your own sharpened, and I

would suggest to you it is right up here. And I love the fact that you quoted Shackleton.

[Laughter.]

Mr. BERGMAN. The greatest example of leadership in the history of mankind who never, ever once accomplished the mission they set out to do, but accomplished something greater than that by leading through adversity over multiple years. Shackleton's Way, a must read for everyone.

Mr. ISCOL, you mentioned that the Headstrong recently received a grant from New York State to treat veterans in rural areas. Could you please describe any unique challenges in treating rural veterans?

Mr. ISCOL. Yeah, absolutely. Thank you, Marine.

I think that the biggest challenge in all of this and I think it is something that is missing from this conversation, and it has come up briefly, is the quality of the providers. My last job in the Marine Corps, I helped build and run the Recruiting, Screening, Assessment, and Selection Program, RSAC, and you have a minimum standard that Marines need to meet before they are invited to our selection program: they have to have a certain physical fitness, a certain intelligence, a certain swim qualification. That alone doesn't make them eligible for special operations.

And so I think the quality of the clinicians is tantamount, and we have a vetting process and a recruiting process and a screening process for the clinicians that we work with. The greatest challenge in providing rural care is the lack of clinicians. And so you have to find hybrid approaches of getting veterans in rural areas in front of competent mental health care providers through a hybrid of telemedicine and in-person care.

And so what we are doing is we have recruited clinicians in key cities like Ithaca, Buffalo, parts of Long Island, that have those competent mental health care providers, we will then get the veteran to see them on some sort of regular basis, especially at the beginning, and then do a hybrid of telemedicine and in-person care. But finding those clinicians is the hardest part in those rural areas.

Mr. BERGMAN. Do you feel—and you mentioned something there—do you feel with the utilization of telemedicine, could you start with telemedicine, or do you need a face-to-face first and then transition to?

Mr. ISCOL. So I am not a medical doctor. I would say that our medical team would think that that is very risky.

I think, you know, one of the stories that our medical director tells is she was treating somebody who was in Long Island who is a meth addict, not in our treatment program, outside of our treatment program, was doing it over the course of a summer, thought he was doing much better. That fall he comes back, is in her office, and she can tell immediately that he is still using. She couldn't tell that through telemedicine. You can't smell somebody, you can't see them, you can't see what they are doing with their fingers.

And so I think that there is a real need to be in front of a person, but I think a hybrid approach can certainly work.

Mr. BERGMAN. Okay. Mr. O'Byrne and Mr. Junger, given the approximately 40 percent of veterans who live in rural communities,

how would you suggest that we encourage a sense of community and peer-to-peer support among veterans who may not live in close proximity to other veterans, or to VA or community services for veterans? So that unique but very important population who might live in some type of semi-isolation.

Mr. JUNGER. It is a huge problem, I am not sure I have a good answer for you. We can provide veterans communities if we have communities for ourselves. I don't think there is a way to solve the veteran community problem, the veteran mental health problem, without solving the wider societal problems that all of us are laboring under.

Mr. BERGMAN. Dr. Kudler, kind of a change in subject here, but suicide rates. Are there any numbers that state the differences between those who have deployed versus those who have not deployed as it relates to the potential for suicide?

Dr. KUDLER. As counterintuitive as it may seem, and I think it calls into question a lot of the things we think we know about veterans, the rates of people who have never deployed but are military members are higher than the rates of people who have deployed.

Mr. BERGMAN. Is there any ongoing data searching to suggest why that is?

Dr. KUDLER. People are researching that question, but it would be premature to say we know why.

Mr. BERGMAN. Okay, thank you.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Ms. KUSTER, you are recognized for five minutes.

Ms. KUSTER. Thank you, Mr. Chairman.

And I do want to say to the Chairman and certainly to the panel, this is by far the most informative and effective hearing I have been in in my four and a half years on this Committee. So I really, really appreciate your time and sharing your personal stories.

I want to say to Mr. O'Byrne, I am delighted that the New Hampshire Humanities Council was helpful to you. That was an intriguing project and I would love to help share that type of public-private partnership around the VA and around the country, and using the humanities to get at the heart of the matter. But just thank you for your testimony.

And as well to Mr. Iscol and Mr. Downs, thank you for sharing your personal experiences. And partly I just feel optimism from this hearing, which is a rare feeling in this panel.

And, Mr. Junger, thank you for taking this to the national level and having this conversation. I think part of the challenge that we have and we want to work with you is so few people out of our total population serve now, but I come from a state in New Hampshire with a very, very high percentage of service and returning veterans, back to 65,000 Vietnam veterans in my district and a high percentage of people. So I just think we can help to engage in that conversation and we certainly do our best every day.

I want to follow-up on a couple of thoughts, because we also are facing an opioid crisis. A heroin epidemic, whatever word you want to put on it, it is happening across the country, but particularly in rural America, Appalachia and all the way up through New England. And I have been working with the VA, a lot of the research

on PTSD and the opioid epidemic are connected to pain management.

And coming out of the White River Junction VA in VISN 1, I am really excited about the progress that they are making. A doctor there, Dr. Julie Franklin, working with alternative pain management, alternative methodologies, acupuncture, mindfulness, meditation, yoga, a lot of the things that you have talked about, and having fantastic results—and I have met with these veterans—literally dropping the use of opioid medication by 50 percent and people having a much higher quality of life.

So I would love to hear just briefly, my time is short, but from each of you, if you have thought about your own experience in conjunction with pain management, physical pain, and if you have any suggestions for us. And then, if we have time, I will go to Dr. Kudler about what progress is being made.

Mr. O'BYRNE. I can't really answer that, I haven't had much physical pain, but I was an alcoholic, I am an alcoholic, I got sober through AA. That has been my story, that is how I got sober, I wouldn't have gotten sober without it.

Ms. KUSTER. Great. Thank you very much. Thanks.

Mr. ISCOL. You know, this is something that I think should be looked into. You hear the statistic about 20, 21, 22 veterans a day dying by suicide, there is a suicide epidemic in this country, and I suspect that if you looked at a demographic overlay of who is most susceptible to suicide, it tends to be white males over the age of 40, maybe over the age of 50, who are on pain medicine, that that might have more to do with the suicide epidemic and that veterans are really a leading edge of some of the issues that we are facing in this country. But I have not seen any studies or research, that is just something that I would suspect.

Ms. KUSTER. And it is very connected, both the opioid epidemic and the suicide epidemic, to mental health. Four out of five heroin users have a co-occurring mental health disorder and so trying to get the services.

I don't know if you have anything to add, Mr. Downs.

Mr. DOWNS. Just something small. I think, Congresswoman, that the underlying discomfort is that we are uncomfortable with discomfort and I think just exercising, just going to the gym, you have to break muscle to build it. And somehow we think that struggle anywhere else is bad for us, so we like to prescribe things for pain.

I think that there are definitely helpful prescriptions for pain and I would never take them away from anyone. I would suggest that we try to connect first before we prescribe, before we diagnose.

Ms. KUSTER. Yes, thank you. I really appreciate your comments on the struggle.

I will yield back and take my questions to Dr. Kudler offline. Thanks very much.

The CHAIRMAN. Thank you.

Mr. Banks, you are recognized for five minutes.

Mr. BANKS. Thank you, Mr. Chairman, and thanks to each of those who are here to testify today about these issues related to post-traumatic stress and traumatic brain injuries, the severe issues that our veteran population faces with these issues and oftentimes the lack of treatment that they are receiving.

Dr. Kudler, I wanted to ask you a few questions. It appears to me, after having Dr. Shulkin testify on March 7th, I am hearing mixed signals between him and you. He was very open to new alternative treatments, we specifically talked about hyperbaric oxygen therapy.

In Indiana, in my state, the Hoosier taxpayers have stepped up to the plate and this year our state legislature is funding a pilot program providing HBOT treatment to Hoosier veterans due to the lack of treatment and opportunities that the veterans are receiving through traditional VA treatments. So they are picking up the slack, the Hoosier taxpayers are putting our tax dollars on the table to fund treatments like that. Yet a moment ago I was disappointed to hear you say that these issues are, to quote you, "too big to discuss in this venue."

If not here, right now, before this Committee, where are these issues and opening up more access for alternative treatments like hyperbaric oxygen therapy or other treatments, where is that discussion appropriate to have if not here before us today?

Dr. KUDLER. Well, first of all, thank you for allowing me a chance to clarify that.

I wasn't trying to imply that talking about complementary and integrative treatments, including hyperbaric oxygen, which I know I mentioned by name, that that was too big, I was simply saying trying to figure out where do you spend the money in the unit allotment, where do you put that? Do you build a new clinic or do you give a hundred people this treatment? That was the part that was too big.

But let's get into this. I want to be really clear that I think that, if a treatment is helpful for people, then veterans should have access to it. I agree entirely with Dr. Shulkin. I don't think we can afford to wait for all the research to be in, because I know from my own career it will be 20 years before we can say definitively what works and what doesn't work, and even then people will argue about it.

So I'm thinking if the standard things aren't working or if a person says, I don't want to do the standard thing, but my brother-in-law did this and it really worked for him, I know as a doctor, I better try to find that for that patient. And I would agree that hyperbaric oxygen is one of the things that I would try, along with Boulder Crest. I have met with the founders of Boulder Crest and on my desk are the notes for beginning a memorandum of agreement to partner with Boulder Crest.

There are a lot of things we need to try. We need to meet veterans where they are in their terms, that is what medicine is really about.

Mr. BANKS. Then how long will Hoosier veterans have to wait before these alternative treatments will be provided to them by the VA?

Dr. KUDLER. We are going to have to find ways to find providers who can provide them and ways of screening veterans to decide which way to go. And, frankly, we have to educate a lot of our own line doctors who have been raised in the era of evidence-based medicine. Well, there is no evidence for that.

This is what the Center for Compassionate Innovation was developed to do and it was Dr. Shulkin's idea when he was Under Secretary. Working with that, we have been providing veterinary benefits for trained service dogs and I have actually been the person who got to redefine mental health mobility limitations so that we could do that under current regulation.

I think we are moving much faster than we ever have, but we need to accelerate.

Mr. BANKS. Agreed. I appreciate the important work that you do. And speaking on behalf of so many of my constituents and my fellow veterans of the post-9/11 generation, we can't afford to wait any longer.

Dr. KUDLER. I am with you.

Mr. BANKS. So thank you for your important testimony here today.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Ms. Esty, you are recognized for five minutes.

Ms. ESTY. Thank you very much, Mr. Chairman. And I think this has been an excellent and very illuminating, and I would agree with Annie Kuster, hopeful, hopeful hearing.

I am really struck, Mr. Junger, by your discussion about community and I have wondered, have we tried speaking with World War II veterans? I think about a lunch I had recently with a 96-year-old who talked to me about why he does not talk about the war, he did not want to do the veterans oral history project, and he told me about how his mother told him you need to sleep in a separate room until you are safe with your wife.

Mr. JUNGER. Yes.

Ms. ESTY. These were people who had moral clarity and I think that is an unbelievably important issue, and that is why I think we need to be debating in AUMF and we need to be doing a lot in this Congress to stand behind our veterans. But what have we learned, we know about the moral clarity, what do we know about our effort to reintegrate? There were many more of them, I know that. So how do we deal with the fact that there are not as many now?

Mr. JUNGER. My wife was the youngest of 12 from Wisconsin, her father was 55 when she was born, he fought in World War II, from Sicily to Anzio, through France, all the way through Germany and Austria, the whole deal, right? As a lieutenant and a captain. He came home to Kenosha, Wisconsin and he lived within—he was wounded, medaled, very heroic man and traumatized man—he came home to Kenosha, Wisconsin, married, moved into a home with his wife, and his six brothers, blood brothers from his family that had all also served lived within a few blocks of him. That is rare and rare in this society. We are a much more mobile society. The Amish in Pennsylvania do not drive. Psychologists believe that one of the reasons they have such low rates of suicide and depression is that they don't drive and they all live within communities, they basically live with people their whole lives that they can't drive away from their community, right? They have to walk away from their community, you know, you can't get very far in a day of walking.

So that has changed in America. I am not sure what we can do about it, but we can, maybe what we can do is understand it and take some steps. We are not going to ban the car, we are not going to burn down the suburbs and live in lean-tos, I mean, I get it, but if we understand the mechanism that is driving some of this unhappiness.

And let me just end, if I may, by making a larger point. The point at the end of my statement, I hope it didn't come across as a gratuitous political point, it was a very serious point. Our neighborhoods, we are not going to tear down and rebuild our neighborhoods in more communal ways, but our largest community is the Nation and that we can do something about. And rhetoric does matter and the citizenry is listening. And when the most powerful people in this Nation sometimes talk about each other as if they are enemies of the state simply for running for office with a certain different set of ideals, when very powerful people do that, it trickles down into the psyches and into the lives of everyone, and that corrodes our conceptual communities while our physical communities are also breaking down and it is tragic.

Ms. ESTY. I couldn't agree more. That is why I refer to my colleagues as patriots when I am in my district, I say they are all patriots. People, not just those who serve in the military, but people who serve in office who are trying to get this country to a better place and I appreciate you making that point.

To our veterans on the panel, what can we do more—and, frankly, for the VA—about the peer-to-peer? I think it is unbelievably important. I know in my district that has been the most successful, in part precisely the programs that do not connect to the VA; they know they have the confidentiality, they know with their band of brothers, and I wanted to underscore again, and sisters too. And I have a niece who served in Kabul for a year, it has been very isolating for her coming back, very tough for her coming back, because there are so few of her comrades that she can share that with.

So anyone who would like to comment on that, please. And, again, thank you all for your service and for your telling your stories here, and illuminating not just for us, but for anybody watching, what this really means.

Thank you.

Mr. O'BYRNE. I go back to what I said about some of those programs like Team Red, White, and Blue, Team Rubicon, Outward Bound for Veterans, Horses and Heroes—Heroes and Horses, these are programs that put veterans together, and Team Rubicon goes around to natural disasters and helps out. I mean, what an empowering thing, right? You are not getting drunk at the VFW, you are having really amazing conversations while helping other people. I think that that kind of stuff is the stuff that we should be looking for.

And Outward Bound for Veterans, you know, you are going on trips at a week-long for completely free with other veterans that served and you are going around to see the best parts of America. You are going down the Colorado River with a bunch of your veterans or you are going sailing or you are going kayaking, sea kayaking.

I mean, these are things, even if you are not talking about the war itself, you are healing, right? It is like Alcoholics Anonymous. I go to AA and maybe I don't talk every day about alcohol when I talk, but whatever I talk about, I am healing while I am talking about it, because everyone else there understands I am an alcoholic and what my experiences were. And the same thing with veterans, getting veterans together in any kind of capacity, we are away from the drinking and, you know, things like that.

Mr. ISCOL. Yeah, I am proud to say that our number-one source of referrals at Headstrong is veterans who have been to the program or in the program referring other veterans to us. Team Rubicon is a great organization, I met my wife through Team Rubicon.

But I think that there is also, you know, if God forbid you had a heart attack and you were getting wheeled in on a gurney and you looked up at the doctor, you wouldn't care where they served, right? You would care that they are the most competent heart surgeon who is going to provide that service. And I think one of the challenges is a lot of people don't see mental health care, a lot of veterans don't see mental health care as real medicine and health care, and there is nobody better to challenge that stigma than another veteran.

And then I would finally just add that our group therapy sessions, for all the reasons that you just discussed, are critical components of what we do, because you have that group of veterans who are there supporting each other.

The CHAIRMAN. Hold that thought.

Ms. ESTY. We are way over. Thank you very much, I appreciate you giving me a little bit of time. Thank you.

The CHAIRMAN. Mr. Poliquin, you are recognized for five minutes.

Mr. POLIQUIN. Thank you, Mr. Chairman, very much.

Mr. O'Byrne, Mr. Downs, and Mr. Iscol, thank you very much for being here today and taking time out of your day. I really appreciate your service to our country. We don't have a country unless we have folks like you to step up. Thank you very, very much. This country is incredibly indebted to our veterans, and those of us on this Committee and elsewhere on the hill, we get it. Thank you very much.

Mr. O'Byrne, your testimony a moment ago when you started out, I caught something that has stuck with me, sir. And Mike asked this a moment ago, is that during your experience is some of them at the VA when you were actually trying to advocate for yourself being less disabled than others thought you were, you got push-back at the VA, correct?

Mr. O'BYRNE. Yes.

Mr. POLIQUIN. Okay. Mr. Kudler, Doctor, you are the Acting Assistant Deputy Under Secretary for Patient Care Services. Now, I am not a doctor, I am a business guy, but I am assuming you are the one of the head bananas over there when it comes to taking care of these folks, is that correct?

Dr. KUDLER. I do my best, sir.

Mr. POLIQUIN. Okay. Thank you very much for doing that. Our job, of course, is to help you to make sure you can take care of these great heroes that we have.

I am going to be listening for this in the future, Doctor. Do you sense anywhere at the VA that there is some sort of attitude whereby the more patients we have, the more services we provide, the more we protect ourselves, our bureaucracy? Because the goal is to take care of these people and if taking care of these people means that they don't need your care, that is good. Am I missing something here?

Dr. KUDLER. Our job as an organization is to help veterans and not to solve our own problems as bureaucrats or doctors or administrators, and I think the people I work with believe that.

There is no question when you work in a giant organization, and VA is the second-largest government organization, organizations of people, the organization takes on a life of its own. But I think that in VA there are over 300,000 people who are dedicated, just as you are, sir, to serving veterans.

Mr. POLIQUIN. Good. Thank you very much for it and I will be watching and listening for that in future hearings.

As has been mentioned here a moment ago, there are about 20, roughly 20 suicides per day among our veteran population. Roughly, Doctor, do you have any kind of feel for how many of those suicides have touched the VA before committing suicide?

Dr. KUDLER. Yes. Of the 20—and this is related to the VA data that we have worked with several government agencies, including the Department of Defense, to pull together—this data wouldn't exist if VA wasn't there to research, it is nobody else's job, but 14 out of the 20 who die on average every day are not currently using VA services; some have never used at all, but that 14 have not used it in at least the last two years.

Mr. POLIQUIN. Okay. And you have an outreach program, I am sure. I know you are a very large organization, you try to bring these folks in-house. What I am saying is touch these gentleman, correct, or these ladies and gentlemen, these folks in uniform?

Dr. KUDLER. We are reaching out, including through peer support and through our Vet Centers, 300 community-based Vet Centers, 80 mobile Vet Centers, our Make the Connection Web site, we are doing our best to reach out.

Mr. POLIQUIN. I appreciate it very much. Keep doing that, please.

We have a terrific family in the State of Maine, I represent the rural part of Maine. We have more veterans as a percent of our state than any other state in the country and we have more rural veterans in our Second District than anywhere in the country. There is a wonderful family, Paul and Dee House, who are Gold Star parents who lost their son Joel in Iraq, and they have put together a tremendous facility in Lee, Maine, way down east. If you haven't been to Maine, you gentlemen should go to Maine, because we know how to shoot straight in Maine.

[Laughter.]

Mr. POLIQUIN. The name of the entity is The House in the Woods and it provides places for our veterans to go with their families where they can engage in outdoor recreational activities. Each of you gentlemen, Mr. O'Byrne, Mr. Downs, Mr. Iscol, if you could comment your experience as far as healing is concerned, specifically for combat veterans coming back, are these facilities helpful,

given the experience you have had, outdoor activities, using your hands, using your bodies, being physical with your families?

Mr. ISCOL. So—

Mr. POLIQUIN. Mr. Iscol, sure.

Mr. ISCOL [continued]. -The short answer is yes. The only thing I would add to that is, you know, a facility that is run by a Gold Star family, I had a Marine named Sergeant Byron Norwood from Pflugerville, Texas who was killed in Fallujah in 2004, the most important conversation I have had in my journey home was with his parents. His dad is a guy named Bill Norwood who we were having a barbecue in Austin and he said to me, you know, Zach, nothing makes me happier than to see Byron's friends go on, start families, start their lives, go to school, start jobs, build businesses. In a sense, that gave me permission to restart my own life.

And so I think any chance you have to get a Gold Star family in front of a veteran to help them overcome survivor's guilt or grief that they are suffering from, for me personally that was hugely instrumental.

Mr. POLIQUIN. Thank you.

Mr. Downs?

Mr. DOWNS. Yes, I think that any of those outdoor recreational activities are key.

At Boulder Crest Retreat, we don't shoot pistols, we don't shoot rifles, we shoot a bow and arrow, because when we shoot a pistol or we shoot a rifle in the cordite, we smell the burn and the powder, it can potentially take us back to a spot where we were sitting here telling you we are fighting. So if we are going to shoot something, we shoot a bow, and we get a release and we get to release something. I mean, I just think we have to be careful sometimes, but outdoor, absolutely.

Mr. POLIQUIN. Mr. O'Byrne?

Mr. O'BYRNE. Yes, they answered the question perfectly and, yes, I wholeheartedly—Outward Bound for Veterans is one of those programs that takes veterans out on outside activities and it is really helpful. Vets like to suffer, you know.

[Laughter.]

Mr. O'BYRNE. And I mean that wholeheartedly. Put him a bad spot and watch him smile.

Mr. POLIQUIN. Mr. O'Byrne, we do not suffer in Maine, we enjoy the great outdoors. But thank you for that comment.

Mr. Kudler, do you have programs at VA—

The CHAIRMAN. Mr. Poliquin, could you wrap this? You are a little over.

Mr. POLIQUIN. Yes, sir.

Mr. Kudler, a yes or no answer, do you have programs at the VA that support these outdoor activities?

Dr. KUDLER. We do, but it would require more time to explain.

Mr. POLIQUIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman. And I agree with my colleague from New Hampshire who said this is the best conversation we have had in this room in the four and a half years that

I have been here. So thank you for bringing everyone together and facilitating it.

And thank you each for your testimony, your work and your service beyond your time in uniform. It is incredibly helpful to the work that we are trying to do.

There are, thanks to this panel, three books that I am going to reread or read for the first time: The Odyssey, I am going to read the Lansing book about the Shackleton expedition, and thanks to my friend Dr. Wenstrup, who just gave me a copy of Tribe, I am going to read Mr. Junger's book.

Dr. Kudler, you mentioned, and I am grateful for this, the fact that you are now providing urgent care to veterans who have other than honorable discharges. I would like you to take a page out of Mr. Iscol's book whose organization provides mental health care for veterans regardless of military discharge and does not wait until they are in crisis. Perhaps that is too late, I think almost certainly for too many veterans that is too late.

And we know from just one four-year reporting period that there were 13,000 veterans who had other than honorable discharges, who before their discharge were diagnosed with PTSD, traumatic brain injury, military sexual trauma, and now are unable to get any help at all. I asked the Secretary and I will ask you, I think it is within your administrative powers to extend this help not on an emergency basis, but proactively and preventively, and I would like an answer by the end of the week as to your interpretation of what you are able to do, the full extent of your powers under current law, and what you will do to fulfill that and what you need us to do legislatively to change the law to allow you to do more.

The second question for you is, Mr. Junger said that he has been unable, despite repeated requests, to find the number of post-9/11 veterans who have been diagnosed with PTSD. Do you have that as an absolute number or a percentage right now, or could you give it to us?

Dr. KUDLER. All right, second question first. I actually got a chance, and I want to thank Mr. Junger, to look at his testimony last evening, and I went to my computer and I probably know the Web site better than a lot of people, there is publicly available information, I printed it out and I will hand it to you. I hope it is the data you want and, if not, I will get you more data.

But I actually was in the room in 2003 when the Under Secretary said you are going to have quarterly data, he told our head of epidemiology, and they have had it every quarter since 2003 on the OEF/OIF, and we have comparison data with all other generations of veterans. So we have that.

Mr. O'ROURKE. And I will follow-up with you on number one, but with limited time I want to ask Mr. Junger, who addressed some of the underlying conditions that we are talking about trying to solve today, your comments about you went from a position where you could not be more necessary to a position where many veterans feel absolutely unnecessary to society and to the country.

I will highlight the Somers family, who lost a son following his service, who talked about a reverse boot camp that would force us as a country to pay just as much attention and make just as much

of an investment in the transition out of service as we do into service.

The second one and my colleague Ms. Esty brought this up, you talked about moral injury and I agree with your admonition to Members of Congress to be responsible in our rhetoric, but I was also struck when I visited Afghanistan with Dr. Roe and other Members of this Committee, we could get from the servicemembers there in exquisite detail what they had done that day or the day before, what their job was, but if we asked them why they were there they would say, I don't know, you tell me. So her idea of having a reauthorization for the use of military force that describes why we fight, what victory looks like, why we are asking people to serve is important.

And then the last issue and I know I am bringing up three big ones, but you brought them up first, since 9/11 fewer than one percent have served in the military. Our foreign policy is essentially being borne by fewer than one percent of this country. What do you think about a universal service bill that helps to address the lack of community that you see nationally? It wouldn't necessarily entail military service for everyone, but some form of national service for every single American, so we have shared sacrifice and what it means to be an American.

I know I gave you three big ones, some of this I will have to take for the record, but give it your best shot.

Mr. JUNGER. Yeah, I will test my memory and go backwards.

I have many times spoken about the value of national service with a military option. One of the things that seems to buffer Israeli citizens and soldiers from PTSD is the fact that virtually everyone serves in the military. I personally think it is not a moral thing to make someone fight a war they don't believe in, but it is an entirely moral thing to ask someone to contribute to the public good for a year or two. Psychologists know that the more a person sacrifices for something, the more they value it.

One of the problems I think in America right now is absolutely zero sacrifice is asked of our citizens. You do have to pay taxes, but if you don't want to do that, you can be fed and housed in prison. I mean, literally, our country asks for absolutely nothing, and I don't think that is good for the country or the citizenry.

As far as the morality of wars go, we know again from Israeli that the further you travel to fight a war, the more ambiguous the moral justification of it is. In the Yom Kippur War, the soldiers were literally fighting on their doorsteps of their villages, of their towns. Even during incursions into Lebanon, the PTSD rate was higher because they had to travel to the combat and the necessity of the combat was more in doubt.

I'm sorry, I have—

Mr. O'ROURKE. [Audio malfunction.]

Mr. JUNGER [continued]. Yes. So boot camp has in some ways an easy job, it is training people to do something that comes naturally to human beings, which is to identify themselves as part of a group and to make the moral choice that their own and personal welfare is less important than the welfare of the group. That is what humans are wired to do and that is why we have survived half a million years in an extremely rough world.

Reversing that goes against human nature, it goes against a lot of human DNA, and it is extremely hard. And I am not sure what it would look like to de-program people to get them to stop thinking communally, I am not sure how that would work.

I am taking you very literally. I do hear what you are saying, there should be a transition program, but one of the things I think that should be addressed in the transition program is, look, you're transitioning to something where there is no there there. I mean, you are going to look for a connection and it will not be there, and it is not because you have a problem, it is because it has a problem. I think that is an extremely important point.

And just finally with the statistic, if I may, I have looked and my researcher looked on the Web site and my friends in the VA looked at the Web site, there is a lot of statistics on it. The specific one I was looking for, which seems like a very obvious one, the percentage of Global War on Terror veterans on PTSD disability, what is that percentage? There's a lot of other percentages, total veteran population, et cetera, that one I think is particularly interesting and I found it particularly hard to find.

The CHAIRMAN. I will let you all decide that after the hearing.

Mr. O'ROURKE. Thank you, Mr. Chairman, for your indulgence.

The CHAIRMAN. Your time is expired.

Mr. O'ROURKE. Yes.

The CHAIRMAN. I am going to wrap up our side of the questioning with a couple things.

One, I thought back years later after I got home from Southeast Asia, I looked at three things: one, I have a strong faith; two, I have a very strong family; and, three, I had a place to go. There was no question when I got out of the military exactly where I was going. So I had a real focus at the end of a time when a lot of young men did not have any focus.

And you mentioned the war, basically I still to this day don't know why we were in Vietnam or 58,000 of my fellow comrades and many close friends didn't make it out of. So I think those things are important. This has been a terrific panel and I just have a couple of quick questions, because the Committee has done a great job and I thank you for being here.

Mr. Downs, you stated that upon seeking helping from the VA you were met with apathy, diagnosis, and denials, rather than the guidance, direction, and connection that you were seeking. The question is what would you do, what would you recommend that the VA do to improve the level of care that you received from the VA, what would you tell them to do or recommend that they do, tell them?

Mr. DOWNS. So one of the things that I like to do after PATHH is to find meaning in things that I didn't necessarily find meaning in before. So I took a phrase that was familiar to me that I hadn't really thought about, which was to be the change you wish to see in the world, and that change starts six inches from my chest. And when I can change that small environment, then I can move out to 12 inches, and then I can move out to 18.

So I think that what I would suggest to the VA is to just consider what they are saying to us and what their representatives are saying. I understand that Dr. Kudler isn't on the phone when I call

the VA, that it is a massive organization, but customer care and customer service I think starts with empathy and starts with understanding what you can do, not necessarily what you can't.

The CHAIRMAN. Here is something, Mr. Junger cited a 2005 IG study that showed that veterans sought less care for PTSD once they received a disability rating of 100 percent. Is that still true? That is very disturbing to me.

Dr. KUDLER. I don't know if it is still true, but I will say that another study, a recent study that showed that veterans who got disability for PTSD, regardless of whether or not they went into treatment for it, had lower PTSD symptoms years later and were much less likely to be homeless or, as I remember, die by suicide. That there are lots of positives in stabilizing someone's life in some ways, and we heard some of that from the panel, and then veterans get to solve that in the way that they want to solve that. But if they want to get treatment and we want them to get treatment, because we believe it is helpful and there is hope for them through treatment, we want to see that part too. We need to bring all this together.

The CHAIRMAN. I will just stay with you, Dr. Kudler—what factors do you attribute to a 50-percent growth in PTSD care in the VA system since fiscal year 2010 and how has that growth impacted access to mental health care at the VA?

Dr. KUDLER. There are several factors, I think one is generational. The Vietnam generation, there are still new Vietnam veterans showing up at VA today saying, I never came for help, I didn't think I had a problem, but now I think I have a problem. That generation, even though they helped get the idea of PTSD out there, were really not quick to say I have got this problem. I think the younger generations are quicker to say, I may have a mental health problem and I think there is help for it. That is one part of it.

Another part is when General Shinseki said, look, you don't have to prove you were blown off that bridge on that day and that is why you have that nightmare. If you show me you were in Vietnam in a combat area, I am going to say you probably had a stressor that would be the A criteria for PTSD. That used to be a tremendous block to people get service-connected for PTSD that helped a great deal.

And then we started screening every veteran who came back from any war or any—actually, every veteran under our care, that is six million-plus every year and we screen them every year for signs of PTSD. So we now look for it and identify it, and refer to treatment when we find it, and make them aware they might be able to get service-connected for it as well, which can help them in a number of ways.

So that I think, those are the main reasons why I believe it has risen so much.

The CHAIRMAN. Well, I think the thing that I heard today and the most encouraging thing I have heard from everyone is that it is not a yoke around your neck that is going to be there forever, you can go on with a normal life and you should go on with a normal life. I mean, I am a lot older than you guys, you guys got a lot of living to do and a lot of fun out there. And the only day that

I look out that is really, really bad is when I am going to play golf that day, I know that is probably going to be a bad day, but the rest of the days are pretty good. And I think that is what we need to be preaching to our veterans that have served this country is that, hey, you have spent part of your time in protecting American freedom and now we want you to have a fulfilling life after that.

And I know Mr. O'Rourke mentioned, my service began with a trip to the mailbox. I went to the mailbox, I got drafted, as millions of us did during my generation, but now today is a very phenomenal, all-volunteer Army, it is different. And as he said, very few people in this country serve and actually give back to the country in a meaningful way, and I think we need to look at that as a Nation. We certainly have seen that in Israel where everybody serves in some way or another. I have been there and it is amazing. That entire country serves and they all feel like that they have contributed to the great Nation that they have.

I am not sure whether my time has expired, but I just expired it.

[Laughter.]

The CHAIRMAN. Mr. Sablan, you are recognized for five minutes.

Mr. SABLAN. This is what happens when you come in late and you are not paying attention. Thinking about an event I had also in basic training when I knew that—I come from a small island and I knew that there was someone also in training who had to be discharged and that person, because at one time in my island everybody knew everybody, and that individual, just thinking what happened to that individual and the rest of his life, he did not live a long life after that. He felt rejected or something like that, because he had been—I don't know what it was, but when I came into this job we had basically no VA presence in the Northern Mariana Islands, I had to urge on the Hawaii office to complete a contract for a private physician and they gave us an administrative person to handle appointments, and I think we are now getting a social worker.

But thanks to the leadership of both Ranking Member Walz and Dr. Roe, and thanks to Dr. Shulkin, who has really given me some time and attention through many things, we may be seeing some improvements in place.

I am very envious to Mr. Iscol talking about his project, because I come from a place where there is—I think today there is no psychiatrist on the island, there may be two clinical psychologists. We are trying to get them hooked on to provide service to our veterans, because what they do now is they go in front of a television screen and talk to a professional, who down the road may resign, and they have to come back and talk to an entirely new person and retell their whole story.

But so, Dr. Kudler—well, first Mr. Iscol, I really would like to talk to you some more if there is a way of getting—

Mr. ISCOL. Yes, I would love that.

Mr. SABLAN [continued]. —getting us involved in your program. I am just so envious, sir.

But, Dr. Kudler, again, I am on the Committee and I am finally getting really some good attention and will hopefully get more improved services to the veterans serving in the Northern Mariana.

The last census we had was like almost 900 veterans and that was 2010, so I am sure there is more now. Our state VA office, I think that there is over 2,000 veterans in a place with a population of 52,000 people. So that is four percent, if it is 2,000.

But I would like to ask about PTS treatment options for veterans suffering PTS in rural and remote areas such as the Northern Marianas, which does not have a VA psychologist or a Vet Center. And telehealth is an option, but the veterans, I am hearing, I am meeting and hearing about are very uncomfortable with that method and so may not seek treatment. Actually, I know some who have not sought treatment. Two or maybe three suicides in the past five years. It just jolts the entire VA community, especially those that served with those who committed suicide. But what can the VA do for veterans for whom telehealth is not effective?

Dr. KUDLER. Yes, I think telehealth, as has already been brought up, is only part of the picture. It is an important part and it helps, but having boots on the ground—and I think just what you said about, okay, we have identified two psychologists on the island and probably maybe primary care docs or family doctors, we can train those people. If they are private and I imagine they are, they are just in there for private practice, maybe they could become Choice providers under the Choice Act, and then we could coordinate with them in other ways.

We have a PTSD consultation service through the National Center for PTSD which actually will answer questions about how to assess and treat PTSD for any clinician in America, they don't have to work for us. So we can work on weaving this web, starting with the available things.

And I will take a page from Mr. Junger's book and saying it has worked in rural Alaska, where we can work with elders of the Chamorro tribe, who serve a cultural foundation, a center of gravity, and we can coach them in talking with veterans in the community on how to identify problems, how to work with them in some of the ways we have heard about today, and how to do it in a culturally-appropriate way, which may lead to treatment or may lead to other solutions.

So we can weave that web, but we have a lot of work to do.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Ryan, we are very glad to have you here with our Committee today and you are recognized for five minutes.

Mr. RYAN. Thank you, Chairman. I really appreciate the opportunity to be here, and I think you having me here and trying to contribute in a small way to this hearing says a lot about you and how you approach this in a bipartisan way, that the veterans are the center for us and we just need good ideas. And I appreciate you having me here, so thank you very much for doing that.

I used to sit on the Veterans' Committee many, many years ago and I remember all of those hearings and I remember this one and I will agree with my colleagues, this is the best one I have ever been at as well, I think when you are talking about getting out some good information that can really be helpful to our vets.

Let me just make a couple points before I have a question or two. Listening, it is not either/or, it is both. Mr. Junger, you made an

amazing point, I am a little upset that Dr. Wenstrup didn't give me your book.

[Laughter.]

Mr. RYAN. I think I am the only one in the room, so I will have to work him on that. But you make the point that is the same point that Mr. Downs made, it is about connection. And it is about connection to your community, you talked about outdoors, it is about the connection to nature, and you made the point about it is about being connected to who you are, the deepest part of who you are. And so this whole hearing could have been called connection, we are having a veterans hearing about connection, and the only place I think I would disagree with you is I do think we can do some things about restructuring our society. I think Representative O'Rourke mentioned it with national service, I think you see it today with young people today who want to move into urban areas and use public transportation, and stay in a community and live in a neighborhood and be connected to that place.

I had somebody, a friend of mine who writes for the Youngstown Vindicator—I know you all don't get a subscription, so I will enlighten you as to what he said—he said I grew up sitting on my front porch, interacting with the neighborhood, and now I come home and I drive to my suburban home, and I go into my back deck that is fenced in in my back yard and I hang out with myself, you know. And I think that signifies that there are some things that we can do here.

So I am delighted to be a part of this. I want to recognize Bob Roth from the David Lynch Foundation, who has done an amazing job trying to outreach to veterans and school kids. There is another group here, Project Welcome Home Troops, Mr. Chairman. They weren't able to testify here today, John Osborne is here representing them. The same kind of thing, it is power breath workshop, deep breathing, processing the trauma, and then onward to some kind of meditation.

And I think about 15 years ago when I sat on the Veterans' Committee, if we had had a hearing where we had a bunch of vets talking about yoga and meditation and acupuncture, you know, you would have gotten run out of the room, but when you go and you see what is happening in these hospitals, the most in demand services that are in these hospitals, whether it is mindfulness-based stress reduction, TM, Project Welcome Home Troops with the breathing, yoga, Tai Chi, because it is helping.

And for us, Mr. Chairman, I sit on the Appropriations Committee, these bills are getting big. So if we can get and we are watching these vets go from 12 or 15 prescriptions, go through some of the things you all talked about here, and they go down to two or three. Like you said, Mr. Downs, it is not about saying you can't have any, but let's get you to a point where you are not taking 15 scripts a day. And then we get the actuaries out and we figure out how much that is saving us, it is everybody wins.

So I just want to say thank you. And I just, Mr. Downs, I want you to talk about something and then anyone else who would want to comment. You talked about post-traumatic growth. Talk to me about what post-traumatic growth means and if anyone else has a comment on it, because I think that shifts the mind set of what you

all were talking about. We are warriors, we can recover, we are not asking for sympathy, how do we take this situation and potentially turn it into a positive.

Mr. DOWNS. Thank you, Congressman. It is probably one of my favorite things to talk about and to sum it up—

Mr. RYAN. You have 20 seconds to do it.

[Laughter.]

Mr. DOWNS [continued]. —to sum it up into two thoughts. The first is that when we recognize that nothing happens to us, it all happens for us, all the pain and suffering is gone. And then the second is that we can choose our own way in any given set of circumstances, to quote Victor Frankel from *Man's Search for Meaning*. And if we can do those two things and learn to do them, because it is a practice, it is every day—it is not just once and you're done, it is not catch and release—that is post-traumatic growth that is struggle to strength.

And at Boulder Crest our definition of a hero is somebody who undergoes an extreme set of circumstances, survives, and comes back to tell their story. And I think that is key, that is post-traumatic growth.

Mr. Ryan nailed it.

Mr. O'BYRNE. You nailed it.

Mr. DOWNS. Thanks, Bro.

[Laughter.]

Mr. RYAN. We say in Congress, you seconded that.

[Laughter.]

Mr. RYAN. Mr. Chairman, thanks again. I really appreciate your time in allowing me to be here.

Mr. Takano and Tim Walz, thank you so much for making this happen.

Mr. TAKANO. Thank you.

Mr. WALZ. Thank you.

The CHAIRMAN. Thank you for being here with us today too and waiting a long time for your question, I appreciate you sharing with the Committee.

First of all, I want to thank the panel. It was an excellent discussion we had today, and I think a lot of people who were watching and other people who participated will take a lot away from it. And I really appreciate you spending your time and coming.

And, Mr. Takano, I want to give you an opportunity to have any closing remarks you may have.

Mr. TAKANO. I will be very brief, it has been a long hearing, but I am intrigued by many of the ideas brought up here today. National service has also been a long-time topic that I have been interested in. We have seen in the past presidential campaign the idea of free college, affordable college, debt-free college, but I have always thought that there ought to be some connection, some exchange that—and that is what we do with the military, we offer young people the opportunity to serve our country and in exchange we offer them the GI Bill. It is not simply a transaction, it is a binding to the Nation. And the idea of a national, a healthy national identity I think is a good thing.

In my mind is the words of John F. Kennedy, ask not what your country can do for you, but what we together can do for our country

and for the interests of liberty. You know, he was a very communitarian, Greek, I use the Greek, the idea of belonging to a polis, a political community.

So I think these are vital things that we should be talking about as Americans. And the idea of a reverse boot camp, the idea that it is not natural and it struck me that, yes, a complex society, a complex economy demands more of the individual, and therefore the type of education we have to offer people to be strong individuals, to be viable and to thrive, is going to take a more sophisticated type of education.

So a very, very thoughtful hearing. Mr. Chairman, I thank you for bringing together such an incredible group of individuals, and I really do enjoy working with you on these issues that face our country.

The CHAIRMAN. Thank you, Mr. Takano.

I will just wrap it up quickly by thanking each and every one of you. You know, Mr. Junger, I read your book. I don't agree with everything in your book and you may not agree with everything in your book.

[Laughter.]

The CHAIRMAN. But I do know that having a look, I think about my own family, my mother's family had ten in the family—I am an only child, that obviously cured her from a large family, but they didn't have a lot. They were sharecroppers. And I remember the first phone we got, it was an eight-party line and you didn't know who was listening in to your conversation, but we were very close, close with our cousins, and I don't know of anybody in that family, eight in my dad's family, I don't know how anybody in that family had ever did anything but supported each other, and then the community supported everybody.

I will give an example of the farm I grew up on. We would work on our place and then, because labor was pretty short, you would go to someone else's farm and help them. You didn't hire anybody. And what you got was lunch and dinner that day when you worked on their farm. You helped, you helped your neighbor out. And I think we have lost some of that, as you mentioned. When you drive into your backyard and close yourself off from the rest of the community, your neighbors around you, you don't feel an obligation or an allegiance to your community or to your neighbors, and I think you were spot-on about that.

And I think the other thing I learned today and, Mr. O'Byrne, I want to thank you for saying this and all of you did, is that I am here to get well and get back and be a productive member of society, as I am. And I absolutely believe that the veterans are some of the most productive people you will ever meet in society, some of the most giving people you will ever meet.

So I want to thank each and every one of you for your service, I want to thank the VA. You have got a big job we have asked you to do to treat all these folks and I think what we found is it is not one-size-fits-all, we need to keep an open about what we are going to do going forward, and I think you all have helped enlighten us today with that.

And being no further questions, I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material.

And without objection, so ordered.

The hearing is adjourned.

[Whereupon, at 12:21 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Brendan O'Byrne

Hello, thank you for allowing me to share my story. My name is Brendan O'Byrne. I served in the military from 2002–2008. In May of 2007, I was deployed to the Korengal Valley, Afghanistan and completed a 15 month tour as a Sergeant/Team Leader with the Airborne Infantry. When my unit and I redeployed back home I did not expect to have any issues from the deployment but I was wrong. I began to have various symptoms of PTSD upon returning from combat. When I was honorably discharged in December 2008, I began to seek help from the VA to deal with the PTSD I had. At the time, I was unemployable, barely able to function in a healthy way so I applied for PTSD disability. After a 4 year back and forth with the VA, I was given a 70% disability rating.

Almost immediately I was told by other veterans and even some workers at the VA that I should fight for my 100%. Now, I don't know if they saw something that I didn't but in my eyes, I was not 100% disabled and told them that. The common response was, "You deserve 100%. You earned it." I take offense to these two statements because I fail to see how I "deserve" or "earned" a disability rating. I have PTSD, a treatable disorder. I did not lose a limb or sustain any permanent physical damage. A PTSD disability rating is not a hand out, it is a tool.

I used the money as a tool, I did not have to worry about my rent or bills, and I could focus squarely on the PTSD symptoms and fix them. I did the work, working through the crippling anxiety, blinding anger, and a slurry of other symptoms. Because of that hard work, today I know I am no longer 70% disabled. Recently, I have been working on the steps to lower my rating. Surprisingly, I have received a lot of pushback. The pushback has come from well-intentioned VA workers, other veterans, family, and friends, all singing the same chorus, "You deserve it, you earned it." What I have to ask is this, if our goal is not to get veterans off disability and to become active, contributing members of society then what is our goal? To me, being an active member of society is the ultimate sign of healing from combat and we should all be striving for it.

On my journey back home, I have tried all forms of treatment, from VA counseling to a service dog. My first concentrated effort was through the VA, signing myself into a 45 day in-patient PTSD treatment facility 8 months after separating from the army. While there I learned many of the mechanics of PTSD, like the triggers of PTSD symptoms and ways to deal with them or avoid them. Every day we would have group counseling sessions. Sometimes I would hear varying stories of trauma, from combat in Vietnam jungles to the streets of Iraq. But more than those traumatic stories, I heard stories that sounded a lot like a bad day rather than a traumatic moment. As weeks went by, I realized the sad truth about a portion of the veterans there, they were scammers, seeking a higher rating without a real trauma. This was proven when I overheard one vet say to another that he had to "pay the bills" and how he "was hoping this in-patient was enough for a 100% rating". I vowed never to participate in group counseling through the VA again.

When there is money to gain, there will be fraud. The VA is no different. Veterans are no different. In the noble efforts to help veterans and clear the backlog of VA claims, we allowed a lot of fraud into the system and it is pushing away the veterans with real trauma and real PTSD.

Since returning home in 2008, I have given speeches all across the country about my struggles with PTSD and talked to thousands of veterans seeking the answers about healing from combat. The trend I have seen among the combat veterans, the most traumatized group, stay away from the VA, or at the very least, the group counseling settings. They have no patience for the fraudulent veterans scamming the system to get a pay check and they are definitely not going to open up about their worst days to those who know nothing about them.

The problem is this, when we talk about healing from PTSD, I consider the most effective form of therapy peer to peer counseling, especially older vets mixed with

younger vets. An easy way to understand the power of peer to peer counseling is looking at Alcoholics Anonymous. In AA, there is no clinicians, no experts, and no money to gain by going to meetings. The only reward is getting sober. Being an alcoholic myself, I did not turn to the doctors or psychologists to stop drinking. I turned to AA, the people who understood my plight through their own experiences, and I am close to 4 years sober now.

Veterans are the same in that we know how to take care of one another. But with the fraudulent PTSD claims and the clinical setting of the VA, it is hard for veterans to really open up about the worst days of their life. Where to go then if not the VA?

Last year, I was a co-facilitator of "From Troy to Baghdad", a program run and funded by New Hampshire Humanities. With a group of 8 veterans, 4 Vietnam, 4 Iraq and Afghanistan, we read and discussed *The Odyssey* by Homer. We met once a week for two hours for 12 weeks. During those 12 weeks, I witnessed something I consider holy. Old veterans and young veterans hashing out the experience of war and homecoming. The old teaching the young and vice versa. The amount of healing that was accomplished in that room is hard to describe. We talked about God, about death, about life, about the feeling of returning to a country you no longer recognized as home. We talked about suicide, about anger, about hate. We talked about fate, bravery in combat, and at home. And in those 12 weeks, I learned more about war and homecoming than I had in all the VA counseling I had received in the years of being home. These are the conversations that bring veterans home and they desperately need to be fostered in the ways that promote the conversations to happen organically.

Around the country small non-profits designed to serve veterans are springing up. Some of these non-profits have done an immense amount to heal vets. Some that I think are doing great work are Outward Bound for Veterans, Heroes and Horses, Team Rubicon, and Team Red, White, and Blue. Though each of these non-profits are vastly different from one another, the one universal is that these groups empower veterans. They show veterans that they are not broken, that they can heal from these experiences, and do great things in the world after war.

When I come back to the question I asked in the beginning, what is our goal for our veteran's futures, programs like the ones just mentioned are helping reincorporate veterans to be active members of society. I encourage more support for these programs.

Prepared Statement of Sebastian Junger

Although every mission of service is crucial in our military, only about 10% of soldiers experience sustained combat. And yet an estimated 25% are thought to suffer from Post Traumatic Stress Disorder, or PTSD. Humans have evolved over hundreds of thousands of years to survive and even thrive despite extreme violence and hardship, and if a quarter of our ancestors were psychologically incapacitated by trauma, the human race would have died out long ago. Many of our vets seem to be suffering from something other than trauma reaction.

One possible explanation for their psychological troubles is that - whether they experience combat or not - transitioning from the close, communal life of a platoon to the alienation of modern society is extremely difficult. Twenty-five percent of Peace Corp volunteers struggle with depression when they return from their service overseas. Humans evolved to live in small groups where survival depended on being tightly bonded to those around us. We did not evolve to live alone or in single-family units that were independent from the wider community. Ironically, when you collapse modern society - such as during the London Blitz or the attacks of 9/11 - there is often an improvement in mental health. Suicide rates in New York City dropped after 9/11. It is thought that the instinctive communalism of a crisis actually buffers people from suicide and depression. As one English official observed during the Blitz, "The chronic neurotics of peacetime are now driving ambulances."

Interestingly, PTSD is virtually unheard of among Afghan and Iraqi fighters, and the Israeli military reportedly has a PTSD rate as low as one percent. All of these societies enjoy both widespread military service and exceedingly tight community bonds. Furthermore, none of these societies incentivize veterans to see themselves as permanently damaged wards of the state. In a misguided attempt at reaching more people, the VA allowed veterans to both "self-diagnose" PTSD, and exempted them from having to cite any traumatizing incident during the war. As a result, the percentage of Global War On Terror vets on PTSD disability is so high that the VA appears unwilling to release the figure. I have tried for two years to get that figure,

without success. Even highly-placed administrators at the VA eventually gave up after trying to help me.

Obviously, a small number of combat vets will experience long-term trauma reactions and need full disability payments. A larger number of combat veterans will need temporary financial support while they undergo counseling and dedicate themselves to rejoining the work force. But if you want to create hundreds of thousands of depressed alcoholics in our society, give them just enough money to never have to work again and then tell them they are too disabled to contribute to society in any meaningful way. In the civilian population - which does not have access to lifelong PTSD disability - trauma reaction is considered both treatable and temporary. It would be interesting to see how the survivors of the Deepwater Horizon disaster are faring - or the survivors of Hurricane Katrina, or the survivors of a town that was hit by a tornado. Surely the vast majority of these people have resumed productive lives despite having been deeply affected by the trauma they survived. We are not doing veterans a favor by warehousing them in a lifelong entitlement program.

I would like to make one further point. In order for soldiers to avoid something called "moral injury," they have to believe they are fighting for a just cause. And that just cause can only reside in a nation that truly believes in itself as an enduring entity. When it became fashionable after the election for some of my fellow democrats to declare that Donald Trump was "not their president," they put all of our soldiers at risk of moral injury. And when Donald Trump charged repeatedly that Barack Obama - the commander-in-chief - was not even an American citizen, he surely demoralized many soldiers who were fighting under orders from that White House. For the sake of our military personnel - if not for the sake of our democracy - such statements should be quickly and forcefully repudiated by the offending political party. If that is no longer realistic, at least this committee - which is charged with overseeing the welfare of our servicemen and women - should issue a bipartisan statement rejecting such rhetorical attacks on our national unity. That unity is all soldiers have when they face the enemy, and you must do everything in your power to make sure it is not taken from them.

Prepared Statement of Zach Iscol

Good morning, my name is Zach Iscol and I am a former U.S. Marine, Iraq War veteran, and the co-founder of the Headstrong Project.

I would like to start by thanking Chairman Dr. David Roe; ranking member, Rep. Tim Walz; and fellow members of the Committee on Veterans Affairs for the opportunity to speak today about Headstrong and the work we do providing world-class, effective, cost, and bureaucracy-free mental health care to our fellow veterans.

Like my beloved Marine Corps, which was founded in Tun Tavern in Philadelphia, Headstrong began in a bar.

In early 2012, I was catching up with my battalion commander, Colonel Willy Buhl, who commanded 3rd Battalion, 1st Marines during the Second Battle of Fallujah. We lost 33 Marines during that deployment and about half the battalion, 500 men, were wounded. By 2012, we had also tragically lost a number of Marines to suicide and Colonel Buhl remarked to me that he was worried we would soon lose more Marines to suicide than we had to enemy action. Today, that count stands at 23 Marines. For us, this work is deeply personal.

Two days later, I relayed this story to two very successful investors, and later co-founders of Headstrong, from Kayne Anderson Capital, a leading investment firm. One of them remarked that he didn't understand why it was so difficult for our veterans to receive the same type of world-class care he could. If he could see the top psychiatrist in New York City tomorrow, regardless of insurance, rates, or schedule, why couldn't a veteran?

Answering that question became the foundation of the Headstrong Project.

Within a few months, we raised \$200,000 and formed a partnership with Weill Cornell Medicine to treat Iraq and Afghanistan veterans in New York City. Since then, we have provided 5,559 clinical sessions, grown to 198 active clients, have expanded our treatment programs to San Diego, Houston, Chicago, and Washington, D.C., through a network of over 80 world-class private practice providers.

Most importantly, we have not had a single suicide.

Prior to our expansion efforts, we intentionally grew slowly to ensure that our model was effective. Among the forty-seven thousand veteran service organizations in our country, there is no shortage of good will, but there is also no shortage of half-baked ideas, ineffective awareness campaigns, or fundraiser efforts without a

foundation of solid programming. For us, it was critically important that we build a program that works before attempting scale.

We will be opening in Denver and Colorado Springs within the next month and recently received a grant from the New York State Health Foundation to begin providing care to veterans in rural areas of New York state through a hybrid of telemedicine and in-person treatment. By the end of the year, we will be in two additional cities and have plans to expand to 20 within the next 24 months.

Our model is simple, effective, and highly efficient. On average, it costs less than \$5,000 to treat one veteran and \$250,000 to expand to a new market. All treatment is tailored to the needs of the individual and managed by our team at Weill Cornell Medicine. We do not limit the number of sessions.

In New York, all care is provided at Weill Cornell Medicine. In other locations, we've built networks of the top psychiatrists, psychologists, and social workers to provide care. Instead of spending millions on building brick and mortar clinics that are often staffed by inexperienced recent graduates, we tap into the capacity of the private market to provide care. These are the same doctors that members of this committee would send their loved ones to should, God forbid, they needed it. These clinicians must meet a very high standard of experience, training, and qualifications. They are also vetted, interviewed, and managed by our team at Weill Cornell.

We then pay these clinicians to provide care. In return, we require that they submit their notes to our clinical team at Weill Cornell and that they participate in case conferences. This ensures that we are able to manage care to ensure our veterans are getting better and that we have accountability of outcomes. Through these networks we are able to provide a variety of evidence based treatments including eye movement desensitization and Reprocessing (EMDR) and cognitive behavioral therapy (CBT)*, drug and alcohol treatment, group therapy, and spouse and family support.

When a veteran reaches out to us, we respond almost immediately and schedule an initial intake call with one of two clinicians at Weill Cornell. During that call, our clinician works to understand the underlying reasons a veteran is reaching out and to ensure they are not in immediate danger to themselves or others. We do not require any paperwork or insurance and provide care regardless of the type of military discharge.

After their phone intake, our clients meet with a psychiatrist in their community to ensure they are a good fit for outpatient care, to begin understanding their goals (i.e., sleeping through the night, improved relationship with their spouse, addressing substance abuse, dealing with anxiety, etc.), and to develop an individually tailored treatment program. The veteran then begins treatment with one of our clinicians that may include substance abuse treatment, group therapy, and other non-clinical activities like yoga, rock climbing, kayaking, and other sports and mind-body techniques.

While undergoing treatment, our clinical team at Weill Cornell Medicine closely monitors the veteran's progress to make adjustments to care and to ensure our client is getting better. This work is not done in a vacuum, but is done in coordination with the client and their clinical team.

While this might seem expensive, it's not. More importantly, it is also very effective.

In addition to their notes and case conference participation, all clinicians are required by Headstrong to submit data tracking forms developed by public health experts at Weill Cornell Medicine to measure symptom severity and improvement. Outcome data analyzed in 2014, which only corresponded to clients in New York City, demonstrated the following impact measurements:

- 86% better sleep
- 89% fewer flashbacks and nightmares
- 85% less hypervigilant
- 88% reduction in avoidance
- 92% reduction in suicidal ideation
- 91% improvement in mood
- 95% improvement in work or at school
- 89% reduction in drug and alcohol use
- 78% reduction of medication for symptoms

In 2016, Headstrong analyzed impact data for both San Diego and New York and found the following measurements+:

- 75% better sleep
- 83% fewer flashbacks and nightmares
- 71% less hypervigilant

- 68% reduction in avoidance
- 86% reduction in suicidal ideation
- 87% improvement in mood
- 77% improvement in work or at school
- 80% less drug and alcohol use
- 67% reduction of medication for symptoms.

I am also proud to say that our number one source of referrals is veterans referring other veterans to our program. We also have a great relationship with some VA hospitals, in cities like San Diego and Houston, which have become important referral partners. We would like to be able to formalize a partnership with the Department of Veteran Affairs, so that we can have the same relationship with have with all VA hospitals that we currently have with a few.

In the special operations community, we adhere to five SOF Truths.

- Humans are more important than hardware
- Quality is better than quantity
- Special operations forces cannot be mass produced
- Competent special operations forces cannot be created after emergencies occur
- Most special operations require non-SOF assistance

I believe these are equally true in providing effective mental healthcare to our nation's veterans and that these truths are the backbone of what makes Headstrong work so effectively. There is no simple app that will solve this problem, instead it requires talented and dedicated humans. The quality of the providers matters immensely and you cannot produce great clinicians overnight or after a national emergency like the current suicide epidemic. And finally, our network is only effective if it is supported by other veteran service organizations, donors, our community, and the VA.

I would add that this human factor extends to the veterans we treat. Our medical director and co-founder, Dr. Ann Beeder, a leading trauma and substance abuse psychiatrist, professor at Weill Cornell, and public health expert, often remarks that in her 30-year career veterans represent the best patients she has had the honor of working with. They are goal-oriented, hard-working, and follow the doctor's orders. Remarkably, once they start getting better, they look for ways to continue to serve and give back.

Often a veteran will reach out to us, usually a Navy SEAL, Ranger, or Marine, and want assurances that our program is completely confidential. They will often remark that they are only reaching out because their spouse threatened to leave them if they didn't talk to someone. After a few weeks of treatment, they are sleeping through the night. Then their anxiety goes away and they no longer need to drink or self-medicate to calm their nerves. Soon, they are back to the best version of themselves and then something remarkable happens and they become ambassadors to Headstrong. They start talking about their therapy, telling their buddies about it, and look for ways to get others to get the help they need and overcome the stigma with getting help.

In my own journey, I've learned that one of the biggest barriers to care is that many do not recognize mental health care as real medicine. I am not talking about drugs or pharmaceuticals, but the hard work that goes into healing and repairing the effects of combat and moral injury on our brain and nervous system. Hidden wounds can be healed.

At Headstrong, we firmly believe that if you have the courage to get help, and you get the right help, you can recover and get back to the best version of yourself. Our clients will tell you this takes hard work, but it is worth all the effort.

Thank you for your time and thank you for your efforts on behalf of our community,

Zachary Iscol
Co-founder and Executive Director
The Headstrong Project

HEADSTRONG PROJECT CLIENT TESTIMONIALS

"Headstrong Project understands how to treat veterans...saved my life when no other administration wanted to. My wife and children thank you." -Client

"My wife and I are expecting a baby in October. I wanted to let you know that without Headstrong in my life there is a good chance this would have never happened for us. There were real doubts when I was going through my PTSD if I could raise a child in a healthy home. I am completely confident in my own health and my ability to raise children in a loving home because of Headstrong." -Former Client

"I am deeply impressed with how amazing an operation you all are running. It was a gigantic weight off my shoulder to have an organization who actually lived up to their promise. Thank you" -Client

* Eye Movement Desensitization and Reprocessing (EMDR) and Cognitive Behavioral Therapy (CBT) are the two treatment modalities recommended by the Department of Veteran Affairs' National Center for PTSD. <https://www.ptsd.va.gov/public/treatment/therapy-med/treatment-ptsd.asp>

+ 2016 numbers were lower than 2014 because many of our San Diego clients had been through some treatment already outside of Headstrong and were therefore starting treatment with some level of improvement than many of our New York clients, who were starting treatment for the first time.

Prepared Statement of Paul Downs

Thank you, Chairman Roe, Ranking Member Walz, and other distinguished members of the Veterans' Affairs Committee for this opportunity to speak with you today, to share my story, and to bear witness for a powerful technique for healing and wellness: Transcendental Meditation (or "TM").

My name is Paul Downs. I served 11 years in the United States Marine Corps as an Infantryman and was deployed a number of times.

When I left the Marines, I was happy that I would be closer to my young children. But what I didn't realize was just how much my identity as a Marine meant to me. When I left the Corps, I lost my tribe, my sense of self, and all that I knew to be true. I lost my sense of forward momentum, purpose, and connection.

What caught up with me weren't just the nightmares relating to my deployments . . . it was all the trauma I carried into the Marine Corps. Like many of my brothers and sisters, my first experience with combat wasn't in Karmah, or Fallujah. My first combat zone was my own childhood home, a place that should have been safe but instead was an active war zone.

The Marine Corps, in actuality, saved my life. At least for a time.

When my service was done, I sought help from the VA. I sought guidance, direction, and connection. Instead, I got apathy, diagnoses, and denials. So, I quit trying. Why add that level of stress to the deep-rooted struggle I was already neck deep in? I suffered from post-traumatic stress (PTS), and to many outside observers, might have seemed like an angry, disgruntled veteran.

The fear and sadness were drowning me. A few months after putting away the uniform, I developed a pretty detailed plan for suicide. I was about as close as you could come to becoming a statistic. While sitting in my truck, ready to proceed, a thought hit me: to die by my own hand is not my birthright. This is not it. This is not to be my end. It CAN'T be. It is not the way of the Warrior. Warriors have a deep appreciation for life, and are not victims of circumstance.

I called the Boulder Crest Retreat Facility in Bluemont, Virginia and said I needed something new in order to live. That something was the Warrior PATHH program, an immersive program where veterans rely on the support, company, and experience of our peers. The program was created by combat veterans, for combat veterans. During the program, many modalities allowed me to face my deep struggle and grow to profound strength and I was able to claim a new and positive diagnosis: Post-traumatic Growth. The modality that most made this change possible was Transcendental Meditation, a simple to learn technique taught by a fellow combat veteran.

I took comfort in knowing how evidence-based TM is. I could cite the research that demonstrates its promise and power - the more than 340 peer-reviewed studies, or National Institute of Health research showing substantial reductions in heart disease, the massive decrease in symptoms of PTS, depression and insomnia. But I'm not a public health expert, so instead, I just want to tell you what TM did for me.

After just a few weeks practicing this meditation for twenty minutes, twice a day, I felt less anxious, less angry, more focused, more energized, more directed. I gained a connection to self that I didn't have before. I found peace with my past. I realized who I am. and there's NO PILL for THAT.

Because of that connection to self, I am now a Warrior PATHH Guide at Boulder Crest, where I get to walk with my brothers and sisters on their path from struggle to strength.

There were many activities that we engaged in at the retreat, but many of them don't apply to everyday post-retreat life. TM is different. I can meditate on an airplane. I can meditate in traffic. That's why TM is so pivotal. You can take it anywhere. And it can be done at any time. Perhaps that's why it has so many other

applications, such as in classrooms filled with at-risk children, or for women and children dealing with the after effects of intimate partner violence.

What I have come to realize is that I needed this training..training to learn how to regulate to be calm, be cool, and be collected at home, just like on the battlefield. We have to be trained to be present and connected. It is hard to believe that twenty minutes, twice a day, is exactly what we require. But it is. It works for me, and for thousands of my brothers and sisters. It has given me the opportunity not just to survive on earth, but thrive here - and to live a life that is truly full of purpose, meaning, connection, and service.

And for that, I want to thank the David Lynch Foundation, and their outstanding Operation Warrior Wellness division, which makes TM available to veterans overcoming PTS and the families who support them. They gave me a gift that changed my life, and the lives of everyone I come into contact with. I'm grateful that they have also been there for many others. In 2016 alone, veterans and Active duty military from 38 states have learned TM from specially trained teachers and experienced its impact.

As you reflect on the changes that are needed at the VA, I would ask that you provide more platforms for the voices of others like me - those who have "been there and done that" on the battlefield and in the depths of despair. The one thing that will never change is that we veterans know what one another need.

Thank you for your time and attention, and for the honor of addressing you today. I look forward to answering any questions that you might have.

Prepared Statement of Harold Kudler

Good morning Chairman Roe, Ranking Member Walz and Members of the Committee. Thank you for the opportunity to discuss Department of Veterans Affairs' (VA) mental health treatment services and programs that promote recovery for post-traumatic stress disorder (PTSD) and support Veteran wellness.

INTRODUCTION

VA is committed to providing timely access to high-quality, recovery-oriented, evidence-based mental health care that anticipates and responds to Veterans' needs and supports the reintegration of returning Servicemembers into their communities. In Fiscal Year (FY) 2016, more than 1.6 million Veterans received mental health treatment in a VA mental health specialty program. This number has risen each year from over 900,000 in FY 2006. Concurrently, VA has accelerated translation of effective treatments for PTSD into clinics and mandated Veteran access to these treatments at all VA medical centers (VAMC) and large VA community outpatient clinics (CBOC). VA ensures integrated PTSD treatment across a continuum of care which respects Veterans' values and preferences. Innovations, such as delivery of effective treatments to Veterans with PTSD via Telehealth, optimize access to care when and where the Veteran needs. Research has recently documented that PTSD treatment delivered directly to the Veteran's home via telehealth is as effective as treatment rendered in the clinic. This creates new opportunities which Veterans and VA are eager to act upon.

PTSD Treatment Services and Programs

Specialized PTSD treatment is an integral component of VA's mental health services. In FY 2016, more than 583,000 Veterans (over 178,000 of whom served in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) received state-of-the-art treatment for PTSD in VAMCs and clinics, totaling more than 10 million clinical visits. Since FY 2010, the number of OEF/OIF/OND Veterans receiving mental health services has more than doubled and PTSD services overall have grown by over 50 percent.

VAMCs, CBOCs and specialized mental health programs provide a continuum of specialty PTSD care. This includes psychologists based in primary care mental health integration clinics, PTSD specialists working on behavioral health integration teams, specialized PTSD residential rehabilitation treatment programs, and specialized outpatient PTSD clinical teams (PCTs) around the country. Nationwide, VA operates 131 specialized PCTs, which provide individual and group therapy for PTSD. Each team includes a staff member trained to treat Veterans with PTSD and concurrent substance use disorder. There are also increasing numbers of PTSD treatment programs to specifically treat Veterans with special needs, including women Veterans or Veterans with co-morbid substance use disorder, traumatic brain injury or military sexual trauma.

VA also continues to lead efforts at increasing the quality and availability of evidence-based care for PTSD. VA recently partnered with the Department of Defense (DoD) to develop the third edition of their joint practice guideline for PTSD and has developed policies and implemented programs to facilitate adoption of guideline recommendations. These include a national training initiative to disseminate two of the most effective psychotherapies for PTSD, Cognitive Processing Therapy and Prolonged Exposure. VA requires that every VAMC offer access to these treatments and has thus far trained over 7,000 VA clinicians in one or both. VA is also acting to ensure that all Veterans have access to Eye Movement Desensitization and Reprocessing (EMDR) therapy and is conducting research on the therapeutic value of Service Dogs for Veterans with PTSD.

VA recognizes the importance of including complementary and integrative health (CIH) services into the services offered to Veterans with PTSD. According to an internal survey conducted in 2015 by the VA Healthcare Analysis and Information Group,

93 percent of Veterans Health Administration (VHA) facilities were offering some type of CIH therapy. For PTSD, the most common approaches reported were guided imagery (81 percent of facilities), stress management relaxation therapy (80 percent), progressive muscle relaxation (73 percent), yoga (61 percent), and mindfulness (58 percent). CIH approaches promote self-healing and complement traditional medical approaches to support Veterans on their path to health and well-being, and some evidence exists supporting the use of acupuncture, chiropractic, yoga and/or mind-body therapies in helping treat chronic pain and mental health conditions. The Integrative Health Coordinating Center, an office within the Office of Patient-Centered Care and Cultural Transformation, was established to help standardize and expand access to evidence-based CIH therapies for Veterans around the country.

There are some conditions that have relatively straightforward and highly successful treatment plans, such as antibiotics for pneumonia or direct-acting antiviral agents for Hepatitis C. However, VA recognizes that there are other conditions with varied, complex symptom presentations that require more nuanced treatment approaches. That was the rationale for creating the Center for Compassionate Innovation (CCI), which serves as an entry point for the private sector to share new treatments or therapies with the VA. CCI seeks to offer hope to a subset of Veterans who struggle with their physical and mental health conditions after traditional, evidence-based treatments have failed to yield the desired or optimal outcome. CCI oversees a rigorous review process to answer whether it is advisable and feasible to offer therapies that have promising anecdotal evidence, but lack significant structured scientific research to a population of Veterans who have exhausted the evidence-based options.

In addition to providing an extensive and comprehensive set of services for Veterans with PTSD, VA also strives to educate Veterans and providers about PTSD treatment and to advance our understanding of PTSD through research. VA's National Center for PTSD (NCPTSD), which has emerged as the world's leading research and educational center of excellence on PTSD, serves as a major resource for information regarding PTSD treatment, research, and education for Veterans, VA clinicians, community providers and other organizations. For example, NCPTSD partnered with DOD to launch the first publicly available VA app, the award-winning PTSD Coach and now supports an entire suite of apps to support Veterans, family members, and providers living with or treating PTSD. The Center also provides, among other things, assessment tools and treatment manuals, online trainings, mobile smartphone applications, on its award-winning website, www.ptsd.va.gov.

The PTSD Consultation Program was launched by NCPTSD in 2011 to provide expert consultation to VA clinicians treating Veterans with PTSD so that Veterans will receive maximum benefit from treatment. This program was expanded in 2015 to offer consultation and resources to non-VA providers who treat Veterans with PTSD in the community. This has become an especially important program given the number of community providers now providing care for Veterans under the Choice program.

To improve Veteran engagement in treatment, NCPTSD created AboutFace, an award-winning website of Veterans sharing their personal experience of how PTSD treatment has helped them turn their lives around. In this way, AboutFace Veterans serve as peers who can provide accurate information about PTSD and challenge misperceptions about mental illness and the value of treatment. A new online PTSD Decision Aid developed by the Center will help patients learn about the benefits and risks of evidence-based treatment options and guide them as they clarify their treatment preferences and goals.

NCPTSD also advances patient care through basic research. A major new initiative is the VA Leahy-Friedman National PTSD Brain Bank. This is the first brain tissue repository dedicated to understanding how psychological trauma and biological systems interact to create anatomical and functions changes in brain tissue in PTSD. The Brain Bank accepts tissue donations from both Veterans and non-Veterans who wish to donate their brains for scientific study after they pass away. Researchers will examine four brain regions critical to PTSD and will be the first ever to use brain tissue to perform RNA sequencing in these areas to examine gene expression unique to PTSD. The brain bank is already generating findings, which may serve as new PTSD biomarkers. In addition, funding through a \$45 million award to establish the Consortium to Alleviate PTSD (CAP) will support an array of new cutting-edge clinical treatment trials and biological studies including efforts to learn more about the biology/physiology of PTSD development and patterns of treatment response to better inform diagnosis, prediction of disease outcome, and new or improved treatment methods.

Suicide Prevention

Recent VA research finds that 20 Veterans die by suicide each day. This means that Veterans are at greater risk than the general public. In 2014, Veterans accounted for 18% of all deaths from suicide among U.S. adults, while Veterans constituted 8.5% of the U.S. population. After adjusting for differences in age and gender, risk for suicide was 22% higher among Veterans when compared to U.S. civilian adults. We know that 14 of the 20 Veterans who die by suicide on average each day do not receive care within VA. We need to find a way to provide care or assistance to these individuals.

VA is committed to ensuring the safety of all Veterans, especially when they are in crisis. When a Veteran's life ends in suicide the lives of those who care about them are also shattered, and the tragedy resonates across communities and the Nation as a whole. Veterans who are at risk or who reach out for help must receive assistance when and where they reach out, in ways that matter to them and can make a difference in their lives. We are committed to preventing Veteran suicide among those who seek VA care and to save the lives of other Veterans through partnerships and community collaboration.

VA has developed the largest integrated suicide prevention program in the country. We have over 1,100 dedicated and passionate employees, including Suicide Prevention Coordinators, Mental Health providers, Veterans Crisis Line staff, Peer Specialists, epidemiologists, and researchers, who spend each day focused on suicide prevention and Veteran engagement. Screening and assessment processes have been set up throughout the system to help identify those at risk for suicide. VA also developed a chart "flagging" system to ensure continuity of care and provide awareness among providers. Those identified as being at high risk receive an enhanced level of care including missed appointment follow-ups, safety planning, weekly follow-up visits, and care plans that directly address the unique individual aspects of their tendency to commit suicide.

We continue to spread the word throughout VA that "suicide prevention is everyone's business." This is part of VA's embracing the Zero Suicide concept through newly engineered application of best practices gleaned from our own experience and from leading programs around the world. These include development of a leadership culture which drives organizational understanding that suicide is a preventable cause of death, which is VA's highest clinical priority; engagement of all VA staff and leaders, building new community partnerships, fielding high quality mental health treatment; and promoting universal education about safety related to lethal means, and robust research and data science on Veteran suicide. Although we understand why some Veterans may be at increased risk, we continue to investigate and take proactive steps.

As part of this commitment, VA has fielded the groundbreaking Recovery Engagement and Coordination for Health Veterans Enhanced Treatment (REACH VET) program. REACH VET launched in November 2016 and was fully implemented in February 2017. It uses a new predictive model to analyze existing data from millions of Veterans' health records to identify those who are at a statistically elevated risk for suicide, hospitalization, illnesses, and other adverse outcomes. Not all Veterans identified have experienced suicidal ideation or behavior; however all have certain risk factors. REACH VET allows VA to provide support and pre-emptive enhanced care to those at greatest risk in order to lessen that risk before challenges become crises.

Once a Veteran is identified, his or her mental health or primary care provider reviews the treatment plan and current condition(s) to determine if enhanced care options are indicated. The provider then reaches out to check on the Veteran's well-

being and inform him or her that he/she has been identified as someone who may benefit from enhanced care. This allows the Veteran to participate in a collaborative discussion about their health care, including specific clinical interventions which can help reduce suicide risk.

Since 2007, the Veterans Crisis Line (VCL) has answered nearly 2.9 million calls and dispatched emergency services to callers in crisis over 77,000 times. The VCL implemented a series of initiatives to provide the best customer service for every caller, making notable advances to improve access and the quality of crisis care available to our Veterans, such as:

- Launching “Veterans Chat” in 2009, an online, one-to-one chat service for Veterans who prefer reaching out for assistance using the Internet. Since its inception, we have answered nearly 344,000 requests for chat;
- Expanding modalities to our Veteran population by adding text services in November 2011, resulting in over 71,000 requests for text service;
- Opening a second VCL site in Atlanta in October 2016, with over 200 crisis responders and support staff; and
- Implementing a comprehensive workforce management system and optimizing staffing patterns to provide callers with immediate service and achieving zero percent routine rollover to contracted back-up centers.

VCL is the strongest it has ever been since its inception in 2007. VCL staff has forwarded over 473,000 referrals to local Suicide Prevention Coordinators on behalf of Veterans to ensure continuity of care with their local VA providers. Today, the facilities in Canandaigua and Atlanta employ more than 500 professionals, and VA is hiring more to handle the growing volume of calls. Atlanta offers 258 call responders and 23 social service assistants and support staff, while Canandaigua houses 254 and 37, respectively. In fact, 99 percent of all calls to the VCL are answered by VA VCL staff. Despite all this, there still is more that we can do.

From October 1, 2015 through March 31, 2016, VA Office of Inspector General conducted an evaluation of suicide prevention programs at 28 VHA facilities during Combined Assessment Program (CAP) reviews. The purpose of the review was to evaluate facility compliance with selected VHA guidelines.

In the report published on May 18, 2017, OIG included six recommendations to VHA, citing inadequate oversight and accountability, and inadequate training for VHA staff. Action plans have been developed to address the recommendations, with target date for completion of all actions by September 2017. The OIG recommended that:

1. Suicide Prevention Coordinators provide at least five outreach activities per month.
2. Clinicians complete Suicide Prevention Safety Plans for all high-risk patients, include in the plans the contact numbers of family or friends for support, and give the patient and/or caregiver a copy of the plan.
3. When clinicians, in consultation with Suicide Prevention Coordinators, identify high-risk inpatients, they place Patient Record Flags in the patients’ electronic health records and notify the Suicide Prevention Coordinator of each patient’s admission.
4. A Suicide Prevention Coordinator or mental health provider evaluates all high-risk inpatients at least four times during the first 30 days after discharge.
5. When clinicians identify outpatients as high risk, they review the Patient Record Flags every 90 days and document the review and their justification for continuing or discontinuing the flags.
6. Clinicians complete suicide risk management training within 90 days of hire.

America’s Veterans are at higher overall risk for suicide than the general public, and Veterans with conditions like depression, PTSD, insomnia and chronic pain are particularly at risk. The Department of Veterans Affairs (VA) is strongly committed to ensuring Veterans in crisis get immediate in-person care if needed, and developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of VA’s healthcare system.

Update on Clay Hunt Suicide Prevention for American Veterans Act

Since its enactment in 2015, VA has been aggressively implementing the Clay Hunt Suicide Prevention for American Veterans Act, as amended, participating in a third party evaluation of mental health programs, developing a publicly available resource tool, and fostering an abundance of public and private partnerships, all in support of VA’s goal to eliminate Veteran suicide.

VA has also contracted with an independent evaluator to conduct an evaluation of the VA mental health and suicide prevention programs to determine the effectiveness, cost effectiveness and Veteran satisfaction with VA mental health and suicide prevention programs. An interim report was dispatched to Congress last year and a second interim report is due in September of this year. The first annual report with findings from the independent evaluation will be delivered to Congress in December 2017. It is our plan to use the results of this evaluation to improve the mental health care and services that VA provides to Veterans.

In addition, VA has developed a VA Resource Locator tool that includes information regarding PTSD, Substance Use Disorder, and Vet Center programs, as well as contact and resource information. This tool is accessible at www.vets.gov and on the Make the Connection website mentioned above. The Vets.gov Facility Locator will continue to be enhanced throughout 2017.

VA is also making strides in implementing the pilot program to repay psychiatrist student loans as a recruitment incentive, as required by Section 4 of the Clay Hunt Act. VA published regulations for this pilot program in the first quarter of 2017, 81 Fed. Reg. 66815. VHA is currently finalizing the advertisement, application policy, and procedures. The Clay Hunt Act prohibited additional appropriations for its implementation, so VA is working to identify sources of funding for this initiative.

In addition to the Peer Specialists mentioned above, VA has set up community peer support networks in five Veterans Integrated Service Networks where there are large numbers of Servicemembers transitioning to Veteran status. Since January 2016, networks have been developed in Virginia, Arkansas, Texas, Arizona, and California. Outreach teams of Peer Specialists and their supervisors have formed coalitions with Veterans Service Organizations, employers, educational institutions, community mental health providers, military installations, and existing VA and DoD transition teams to connect Veterans in the community with mental health assistance when necessary. This has included providing community partners with training on Veteran and military culture, and peer support skills and interventions, as well as invitations to annual mental health summits.

VA is working with and/or building new partnerships with more than 150 non-federal mental health organizations around suicide prevention, to include collaboration with the George W. Bush Institute to host 10 executives from the pharmaceutical industry to discuss the invisible wounds of war and suicide prevention collaborations. Areas for collaboration include patient and provider marketing of educational materials and research. For example, VA has partnered with Psych Armor, a non-profit devoted to free, online training for non-VA providers to better serve Veterans. Psych Armor uses VA expertise to help inform its course content, which is geared towards healthcare providers, employers, caregivers and families, volunteers, and educators. These types of partnerships are a powerful strategy to increase outreach to vulnerable Veterans.

Expanding Mental Health Services

VA is determined to address systemic problems with access to care in general and to mental health care in particular. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increased staff in mental health services. Between 2005 and 2016, the number of Veterans who received mental health care from VA grew by more than 80 percent. This rate of increase is more than three times that seen in the overall number of VA users. This reflects VA's concerted efforts to engage Veterans who are new to our system and stimulate better access to mental health services for Veterans within our system. In addition, this reflects VA's efforts to eliminate barriers to receiving mental health care, including reducing the stigma associated with receiving mental health care. VA is committed to working with public and private partners across the country to support full hiring to ensure that no matter where a Veteran lives, he or she can access quality, timely mental health care. For example, multiple professional organizations, including the American Psychiatric Association and American Psychological Association, have offered support in getting announcements to their members about career opportunities in VA.

Making it easier for Veterans to receive care from mental health providers has allowed more Veterans to receive care. VA is leveraging telemental health care by establishing four regional telemental health hubs across the VA health care system. VA telemental health innovations provided more than 427,000 encounters to over 133,500 Veterans in 2016. Telemental health reaches Veterans where and when they are best served. VA is a leader across the United States and internationally in these efforts. VA's Make the Connection campaign (www.maketheconnection.net), Suicide Prevention outreach campaigns, and mobile apps contribute to increasing mental health access and utilization. VA has also created a suite of award-winning

tools that can be utilized as self-help resources or as an adjunct to active mental health services.

Additionally, in 2007, VA began national implementation of integrated mental health services in primary care clinics. Primary Care-Mental Health Integration (PC-MHI) services include co-located collaborative functions and evidence-based care management, as well as a telephone-based modality of care. By co-locating mental health providers within primary care clinics, VA is able to introduce Veterans on the same day to their primary care team and a mental health provider in the clinic, thereby reducing wait times and no-show rates for mental health services. Additionally, integration of mental health providers within primary care has been shown to improve the identification of mental health disorders and increase the rates of treatment. Several studies of the program have also shown that treatment within PC-MHI increases the likelihood of attending future mental health appointments and engaging in specialty mental health treatment. Finally, the integration of primary care and mental health has shown consistent improvement of quality of care and outcomes, including patient satisfaction. The PC-MHI program continues to expand, and through January 2017, VA has provided over 6.8 million PC-MHI clinic encounters, serving over 1.5 million individuals since October 1, 2007.

Peer Support Is Integral to VA Mental Health Care

The introduction of Peer Specialists to the mental health workforce provides unique opportunities for engaging Veterans in care. As of April 2016, there were almost 1,100 peers providing services at VAMCs and CBOCs. Peer support programming has been implemented at every VAMC and very large CBOCs since 2013. Peers provide services in many mental health programs and some primary care clinics. Certified peer specialists are Veterans in recovery from mental health conditions, employed by VA to provide support and advocacy for Veterans coming to the VA for treatment of mental health conditions, including PTSD. Crisis intervention and suicide prevention are skills that peer specialists apply from the moment they first meet Veterans coming in for treatment and throughout their treatment cycles. Having Veterans who have recovered from mental health conditions, including many who have also survived suicidal ideation or attempts themselves, demonstrates to Veterans that there is hope for recovery and a quality life after treatment.

Vet Centers

Vet Centers (www.vetcenter.va.gov) provide free readjustment services for Veterans who served in combat. Vet Centers are community-based counseling centers within VHA's Readjustment Counseling Service (RCS). They provide a wide range of social and psychological services, including professional readjustment counseling, to Veterans and active duty Servicemembers. This includes individual and group counseling, family and bereavement counseling, and more.

There are 300 community-based Vet Centers and 80 mobile Vet Centers located across the 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands. In FY2015, Vet Centers provided more than 228,000 Veterans, Servicemembers, and their families with over 1,664,000 visits. When determined to be necessary to facilitate the successful readjustment of Veterans to civilian life, Vet Centers refer them, within the limits of Department facilities, to receive needed VA outpatient mental health care.

Other than Honorable Servicemembers

Driven by the need to reduce the number of suicides and treat mental illnesses in at-risk populations, VA will expand provisions for urgent mental health care needs to former Servicemembers with other-than-honorable (OTH) administrative discharges by using existing legal authorities to expand the provision of emergent mental health services.

This initiative is specifically focused on expanding access to assist former OTH Servicemembers who are in mental health distress and may be at risk for suicide or other adverse behaviors. This is for emergent mental health services only. Individuals seeking mental health care in emergency circumstances may enter the system to use this benefit by calling the Veteran Crisis Line or visiting the VA Emergency Department, Urgent Care Center, or Vet Center. Those who assert that their condition is related to military service would be eligible for evaluation and treatment for their mental health condition.

Eligible individuals may receive follow-up outpatient, residential and inpatient mental health and substance use disorder services for up to 90 days, with social work engagement and non-VA covered community transition to longer term care and appropriate transition of medical needs. Services may also include: medical assessments, medication management, therapy, lab work, case management, psycho-

education, and psychotherapy. We may also provide services via telehealth. It is important to note, VA does not have the legal authority to utilize Community Care at VA's expense to provide care to former Servicemembers with OTH discharges.

This is a national emergency that requires bold action. It is estimated that there are approximately 500,000 former Servicemembers with OTH discharges who could need mental health care in the future. We know the rate of death by suicide among Veterans who do not use VA care is increasing at a greater rate than Veterans who use VA care. We must and we will do all that we can to help former Servicemembers who may be at risk. When we say even one Veteran suicide is one too many, we mean it.

Conclusion

Our work to effectively treat Veterans who desire or need mental health care, including care for PTSD, continues to be a top priority. We remain focused on providing the highest quality care our Veterans have earned and deserve and which our Nation trusts us to provide. We emphasize that we are committed to preventing Veteran suicide, aware that prevention requires our system-wide support and intervention in preventing its precursors. We appreciate the support of Congress and look forward to responding to any questions you may have.

Statements For The Record

OUTWARD BOUND VETERNAS

The challenges facing today's veterans are well documented and alarming. Nearly 57% of veterans enrolled in Veteran Affairs (VA) services who deployed after September 11, 2001 have been diagnosed with a mental health disorder. (Epidemiology Program, Post Deployment Health Group, Office of Public Health, Veterans Health Administration, & Department of Veterans Affairs, 2015)

As Chairman Roe noted in his opening remarks "Since 2010, the number of veterans receiving care for PTSD from the VA healthcare system has grown by more than 50 percent and despite historic and ever-increasing investments in VA mental health services and supports since the turn of the century, suicide rates among veterans with PTSD are not declining."

Furthermore, veterans' underutilization of (Hundt et al. 2014) and stigma towards traditional mental health interventions (Burman, Merideth, Tanielian & Jaycox, 2009; Vogt, Fox, & Di Leone, 2014) exacerbate veterans' mental health needs.

Given the complexity of the challenges facing this generation of veterans, and their reluctance to engage in traditional forms of mental health treatment it is critical that our nation explore therapeutic alternatives that do not carry the same perceived stigma to help veterans successfully navigate the transition to civilian lives.

One complementary approach that has shown promise in preliminary studies is Outward Bound Veterans. (OBV)

Outward Bound

At Outward Bound we utilize some of our nation's most inspiring wilderness locations as classrooms to provide unparalleled opportunities for a variety of populations to experience self-discovery, personal growth, self-reliance, teamwork, and compassion. Outward Bound methodology is driven by the fundamental belief that physically and mentally challenging experiences, when facilitated by trained outdoor professionals, can help participants discover their strength of character, ability to lead, and foster a desire to serve in their homes, communities, and our nation.

Outward Bound Veterans

OBV is a primary program of Outward Bound. Originally established in 1983, OBV has helped thousands of veterans and active duty service members readjust to life at home through 6-7 day expeditions that capitalize on the healing power of teamwork and challenge through use of the natural world at no cost to the veteran participants. Curriculum is built on the foundation of Outward Bound methodology, but has been custom-designed to support veteran transitions. Program design and delivery is driven by the belief that veterans possess a wealth of highly-valued skills as a result of their service, and that while the transition to civilian lives is challenging for many veterans they are not defined by those challenges. These transformative programs intend to reconnect veterans to those skills and the strength associated with military service in a civilian context, while simultaneously addressing the challenges veterans face transitioning to civilian lives.

On expeditions, wilderness activities are used as metaphors for daily life experiences in the pursuit of individual and group excellence, illuminating how the support and collaboration needed to meet goals can positively impact participants' interactions with others at home. Whether whitewater rafting, backcountry mountaineering, kayaking, or sailing, expeditions center on teamwork and challenge. Instructors present sequential activities that gradually increase in both physical and emotional challenge while transferring leadership over to the veteran participants. They emphasize camaraderie and shared life experiences through facilitated conversations about challenges veterans face transitioning to civilian life. Outward Bound Veterans expeditions provide the sense of purpose, trust in one another, and physical challenge that our service men and women experienced in the military. As they work as a group to overcome shared obstacles and achieve shared goals in a non-combat wilderness setting, many veteran participants say they feel more "at home" than they have in all their time back on U.S. soil.

Documented Outcomes

As an organization serving veterans, OBV is committed to the principles of evidence-based intervention for veteran participants. To better understand the psychosocial outcomes of OBV's

work we contracted with the University of Texas to examine the efficacy of our programs for veteran participants. Utilizing both quantitative and qualitative data analysis this study highlights

promising outcomes across a variety of variables. Highlights of the outcomes include: (Full study available on request)

- A clinically significant improvement in overall mental health
- Significant improvements in symptoms of depression and anxiety
- A decrease in sense of loneliness, and an increase of a sense of social connection
- Significant improvements in veterans' attitudes towards seeking psychological help, an increase in interest in gaining insight about themselves, and an increase in confidence to utilize resources available to them

These outcomes are significant considering the increasing rates of mental health issues among Veterans, particularly issues related to reintegration adjustment, depression, and anxiety/post-traumatic stress. Interpersonal factors, such as loneliness and sense of social connection, and mental health factors, such as depression and post-traumatic stress, are considered critical predictive factors of suicidal ideation.

We are incredibly grateful for the leadership shown, and the work being done by the House Committee on Veterans Affairs to explore alternative and complimentary approaches to veterans' transitions and mental health. We are honored to have the opportunity to contribute to the work of the committee by submitting this written testimony, and would be humbled by the opportunity to participate in future hearings or further discussions regarding complimentary approaches to veterans.

THE AMERICAN LEGION

Introduction

The United States military fosters a mission-first culture that prioritizes selflessness and teamwork, where most servicemembers feel a sense of higher purpose in the defense of our Constitution and the people of the United States of America. When active duty members transition from this environment of camaraderie to the civilian world, many feel confused, isolated, and misunderstood. Today, around eight percent¹ of the U.S. population has served, and while the public generally holds the military in high regard, many do not understand its culture or the values of the people who serve. With less than one-half of one percent of the American population currently serving on active duty, a shrinking minority of citizens shoulder the physical and psychological burdens of war. To visualize the cost of 16 years of continuous combat, it is important to recall that nearly 60,000 servicemembers have been killed or wounded in action since September 11, 2001 - enough people to fill Chicago's Soldier Field to capacity. A new generation of America's best young men and women now carry these scars and memories of war.

Chairman Roe, Ranking Member Walz, distinguished members of the House Veterans' Affairs Committee; The American Legion works every day to ensure our 2.2

¹Pew Research Center. "Profile of U.S. veterans is changing dramatically as their ranks decline." 2016.

million members, and veterans everywhere, receive the expert care they have earned while serving in defense of this nation. We appreciate the opportunity to share our research and offer this testimony for the record before this committee.

After a decade and a half of conflict around the globe, post-traumatic stress disorder (PTSD) along with traumatic brain injury (TBI) are now recognized as the “signature wounds” of this war. The latest studies estimate that anywhere between 11 and 20 percent of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans are experiencing or have experienced PTSD. By comparison, Gulf War veterans experienced PTSD at a 12 percent rate and Vietnam veterans around 30 percent². This variance can be explained by comorbidities, or symptoms belonging to multiple diagnoses, which are a frequent barrier to accurate assessment and diagnosis³. PTSD is a clear and present threat to our nation’s veterans. For many, the war continues well after they return to American soil and attempt to reintegrate into civilian life.

American Legion Leadership and Activism

In 2010, The American Legion commissioned a TBI and PTSD Ad Hoc Committee to “investigate the existing science and procedures, and to study alternative methods for treating TBI and PTSD.”⁴ The American Legion’s PTSD/TBI Ad Hoc Committee has carefully and compassionately studied these conditions and the way in which our government is responding to them. During the three-year study, the Committee held meetings and met with leading authorities in the Department of Defense (DoD) and the Department of Veterans Affairs (VA) while simultaneously interviewing veterans within our organization. In 2013, the Committee published the first iteration of “The War Within”⁵, which identified obstacles to care, and made recommendations to improve mental health services at VA for PTSD. We concluded there was an urgent need to pursue research and urged the VA to use complementary and alternative medicines (CAM), such as hyperbaric oxygen chambers, animal-assisted intervention, and more. The Committee determined that CAM treatments could assist in reducing substance abuse and death resulting from opioid overuse for pain management and PTSD symptoms.

Following the publication of *The War Within*, the TBI/PTSD Committee launched a 30-day web survey with more than three-thousand veterans - approximately 10 percent female and 90 percent male - opting in. The Committee presented the findings at a two-day “Advancing the Care and Treatment of Veterans with TBI and PTSD” symposium in Washington, D.C. Subject matter experts from VA, DoD, relevant nonprofits, and the private sector discussed gaps in care, proposed best practices, and advocated for innovative treatments.

The TBI/PTSD Committee continues to expand its expertise and influence in the veteran mental health community through its work in evaluating diagnostic procedures, treatments, and prevention efforts. For the past seven years, our “System Worth Saving” (SWS) site-visits have collected data on the preparedness of VA facilities to handle mental health issues, and the Committee has published a series of resolutions in support of veterans struggling with PTSD. These resolutions included the establishment of a Suicide Prevention Program as well as support for a number of diverse programs that have helped a great number of veterans we have worked with.

The American Legion’s TBI/PTSD Committee has advocated for a peer-to-peer and more holistic approach in treatment of PTSD. In 2016 The American Legion Departments of Alabama and Michigan held Veteran Retreats, taking over 60 veterans currently utilizing VA facilities, and showcasing a variety of CAM treatments and peer-to-peer activities and therapy.

A Navy veteran who receives care at the Birmingham VA Medical Center for PTSD told us “Here I am sharing things with people who know what I am talking about. In civilian life, they want to say, ‘I know how you feel.’ But they really don’t. Here, they know how you feel. It’s been fabulous.”

Another attendee amplified this sentiment saying, “I suffer from PTSD. This camp has done more for me than any counseling or medication.”

The VA has recently taken several positive steps to care for veterans struggling with mental health issues. VA Secretary Dr. David Shulkin has named veteran suicide his highest clinical priority, launched the Center for Compassionate Innovation, and expanded access to mental health services for veterans with other-than-honorable (OTH) discharges; many of whom were wrongfully separated administratively

²U.S. Department of Veterans Affairs. “How common is PTSD?” 2015.

³U.S. Department of Veterans Affairs. “How common is PTSD?” 2015.

⁴Resolution #9 - Appointment of PTSD/TBI Committee

⁵The American Legion. “The War Within.” TBI/PTSD Committee Publication, 2014.

due to mental health issues⁶. The American Legion applauds these efforts and looks forward to working with this committee and the administration to improve treatment options even further, and we call on VA to maintain their commitment to exploring more CAM treatments for PTSD through the newly created Center for Compassionate Innovation.

In 2011, Marine veteran Clay Hunt committed suicide. Before taking his life, Hunt was actively seeking to help other veterans with their mental health issues but often remarked to a friend that, “[PTSD] is like a bad movie on rewind. It plays, it rewinds, plays, rewinds”. Hunt had complained of extremely long wait times for mental health counseling appointments at VA⁷, and in an attempt to immortalize his struggle, Congress passed the Clay Hunt Suicide Prevention Act in 2015, which took good steps to increase access to mental health care by creating peer support and community outreach pilot programs to assist transitioning servicemembers, as well as a one-stop, interactive website of available resources⁸. But VA’s most comprehensive suicide prevention report to date, published in 2016 concluded that 20 veterans a day are still committing suicide⁹. According to the report, the majority of suicides are committed by Vietnam veterans, and that OIF/OEF veterans commit suicide at a higher rate than their non-veteran peers. The report also found that 14 out of the 20 suicides that end veterans’ lives every day do not receive treatment at VA healthcare facilities. In an attempt to increase awareness of resources and connect with the 70 percent of veterans at risk of suicide, the report states:

Veterans’ Health Administration requires that facilities complete five outreach activities each month for community organizations, [mental health] groups, and/or other community advocacy groups. Outreach activities have direct effects on suicide hotline call volume and VHA’s ability to get help to veterans in need.” Reasons SPCs (suicide Prevention Coordinator) gave VAOIG for not providing outreach activities included lack of leadership approval or support to attend events or activities.”

The report explains further that employee training for primary care and mental health providers on suicide risk assessments were mandated to occur by VHA during orientation, and that clinicians complete a separate risk management training within 90 days of hire, however:

“45.7 percent of the time clinicians did not complete suicide risk management training within 90 days of hire. Reasons clinical managers gave VAOIG for not training clinicians included lack of allocated time to complete training, lack of leadership support, and not understanding that it was required.”¹⁰

Clinical and administrative leadership must improve cooperation, and the VA Central Office leadership must implement the IG’s incomplete recommendations for improvement to seize these opportunities. VHA will continue to have challenges in their essential mission of providing mental health resource access to veteran populations living in rural areas, or those who feel a strong stigma asking for help through in-person resources.

An American Legion survey of over 3,000 veterans found that 14 percent were prescribed 10 or more medications for PTSD symptoms. 52 percent of all respondents reported no change or worsening symptoms after medication by a mental health professional, and 30 percent terminated treatment before completion. Reasons for termination consisted mainly of two categories: “Stigma/Solve By Myself” comprised 25 percent of early treatment termination and “Side Effect/Lack of Improvement” comprised 44 percent¹¹. These concerns mirror the most frequently cited barriers to good care for PTSD in the general veteran¹² population¹³.

The Path Forward: Suggestions in Wellness and Healing for Veterans with PTSD

Leadership Sense of Urgency, Outreach, and Accountability

The American Legion applauds the passage of H.R. 1259, “VA Accountability First Act of 2017”, and thanks Chairman Roe for his leadership on this issue. The recent VAOIG report indicating negligence at VA facilities in mental health training and

⁶ GAO Report. “Actions Needed to Ensure Post-Traumatic Stress Disorder and Traumatic Brain Injury Are Considered in Misconduct Separations.” 05/17.

⁷ The American Legion. “The War Within.” 2014.

⁸ The Clay Hunt Suicide Prevention Act of 2015.

⁹ VA Report, “Suicide Among Veterans and other Americans 2001–2014.” 2016.

¹⁰ VAOIG. “Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities” May 2017

¹¹ Survey. “The American Legion Survey of Patient Healthcare Experiences.” 2014.

¹² Corrigan P. “How stigma interferes with mental health care.” 2004.

¹³ Institute of Medicine Report. “Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families.” 2013.

outreach are a perfect example of why the Secretary needs authority to hold employees accountable. The American Legion and its TBI/PTSD Committee applauds Secretary Shulkin for his focus on PTSD and encourages him to ensure all VA facilities promote a greater sense of urgency in outreach.

Public-private partnerships (PPPs) and more aggressive engagement are crucial in expanding access to high-quality mental health services for veterans who may not qualify or do not wish to use VA or DoD medical care for PTSD treatment. VA must ensure partnered organizations provide military cultural training to their counselors.

The American Legion recommends VA medical facility leaders and suicide prevention coordinators research grassroots resources for veterans who desire a sense of camaraderie or community outside of VA care. The VA should then provide a list of these resources to primary care physicians, mental health providers, and veteran patients¹⁴. VA leadership should also ensure full compliance in suicide risk management training and suicide prevention outreach activities.

Complementary and Alternative Medicines

Cannabis

After 16 years of war in Afghanistan and Iraq, many Americans view post-traumatic stress disorder, or PTSD, and traumatic brain injury, or TBI, as the “signature” wounds of these conflicts. The Department of Veterans Affairs has spent billions of dollars to better understand the symptoms, effects, and treatments for these injuries. But despite advances in diagnostics and interventions in a complex constellation of physical, emotional, behavioral and cognitive defects, TBI and PTSD remain leading causes of death and disability within the veteran community.

There is something else the U.S. can do for suffering veterans: research medical marijuana.

Many Afghanistan and Iraq veterans have contacted The American Legion to relay their personal stories about the efficacy of cannabis in significantly improving their quality of life by enabling sleep, decreasing the prevalence of night terrors, mitigating hyper-alertness, reducing chronic pain, and more. This is why the 2.2 million members of the American Legion are calling on the Trump administration to instruct the Drug Enforcement Agency to change how it classifies cannabis, release the monopoly on cultivation for research purposes, and immediately allow highly regulated privately-funded medical marijuana production operations in the United States to enable safe and efficient cannabis drug development research.

The opioid epidemic that continues to grip veterans is yet another reason to ease the federal government’s outdated attitude toward America’s marijuana supply. The Trump administration should lead a new effort to combat opioid abuse, and it should include the elimination of barriers to medical research on cannabis. The result, potentially, could provide a non-addictive solution to the most common debilitating conditions our veterans- and others in society- face, including chronic pain, PTSD, and TBI.

The American Legion is asking Congress to amend legislation to remove marijuana from Schedule I and reclassify it in a category that, at a minimum, will recognize cannabis as a drug with potential medical value.

A recent comprehensive study by the Committee on the Health Effects of Marijuana at the National Academies of Sciences, Engineering and Medicine found that there is, “conclusive or substantial evidence that cannabis or cannabinoids are effective for the treatment” of chronic pain, reducing nausea and vomiting during chemotherapy, and lowering spasticity in multiple sclerosis sufferers, that there is “moderate evidence” that cannabis is effective in treating sleep apnea, fibromyalgia, and chronic pain, and “limited evidence” that cannabis improves symptoms of posttraumatic stress disorder and creates better outcomes after traumatic brain injury.

We need to know more. With 20 veterans committing suicide every day, we cannot afford to delay research into this promising potential solution.

Service Dogs

In 2009, Congress mandated in the National Defense Authorization Act that the VA study whether service dogs have therapeutic benefits, reduce the cost of hospital stays, or help prevent suicides.

Unfortunately, eight years later, the study has not been completed. Other recently published studies show service dog assisted interventions, “may provide unique ele-

¹⁴American Legion Resolution No. 160, “Complementary and Alternative Medicine.” Sept. 1, 2016.

ments to address several PTSD symptoms,”¹⁵ and the National Center for Complementary and Integrative Health recently authorized funding for a practical trial with service dogs. On March 7, 2017, Secretary Shulkin testified at a Congressional hearing on the use of service dogs for veterans with PTSD or psychological disorders, stating, “[I] think it’s common sense that service dogs help. We hear it every day from veterans. I’m not willing to wait [on congressional authority to implement what I can through my existing authority] because there are people out there today suffering.” The American Legion calls on Congress to pass responsible legislation providing service dogs to veterans with PTSD and to clearly define regulations for certification of service dogs for mental health and mobility issues.¹⁶

Reducing Stigma and Prescription Drug Abuse

The American Legion applauds this Committee, Congress, VA, DoD, the National Center for PTSD, and many of the VA Medical Centers for their efforts to reduce the stigma of asking for mental health treatment. Public awareness campaigns like PTSD Awareness Month, “Make The Connection,” and “Use Your Voice” save lives. The PTSD Treatment Decision Aid and Veterans’ Crisis Line increase access and greatly reduce the stigma of asking for help by enabling veterans to seek treatment anonymously.

Improve Services for Female Veterans

Women comprise 11 percent of the veteran population and are the fastest-growing demographic in the military.¹⁷

More than 20 percent of female veterans report disproportionately higher rates of military sexual trauma (MST) when compared to their male peers¹⁸, and women have unique challenges when seeking treatment for PTSD¹⁹.

Recent studies show that both sexes who report MST demonstrate an increased risk of PTSD and suicide, and MST remains an independent risk factor even after adjusting for mental health conditions, demographics, and medical ²⁰conditions.²¹

The American Legion calls on VBA to provide sensitivity training to claims processors, analyze MST claim volume, assess adjudication consistency, and determine the need for training and testing on processing these claims,²² and finally The American Legion urges the VA to work with DoD and the Department of Labor (DoL) to create a customized healthcare track for the Transition Goals, Plans and Success program facilitated by female clinicians.²³

Conclusion

The Department of Veterans Affairs has made real progress in mental health awareness, outreach, and treatment through telehealth, digital media, and in-person care, but there is much work yet to be done. The last 16 years of continuous war has taken its toll on our active-duty and veteran communities. With 20 veterans committing suicide every day, all of us need to act quickly to mitigate the impact of PTSD, provide veterans the best possible care, and aggressively pursue all therapies that show promise in improving the lives of those who have given so much in the defense of our Nation.

To adequately care for those who have “borne the battle,” the VA must reinvigorate a sense of urgency within leaders at the facility level to include more holistic CAM treatments for PTSD, aggressively reach out to grassroots peer-to-peer organizations, and create new PPPs in expanding culturally competent access to care.

Together, we can help veterans suffering from PTSD (and comorbid psychological conditions) mitigate their symptoms, and work toward helping them regain their sense of community and identity.

The American Legion thanks this committee for its leadership and looks forward to working together to improve the lives of America’s veterans.

¹⁵Habri. “Animal assisted intervention for PTSD: A systematic Review.” 2016

¹⁶American Legion Resolution No. 134, “Service Dogs for Injured Service Personnel and Veterans with Mental Health Conditions,” Sept. 1, 2016.

¹⁷Rachel Kimerling, Kerry Makin-Byrd, et al. “Military Sexual Trauma and Suicide Mortality.” 2016.

¹⁸Alina Suris and Lisa Lind. “Military Sexual Trauma: A Review of Prevalence and Associated Health Consequences in Veterans.” 2008.

¹⁹American Legion Resolution No. 147, “Women Veterans.” Sept. 1, 2016.

²⁰Yaeger, Cammack. “Diagnosed PTSD in women veterans with and without MST.” 2006

²¹Cohen. “Gender differences in MST and mental health diagnosis among Iraq and Afghanistan veterans.” 2012

²²American Legion Resolution No. 67, “Military Sexual Trauma.” Aug. 28, 2014.

²³American Legion Resolution No. 37, “Improvements to VA Women Veterans Programs”. Sept. 1, 2016.

For additional information regarding this testimony, please contact Mr. Derek Fronabarger, Deputy Director of The American Legion Legislative Division, at (202) 861-2700 or dfronabarger@legion.org.

COALITION TO HEAL INVISIBLE WOUNDS

ROGER MURRY, EXECUTIVE DIRECTOR

Chairman Roe, Ranking Member Walz and members of the Committee,
On behalf of the Coalition to Heal Invisible Wounds, thank you for this opportunity to provide written testimony on the effectiveness of care for post-traumatic stress disorder (PTSD) within the current system of health care services and benefits of the Department of Veterans' Affairs (VA).

In this testimony, we introduce the Coalition and its objectives and outline initial steps at the VA to begin addressing these objectives through, in the words of VA, "radically collaborative science."

I. Introduction

The Coalition to Heal Invisible Wounds was founded in February 2017 to connect leading public and private scientific investigators of new PTSD and traumatic brain injury (TBI) treatments with policymakers working to improve care for Veterans.¹ Coalition members support innovators at all stages of the therapy development life-cycle, from initial research to late-stage clinical trials. The Coalition aims to spur strategic federal institution support to create better treatment and care for veterans suffering from PTSD and TBI. The Coalition seeks to work with the VA and the Department of Defense (DOD) on immediate improvements to public-private partnerships for:

- Developing and validating PTSD and TBI biomarkers and diagnostics;
- Providing research access to PTSD and TBI datasets;
- Providing institution-wide support for PTSD clinical trials;
- Improving messaging of relevant policies and practice guidelines; and,
- Providing up-to-date education around clinical trial endpoints and drug therapy options.

The Coalition also seeks renewed investment in VA-funded PTSD research and an expansion in the types of research supported. Through strategic collaboration between the public and private sectors, the Coalition believes that our nation can improve treatment of Servicemembers and Veterans suffering from PTSD.

II. Institutional Hurdles to Next Generation Research Partnerships

Private researchers in both the non-profit and for-profit sectors seek to partner with the VA to leverage extensive VA resources to unlock new medical therapies, but they have faced major institutional barriers. Examples of these barriers include the following:

1. The VA has world-class PTSD datasets and biological samples. However, while the VA has a two-year old policy encouraging public-private partnerships, VA sites often are not aware of it and the VA, in general, does not share biological samples, such as blood draws, with external researchers. When undertaking analyses itself, it can take the VA more than six months to process just small batches of samples, which are analyzed with older technology and assays preventing the combined analysis of all data and severely limiting cooperation with other organizations. Recently, several VA researchers were enthusiastic partners in a global PTSD research initiative. Despite their best efforts, the need to execute multiple agreements and then have the VA samples run on different platforms from the rest of the consortium and then analyzed by separate statisticians ultimately led to significant delays in results and higher costs.

2. The VA has an extensive patient population and facility network, but it provides little support for non-VA clinical trials. One recent multi-center Phase II clinical trial in Veterans for a potential PTSD medication sought to recruit participants from three VA facilities. While the non-VA sites participated on schedule, the VA facilities were slow to secure the necessary approvals. One received approval at the

¹The Coalition's members are Cohen Veterans Bioscience (co-chair), Otsuka America Pharmaceutical Inc. (co-chair), and Tonix Pharmaceuticals. The Coalition was founded as the Veteran's Post-Traumatic Science and Policy Coalition.

very end of the study, which was too late for meaningful participation, and another failed to obtain approval entirely.

3. The VA creates unnecessary hurdles to providers of external funding. The VA requires external entities seeking to support multi-site VA research to do so through a network of non-profit centers, each affiliated with an individual VA facility. Each center has different contracting procedures and personnel, and requires the funder to sign different contracts. While the VA has a central ethics review committee (IRB) that enables more efficient and consistent start-up VA clinical trials, this central IRB is not able to serve as the ethical reviewer for VA sites participating in clinical trials sponsored by other entities. These serve as significant disincentives, as they add costs and major delays.

III. Understanding the National Mental Health Crisis

Too many of our nation's Servicemembers and Veterans suffer and have suffered from PTSD and the lasting effects of TBI. The prevalence of PTSD ranges from about ten percent of Gulf War Veterans, up to 20 percent of those who have served in Operations Iraqi Freedom and Enduring Freedom, and as high as 30 percent of Vietnam Veterans. A staggering 20 Veterans commit suicide per day, more than 7,400 in 2014. Since 2011, there have been more deaths each year than the total number of combat casualties of the Iraq and Afghanistan wars. One in ten VA health care users have been diagnosed with PTSD, which includes one in four treatment-seeking veterans of the recent wars in Iraq and Afghanistan, according to the VA Working Group described below. Of those, too few receive effective care.

In June 2016, the VA commissioned an internal PTSD Psychopharmacology Working Group to review "the status of the current pharmacotherapy options and drug development." Through the Working Group, the VA sought to define a central component of the problem, the "critical lack of advancement in the psychopharmacologic treatment of PTSD." In March 2017, the Working Group concluded that "The urgent need to find effective pharmacologic treatments for PTSD should be considered a national mental health priority," as published in the *Journal of Biological Psychiatry*.²

Both the pharmacy shelves and pipeline for research and development of PTSD treatments are thin. Despite the "high prevalence and costly impact" of PTSD in military personnel and Veterans, "most patients are treated with medications or combinations for which there is little empirical guidance regarding benefits and risks," and there is "no visible horizon for advancements in medications that treat symptoms or enhance outcomes in persons with a diagnosis of PTSD."

This hearing provides the Committee an important opportunity to understand how the Working Group reached these conclusions and to identify options for addressing these critical challenges.

First, there is a crisis of efficacy in PTSD treatment. Drug therapies are frequently a component of PTSD treatment- in Fiscal Year 2015 "70% of VA patients with a diagnosis of PTSD were prescribed an antidepressant"-but evidence suggests that "available medications are often ineffective in usual clinical practice."

The Working Group found that "most patients are treated with medications or combinations for which there is little empirical guidance regarding benefits and risks." For example, sertraline, an antidepressant and one of only two drugs approved by FDA to treat PTSD, was prescribed to over 30 percent of VA patients in Fiscal Year 2013 following an initial PTSD diagnosis, but failed to show efficacy in Veterans in two studies. This has led VA doctors to try different off-label drug combinations, or polypharmacy, "for the vast majority of patients treated." To address this problem, the Working Group called for "studies that would serve to provide critical basic information about the optimal treatment of PTSD" in order to begin to close the efficacy gap.

Second, the research pipeline is thin. There are only two medications approved for treating PTSD, both antidepressants, and the last one to secure the PTSD indication did so in 2001. The Working Group found that "the past decade of investments from VA and other federal funding agencies in research on medical treatment of military personnel and veterans with PTSD have yet to bear fruit in the form of new validated pharmacotherapies for PTSD." Federal research dollars are not going to the evaluation of pharmacotherapies for PTSD, just three of 21 active federal grants related to human PTSD research. Few dollars are flowing from the private sector, as well. The Working Group found that in the last decade, "the pharma-

²John H. Krystal et al., *It Is Time to Address the Crisis in the Pharmacotherapy of Posttraumatic Stress Disorder: A Consensus Statement of the PTSD Psychopharmacology Working Group*, *J. Biological Psychiatry* (2017) [http://www.biologicalpsychiatryjournal.com/article/S0006-3223\(17\)31362-8/abstract](http://www.biologicalpsychiatryjournal.com/article/S0006-3223(17)31362-8/abstract)

ceutical industry has completed four Phase II clinical trials and one Phase III clinical trial testing the efficacy of new agents for the treatment of PTSD.” Indeed, “few PTSD psychopharmacology experts are submitting clinical trial applications.” To address this problem, the Working Group endorsed “novel collaborations between government, industry, and academia.”

Third, we need more basic scientific research concurrent to new clinical trials. There are many targets for new drug therapies, according to PTSD psychopharmacology experts, but we need to expand the pipeline further. The Working Group noted that “our understanding of the pathophysiology of PTSD is limited.” Indeed, PTSD is not a single entity with a single biological mechanism. There are in effect many PTSDs, and each of them likely has a different pathological mechanism for which different treatment will likely be needed. Through more investment “in translational neuroscience studies” related to PTSD, such as the pathophysiology of PTSD, we can define these mechanisms and better define patients by their specific pathology or endophenotype.

The Working Group’s action plan emphasized the shared nature of the work ahead. “Federal, industry, scientific, and clinical communities [should] cooperatively address the state of affairs.” Importantly, the Working Group called for more clinical trials conducted in Veterans and “an ongoing effort for the VA and other funding organizations to engage companies on a proactive basis to encourage medication development for PTSD and to develop efficient mechanisms for partnering (financial support, infrastructure support).” Together, we can provide Veterans PTSD clinical practices truly guided by evidence-based PTSD pharmacotherapy research.

IV. Recommendations for Action

The VA has begun to convert the feedback of the Working Group into action. We ask that the Committee support this and further steps in the coming months.

In May, the VA and Coalition member Cohen Veterans Bioscience announced a public-private partnership alliance, called the Research Alliance for PTSD/TBI Innovation and Discovery Diagnostics (RAPID-Dx), “to enable different institutions to coordinate efforts and integrate data across dozens of labs and leverage synergistic capabilities for a “big data” team-science approach to discover and support development of first-generation validated biomarkers and diagnostics for PTSD and TBI.”³ The partnership will to develop new tools “to consistently and accurately diagnose” PTSD and TBI or assess if treatment is working. The VA framed the partnership as “affirming our commitment to a new type of radically collaborative science defined by data sharing and coordination of efforts toward our shared goal of finding clinically-useful diagnostics and treatments for these invisible wounds of war.” Secretary David Shulkin reiterated the view of the Working Group in saying that “we’re able to accomplish so much more when we work strategically with our private and public sector partners.”

We encourage the VA to work with the Committee to maximize the effectiveness of this new partnership, as well as work of similar initiatives to provide researchers access to PTSD datasets and provide institution-wide support for multi-site PTSD clinical trials.

Further, the VA should create a master plan to support external research through a strategic, top down approach. In the plan, the VA should move toward larger, multi-site studies, with a focus on clinical trials and research. Today, grant money is divided across too many different projects, leaving each with too little money to appropriately design and run a clinical trial, and unable to lead to the next step of investigation. The plan should include innovation grants for external research, such as the Industry Innovation Competition, in which the VA spurs activity in the private sector to help solve VA’s most pressing challenges.

V. Conclusion

Again, thank you for this opportunity to share our perspective on these important issues. We welcome the VA’s renewed efforts to address the challenges facing Veterans with PTSD and TBI, and we feel strongly that more can and must be done to ensure that our nations Veterans receive high-quality and effective treatment.

³ Cohen Veterans Bioscience, Press Release CVB and the Veterans Health Administration Announce Landmark Partnership to Advance the Diagnosis and Treatment of Trauma-Related Brain Disorders (May 17, 2017), <http://www.cohenveteransbioscience.org/2017/05/17/cohen-veterans-bioscience-and-the-veterans-health-administration-announce-landmark-partnership-to-advance-the-diagnosis-and-treatment-of-trauma-related-brain-disorders/>

DISABLED AMERICAN VETERANS (DAV)

STATEMENT OF SHURHONDA Y. LOVE

DAV ASSISTANT NATIONAL LEGISLATIVE DIRECTOR

Mr. Chairman and Members of the Committee:

On behalf of DAV (Disabled American Veterans) and our 1.3 million members, all of whom are wartime injured or ill veterans, I am pleased to present our views at this oversight hearing focused on post traumatic stress disorder (PTSD) in the veterans' population and the effectiveness of the mental health treatment and services provided to these veterans by the Department of Veterans Affairs (VA). We appreciate the Committee's attention to this important issue. Timely access to VA's specialized mental health services is critical to many DAV members.

Assessing the Effectiveness of VA Mental Health Programs, Including Post-Traumatic Stress Disorder and Suicide Prevention Efforts

VA mental health care has come a long way in meeting veterans where they are at demobilization sites, on college campuses, at Transition Assistance Program briefings and in military hospitals. It has also deployed new information technology to better inform the tech-savvy new generation of post-9/11 veterans and their family members. Today, it offers web-based curriculum, self-help apps, and a website with a peer-to-peer focus to provide information and awareness to all eras of veterans, service members and their family members, in addition to community health care practitioners. VA has the distinction of being the only national health care provider to integrate mental health care services into primary care. Its comprehensive and holistic approaches to managing care for vulnerable veterans have yielded good outcomes, including increasing the expected longevity of veterans with severe and chronic mental health conditions.

We acknowledge and commend the dedication of VA mental health clinicians who compassionately care for our nation's combat veterans struggling with post-deployment mental health issues, including PTSD. While VA remains the leader in providing our nation's veterans high quality mental health services and specialized treatment following wartime service, the Department must find new ways to improve access, decrease veterans' suicide and meet the unique needs of a diverse population.

Use of Clinical Practice Guidelines

VA's National Center for PTSD has been a global leader in developing techniques to screen, diagnose, treat and measure clinical outcomes for people with post-traumatic stress reactions. Based largely on its work, a VA and the Department of Defense (DOD) working group was convened to develop clinical practice guidelines based on review of evidence-based practices for preventing, identifying, managing and treating acute stress reactions and PTSD. We understand that the 2010 guidelines currently used are being updated. Existing guidelines emphasize the use of normalization, expectation of recovery and acute symptom management, as necessary, for acute disorders. For chronic and severe PTSD the working group gave its strongest recommendations for the use of psychotherapy including trauma-focused therapies (with exposure and/or cognitive restructuring, such as prolonged exposure or cognitive processing therapy), stress inoculation training (anxiety management and stress reduction techniques), and eye movement desensitization and reprocessing, along with pharmacotherapy as necessary for management of depression or other symptoms for treatment of severe PTSD.

According to VA, following these guidelines is time and staff-intensive, but ultimately results in better outcomes for veterans. However, hiring mental health providers and ensuring that adequate numbers of staff are fully trained in using these techniques has been an ongoing challenge for VA. VA reports that it has trained 6,800 staff in its medical centers and in Vet Centers in using these guidelines but this specialized treatment and recommended adjunct care modalities of care such as psychosocial rehabilitation are not available at all VA facilities. The working group also opined about the lack of evidence-based practices for concurrent treatment of common comorbidities such as mild TBI, substance use disorders (SUD), depression and other mental health conditions. We share this concern and hope that VA researchers continue to identify approaches that will fill this knowledge gap. Unfortunately, some of these therapies are viewed by patients as too intense, leading many veterans to drop out. For these reasons, we concur that complementary and alternative therapies showing benefit must also be available to those who need help.

DAV supports the use of these clinical guidelines, and looks forward to reviewing the updated recommendations. Wide dissemination and training on these standards of care better ensures that veterans have the most effective care, but sufficient resources must follow to ensure adequate staffing levels so that veterans have timely access and availability to these specialized services.

Far from easing the access issue for veterans, contracting care to private-sector providers (through the current Choice program or existing contracts) without supplementing VA's budget may actually exacerbate the problem. Few providers in the private sector have the specialized training necessary to use the VA/DOD clinical practice guidelines with fidelity. In addition, directing resources away from VA has the potential to compromise VA's ability to provide high quality mental health care and the most appropriate care for veterans. DAV appreciates the need for access to community care and supports veterans' access to such care in certain circumstances, but we are also concerned about the risks to current programs if sufficient funding is not provided to ensure veterans who want to remain in VA care for its specialized mental health care services can do so.

We continue to hear from front line mental health providers that the outdated scheduling package and Choice rules often impede their ability to provide the most appropriate care for their veteran patients and urge veterans to accept care in the community if they must wait over 30 days to see a provider—even when they prefer to remain in VA so they can see their established provider. One clinician argued that in focusing so narrowly on addressing and avoiding future scheduling manipulation, VA has inadvertently created a more rigid system that disempowers and endangers the veterans that they were supposed to protect. For example, a woman veteran suffering from PTSD due to MST who is stable with her psychiatrist and now is pressured to “choice out.” The frustrated clinicians call it the “non-choice” program. One provider stated, “I don't know who makes up these scheduling rules but probably individuals who don't understand the meaning of the metrics produced and don't understand the impact where the rubber meets the road, in the personal lives of each veteran. As long as the veteran is not in crisis and acknowledges it his/her choice to delay a visit in order to stay with his/her psychiatrist, why would we not empower that veteran to make that choice?” As Congress and VA move forward with plans better integrate VA and community care options we urge VA to engage with front-line providers and veterans to determine a proper balance that allows clinicians and veterans to make appropriate health care decisions and choices based on their needs and desires.

Crisis Management and Suicide Prevention in the Veterans Health Administration (VHA)

Suicide among veterans is a complex problem that VA cannot solve alone. Over the last decade, the number of veterans seeking specialized mental health care from VA has almost doubled. In response to this rapid growth, VA has implemented new programs, enhanced existing ones, and hired more personnel; yet the number of veterans committing suicide remains too high to bear (about 7,300 per year). Despite these numbers, the fact that VA patients are less likely to commit suicide and, in fact, are more likely to live beyond the years of life expected for those diagnosed with serious chronic mental illness is a strong testament to the effectiveness of VA's mental health programs. Integrating mental health into primary care helps with early identification and treatment of those who regularly rely upon VA for care. Outside of VA, however, veterans lack access to the same specialized and comprehensive mental health care services and the cultural competency of VA providers. Additionally, medical records are not routinely shared and care is not coordinated. This results in care that is disparate, fragmented and may even work at cross purposes.

To do our part, during National PTSD Awareness Month, DAV distributed information to our National Service Officers and Transition Service Officers, who serve hundreds of veterans every day, on how to effectively handle calls from veterans in distress, and refer callers to the Veterans Crisis Line when appropriate. DAV will also continue to advocate for effective policy, and promote VA's awareness campaigns that assist veterans with post-deployment challenges, treatment for military sexual trauma and mental health issues. We look to Congress for continued oversight and introduction of legislation necessary to improve mental health services for our nation's veterans with a goal of putting an end to the national crisis of veterans' suicide.

We do however recognize our efforts must extend beyond Capitol Hill and beyond the outreach of traditional veterans service organizations to reach those veterans at greatest risk. We must all take time to learn the warning signs of distress, and know the proper actions to take when we see them. We must all do our part to help

to remove the stigma associated with seeking mental health counseling and treatment. We must communicate to veterans that it is okay, even brave and wise, to seek the care that they have earned through their service to this nation. DAV is a committed partner in this effort and we encourage everyone to do their part with a shared goal of ending veterans' suicide.

The high rate of veterans' suicide and the media attention to this issue has at times called into question VA's ability to effectively manage veterans in mental health crises. To understand how suicide prevention efforts can be improved in VA one must assess the whole spectrum of programs the Department has in place. There are opportunities to reduce stigma, improve outreach, screening, treatment and recovery potential. While VA has made tremendous strides in identifying veterans at risk of suicide and treating those within its care, the fact is many-about three quarters-of the veterans that commit suicide are not VA patients. Eligibility barriers, limited resources, hiring issues and challenges with community collaboration, including difficulties exchanging medical information with private sector providers, complicate VA's ability to reach these individuals.

Given these specific challenges, it is essential for VA to partner with nonprofit organizations such as the National Alliance on Mental Illness and the National Association for Mental Health, and with private sector providers (psychiatrists, psychologists, social workers, and community social workers) who want to help capture all veterans who need help. However, increased efforts to improve fundamental education about the needs of the veteran population for non-VA providers will be necessary so they can effectively treat veterans with service-related conditions such as PTSD, TBI or issues related to military sexual trauma.

One area VA can improve and better serve veterans is crisis management. Over the last two decades, VHA has had to adapt to fill the gaps in its benefits package for emergency medicine and urgent care at many locations. Immediacy is fundamental to effectively addressing the needs of individuals in crisis and/or with suicidal ideation. While VA has good policies and directives in place, unfortunately, most VA medical centers do not operate as round-the-clock providers. While hospitals are always open, admission criteria for mental health inpatient programs are stringent. Unless the veteran proclaims that he or she is a threat to himself/herself or others (in which case they are admitted) they are likely to be evaluated and given an appointment for a later time.

While VA has recently amended its emergency medicine directive (VHA Directive 1101.05) to standardize care provision and ensure that necessary staff, including mental health professionals, are available onsite and 24/7 by phone, there are still, at times in certain locations, problems in accessing mental health care.

Only VA's "level 1" facilities are likely to have emergency departments that are required to be staffed by a physician and nurse 24/7; the most medically advanced of these (level 1a) are required to have mental health available onsite from 7 a.m. to 11 p.m. and on-call other hours. These facilities are advised to have a psychiatric intervention rooms for patients who are seriously disturbed, agitated or intoxicated, but do not meet the "life or death" criteria for admission to an inpatient psychiatric bed. Other facilities may have "urgent care centers" that only operate during normal business hours. In addition, certain enrolled veterans (those who have used VA care within the last two years and have no other health care coverage) are eligible for emergency care from community providers at VA's expense. However, this benefit has proven difficult to administer and difficult for veterans to understand, particularly when in a health crisis. We urge Congress to reduce the administrative burden for this benefit as it considers and redefines veterans' access to emergency care services in the community.

Because VA emergency care is not always accessible to veterans and in light of the continuing crisis of veterans suicides, in 2008, VA established a crisis line. The Veterans Crisis Line (VCL) has become a critical part of VA's care management plan for extremely vulnerable veterans-those in distress, crisis or with suicidal ideation. Based on the number of calls, it is clear the VCL tapped into a tremendous unmet need. Since first activated, call volume has grown by 700 percent and such rapid growth resulted in a number of issues related to this life-saving service.

Congress has justly criticized VA for VCL's problems with timeliness and availability in responding to veterans' calls or text messages. As recently as this April, the Government Accountability Office (GAO) testified that VA did not meet its call response time goals for more than a quarter of its calls (GAO 17-545T). It also found that a significant portion (29 percent) of "text" texts went unanswered. Veterans have also mistakenly reached "Lifeline"-a shared public-private crisis intervention line rather than the VCL on some occasions, but VA has not looked into the extent of the problem nor why this has occurred. Finally, GAO found that VA

lacked measurable goals and timelines to address identified issues and implement suggested improvements.

The VCL provides more than just a sympathetic ear—it's a critical part of the mental health safety net for our veterans. Its specially trained responders send ambulances and make referrals to local VA facilities' suicide prevention teams or coordinators to ensure they follow-up with the veterans who use its services. In light of the essential service it performs, DAV believes ensuring that VA fixes the problems identified by GAO should be among the Committee's oversight priorities. Congress needs to maintain oversight of this program and ensure VA is given the necessary resources to provide these essential services to veterans in crisis.

There are two initiatives underway to improve care for veterans using VA mental health care services that are worth noting. The VA's Recovery Engagement and Coordination for Health (REACH) VET initiative uses a predictive model to systematically flag charts of veterans who may be at risk of suicide. This allows VA to identify and treat high risk veterans before a crisis occurs. VA is also proposing a Measurement Based Care initiative that will allow veterans using mental health services to identify changes in symptoms and how they are able to manage their daily life activities. Under this initiative, reviewing treatment progress and goal-setting with veterans become central to mental health encounters. We believe this initiative is more veteran-centered and has a great deal of potential in identifying the most important and effective treatment for an individual veteran. Analysis of VA's current mental health services required under the Clay Hunt SAV Act (Public Law 114-2) should also help VA understand how these initiatives affect patient outcomes and the effectiveness of its suicide prevention efforts.

Readjustment Counseling Service-VA Vet Centers

One VA's most popular programs is provided through its Readjustment Counseling Service (RCS). Through community Vet Centers, Mobile Vet Centers, and the Vet Center Call Center, VA is able to provide non-traditional readjustment services that are driven directly by the needs of war veterans, active duty service members, and their families. Vet Center staff, many of whom are veterans themselves, conduct important outreach to fellow veterans and focus on the therapeutic relationship, individual treatment plans, and providing a non-medical model of readjustment counseling that encompasses services for a spectrum of clinical and socio-economic issues. According to RCS, in fiscal year (FY) 2016, Vet Center staff participated in over 40,000 outreach events and increased access at Vet Centers to veterans by 18 percent over the previous fiscal year.

Vet Center staff also focus on decreasing known barriers associated with receiving readjustment counseling and are purposely positioned in the community to create easy access points for the veterans they serve. We are pleased to see RCS is increasing its flexibility and expanding its services beyond traditional brick-and-mortar Vet Centers through the use of Vet Center Community Access Points (CAPs). Through CAPs, VA clinicians are able to provide readjustment counseling from these locations that is more in line with the needs of the community and can range from once a month to several times a week. This approach allows Vet Center staff to move with veterans and service member population as demand changes.

Vet Center staff also respond to major emergency events and frequently partner with the Red Cross providing clinical support in local communities in the aftermath of shootings, floods and other disasters. As a testament to their effectiveness and popularity Vet Center services appear to be steadily increasing. In FY 2016, RCS provided over 1.7 million readjustment counseling visits and outreach contacts (8.2% increase over FY 2015) for 258,396 veterans, service members, and families (17.7% increase over FY 2015). The Vet Center Call Center handled 116,596 live telephone calls from veterans, service members, families, and community stakeholders (3% increase over FY 2015).

Expanding Access to Veterans with Discharges Characterized as Other Than Honorable

One group that has traditionally lacked access to VA care are those with military service discharges characterized as other than honorable. Ironically, among veterans with these discharges many may have undiagnosed or untreated mental health conditions or mild traumatic brain injuries (TBI) that may have contributed to their misconduct during service. A recent GAO report (GAO-17-260), indicated that 62 percent of service members separated from service because of misconduct had been diagnosed with TBI, PTSD or other mental health conditions in the preceding two years. DOD policy requires that TBI and PTSD be considered in determining the characterization of discharge, yet 23 percent of these individuals received "other than honorable" discharges. Likewise, longstanding VA policy created eligibility bar-

riers for VA health care services for many of these veterans. We commend Secretary Shulkin for revisiting this policy to allow an estimated 500,000 veterans with other than honorable discharges to seek urgent mental health care and potentially prevent these veterans from injuring themselves or others due to untreated mental health conditions. The Vet Center program will likely be primary providers of this service. As such, additional funds should be provided to meet expected increased demand.

Use of Peer Specialists

DAV fully supports VA's Peer Specialist Program and we believe there are more opportunities to integrate peers in VA's mental health programs and related services. VA has hired 1,100 peer specialists to assist their peers by providing patient education, coordinating appropriate care, and assisting veterans with maintenance of clinicians' orders for managing mental health conditions. As VA began to hire peers, some clinicians expressed concerns about vague duties and oversight but these concerns seem to have been addressed by developing specific job descriptions, requiring certification and creating job-specific core competencies to ensure incumbents have the requisite skills. We understand that VA plans to expand its use of peer specialists into primary care settings as part of the integration of mental health into primary care.

DAV supports using peer specialists as a means of expanding VA's workforce and providing additional support to veterans with complex and comorbid conditions such as PTSD, SUD and TBI. Use of peers has been shown to enhance patient engagement, increase their self-advocacy skills, ensure more appropriate use of services, and increase patient satisfaction and quality of life. Such time-honored programs as Alcoholics Anonymous and other addiction recovery programs operate solely as peer-sponsored support programs. The National Alliance for Mental Illness also advocates and exploits these models to help those with mental illness progress toward recovery.

Early on, VA saw the benefits of peer interaction with veterans with serious mental illness and has promoted this model of peer-support. VA's Vet Center program has always embraced this model and was specifically developed to reflect the communities they serve. These individuals are able to effectively connect with a veteran because of their shared experience of military service. Overall, peer specialists play an important role and can improve veterans' care outcomes and assist VA with cost containment by helping some of the system's most fragile and complex care patients better manage their own care.

We continue to hear VA clinicians perceive peer specialists as valuable members of their clinical care teams. The Clay Hunt SAV Act sought to take on a broad community-based approach by establishing a pilot program to develop peer networks with community outreach teams to better collaborate with local mental health organizations. Unfortunately, in identifying implementation barriers for Clay Hunt provisions, VA reports they do not have funds available for hiring or training additional peer specialists. We urge the Committee to consider this information as they work through the budget process and make recommendations.

As noted, we see additional roles for peer specialists including assisting with deescalating veterans in crisis, following up with intensive care users to ensure they are following their care regimens, serving as points of contact or mentors for the veteran as they establish trusting relationships with mental health providers or are waiting for services. They can also assist veterans with navigating the VA system and highlight various services and treatment options.

Outreach

We applaud VA for development of its excellent outreach campaigns. VA credits its "Make the Connection" campaign with successfully linking many veterans and family members to needed health care resources. Public awareness campaigns are essential in addressing the stigma many veterans still confront in seeking mental health care by alerting veterans, family members, and members of the community to the high rates of suicide in the veteran population and educating the broader community about the signs and symptoms of mental illness.

VA's Coaching into Care initiative has been a successful telephone program that employs VA mental health professionals to assist family members and friends with identifying ways to motivate veterans to seek mental health care treatment and locating local resources. DAV supports this innovative program as a way of offering help to families in crisis that may pre-empt veterans from harming themselves, their loved ones, or others.

DAV supported the Clay Hunt SAV Act addressing veteran suicide through a multi-faceted approach including public awareness, assisting veterans and family

members with obtaining care and building coalitions between national nonprofits and local providers who want to treat veterans who are not willing or able to use VA health care. We agree that meeting the individual needs of all veterans with post-deployment readjustment and/or mental health issues will require collaboration and education of private sector primary care providers, mental health providers and clinicians providing SUD treatment. The Clay Hunt SAV Act requires joint collaboration and information sharing with non-governmental mental health providers to reach veterans who are unaware, unwilling or unable to access VA services. Collaborations with VA providers and nonprofits at the local and community level could help identify veterans at high risk of suicide who are not using VA for health care. Full implementation of this law would also assist veterans in identifying all available mental health resources in their community by creating web-based repositories for each Veterans Integrated Service Network.

In closing, we appreciate the opportunity to provide testimony for the record. We ask the Committee to consider our views as it deals with its legislative plans for this year. I will be happy to address any questions from the Chairman or other Members of the Committee.

MILITARY ORDER OF THE PURPLE HEART

SUBMITTED BY ALEKS MOROSKY

NATIONAL LEGISLATIVE DIRECTOR

Chairman Roe, Ranking Member Walz, and Members of the Committee, on behalf of the Military Order of the Purple Heart (MOPH), whose membership is comprised entirely of combat wounded veterans, I thank you for allowing us to testify today on mental health care provided by the Department of Veterans Affairs (VA), particularly as it relates to posttraumatic stress disorder (PTSD). MOPH appreciates the effort that you and the committee have dedicated to this important topic in recent years, and we are grateful for the opportunity to submit our views.

Due to the nature of the membership criteria of our organization, MOPH members suffer from PTSD at a relatively high rate. This is no surprise, since every Purple Heart recipient has experienced direct combat with enemy forces. This also means that a large percentage of MOPH members are consumers of VA mental health care. In listening to them, we have identified many of the challenges that VA faces in providing that care, and would like to offer a number of solutions.

One improvement MOPH supports is requiring VA to track and report wait times according to the next available appointment. While we understand that wait times are only one component of gauging access, we feel that VA's current practice of tracking appointment wait times for established enrollees based on the "Patient-Indicated Date" does not always accurately reflect the veteran experience. For instance, VA currently reports that the average wait time for a mental health appointment at the Washington, DC VA Medical Center (VAMC) is two days. Veterans enrolled at the DC, VAMC, however, know that they can often expect that a mental health appointment will not be available until weeks after they call to schedule. MOPH feels that tracking and reporting the time veterans are waiting for the next available appointment would give VA and Congress a better idea of where and to what degree VA is struggling to meet demand, so that appropriate resources can be allocated to those locations.

It is noteworthy that VA recently established a new interactive website that allows veterans to compare appointment wait times at different VA facilities, and the intent of this website to increase transparency is commendable. Still, the data that the website uses is based on the "Patient-Indicated Date" for established veterans. For this reason, MOPH believes that the data on the site risks creating unreasonable expectations for the veterans who view it. We believe that the data reported on the site should include wait times for the next available appointment in addition to wait times from the "Patient-Indicated Date," so as to more accurately reflect the veteran experience at each VA facility.

Another way VA could improve access to mental health care, and all care in general, would be to offer extended operating hours during nights and weekends at VAMCs. Currently, most VAMCs only schedule outpatient appointments from 8:00 am to 4:30 pm, Monday through Friday. Scheduling appointments on nights and weekends would not only grant more timely access to all veterans, it would also offer more convenient options for veterans who work full time during normal business hours. While MOPH understands that this would require additional resources,

as well as a shift in culture for VA employees and new workforce management strategies for administrators, we firmly believe that offering extended appointment hours would be an efficient means of maximizing access without the need for additional capital assets.

MOPH also believes that VA facilities could work to broaden the array of PTSD services they offer. Currently, many VAMCs offer psychiatric services, in addition to intensive outpatient PTSD counseling. This counseling may be in group or individual settings, but often requires the veteran to agree to lengthy treatments several days a week for a number of weeks at a time. Again, for veterans who work full time, this may be impossible, even if they are suffering significantly from PTSD. Vet Centers, by comparison, offer mental health counseling as needed to both combat veterans and their families, either by appointment or on a drop-in basis, often during non-traditional hours. MOPH believes that the range of mental health services at VAMCs would be greatly improved if they offered a similar model as an option.

It should be noted that Vet Centers were established during the Post-Vietnam era, when many veterans felt uncomfortable receiving care at VAMCs. MOPH believes that those attitudes have shifted for many veterans as times have changed. Today, many veterans prefer to receive all their care from the VAMC, rather than receiving most of their care at the VAMC, and then having to adapt to a new environment to receive PTSD counseling. Additionally, VAMCs are geographically more accessible for some veterans. To be clear, MOPH strongly supports Vet Centers as a proven model, and believes they should continue to exist as they currently do. We simply believe that the more informal counseling setting they offer should also be incorporated at VAMCs wherever possible.

MOPH would also like to see VA pilot certain complementary and alternative medicine (CAM) PTSD treatments that it does not currently offer. In recent years, VA has made great strides in increasing CAM options, to include therapies such as yoga, meditation, and acupuncture, which we find commendable. However, MOPH believes that VA should begin trials with other alternative therapies such as hyperbaric oxygen therapy (HBOT) and magnetic EEG/EKG guided resonance therapy. Although these therapies are unconventional, MOPH has heard anecdotal accounts from our members who have used these therapies that they were highly successful in treating PTSD symptoms. We believe that the potential benefits of these therapies warrants further exploration, which is why we support Representative Knight's H.R. 1162, the No Hero Left Untreated Act, which would establish a pilot program to treat a small number of veterans with magnetic EEG/EKG guided resonance therapy, and also support the establishment of a similar VA pilot program for HBOT.

Another non-traditional treatment for PTSD that many members of MOPH find helpful is canine therapy. Service dogs not only make veterans with PTSD feel more secure in stressful situations, but many find the act of caring for an animal therapeutic in itself. MOPH believes that other veterans could also receive therapeutic benefits from training service dogs to be used by other veterans. Accordingly, we support Representative Stivers' H.R. 2225, the Veterans Dog Training Therapy Act, which would direct VA to carry out a pilot program on dog training therapy.

MOPH also believes that veterans with other than honorable (OTH) discharges should be entitled to emergent mental health care, at a minimum. While we agree that certain VA benefits and services should be reserved for those who received honorable discharges, we believe that it is cruel and unnecessary to deny care to anyone who served our country when they are in an hour of great need. Furthermore, our nation can never hope to fully eliminate veteran suicide if we deny any and all care to this population. We recognize that Secretary Shulkin recently announced that VA would begin treating OTH veterans in mental health crisis, and for that, he should be commended. Still, MOPH believes that this policy should be codified. For this reason, we support Representative Coffman's H.R. 918, the Veteran Urgent Access to Mental Healthcare Act, which would require VA to furnish certain mental health services to veterans who are not otherwise eligible.

With regards to the Veterans Benefits Administration, MOPH would like to take this opportunity to voice our strong opposition to the provision of the current VA budget proposal that calls for the elimination of individual unemployability (IU) benefits for veterans age 62 and over. Many veterans receiving IU benefits are unable to work entirely or in part due to PTSD. Taking away this benefit that they rely on when they reach a certain age is not only arbitrary; it would certainly create a stressor that would seriously exacerbate the mental health conditions that entitled them to the benefit in the first place.

While we understand the rationale that allowing veterans to simultaneously collect IU and Social Security retirement benefits could be considered a "duplication

of services,” we feel this argument is deeply flawed. Many veterans are unable to work the majority of their lives, denying them the opportunity to pay enough money into Social Security to receive any meaningful retirement benefit at age 62. Cutting them off from IU benefits with no other benefits to fall back on would seriously jeopardize their ability to support themselves. Additionally, they would lose a host of other benefits as a result, including but not limited to, CHAMPVA, education benefits for their children, and military base access. In the past two weeks, MOPH has been inundated with calls and emails from our members voicing their deep concerns about this proposal. Therefore, MOPH asks that Congress reject this misguided provision of the VA budget request.

Chairman Roe, Ranking Member Walz, this concludes my testimony. Once again, I thank you for the opportunity to submit this statement, and I am happy to answer any questions you or the other Members of the Committee may have.

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

WRITTEN TESTIMONY SUBMITTED BY: EMILY BLAIR

MANAGER-MILITARY, VETERANS & POLICY

Chairman Roe, Ranking Member Walz, and distinguished members of the Committee, thank you for affording NAMI, the National Alliance on Mental Illness, the opportunity to submit written testimony on VA’s current efforts to treat veterans with Post Traumatic Stress Disorder (PTSD).

NAMI is the nation’s largest grassroots mental health organization, dedicated to building better lives for the millions of Americans affected by mental illness. NAMI has over 900 affiliates and more than 200,000 grassroots leaders and advocates across the United States—all committed to raising awareness and building a community of hope for all of those in need, including our men and women in uniform, veterans, and military families.

VA’s current efforts on PTSD and mental wellness

NAMI applauds Secretary Shulkin’s recent and ongoing efforts to enhance mental health services for veterans within the walls of VA and through Choice providers in the community. Among the many recent transformations the Secretary has instituted, there are three examples which NAMI would like to highlight, and believes will make a positive difference in the lives of veterans diagnosed with PTSD:

1. Establishing the reduction of veteran suicide as the Department’s top clinical priority;
2. Offering urgent mental health care services to veterans with Other-than-Honorable discharges; and
3. Streamlining veteran medical records with the Defense Department for interoperability.

These are all positive steps to improving health services for veterans with PTSD and other service-related mental health conditions.

Peer Support

Peer support is an important treatment tool that promotes mental wellness, reduces the stigma of seeking care, and empowers veterans by improving coping skills and overall quality of life. Peer support is specifically beneficial to the veterans’ community for addressing mental health conditions, principally PTSD. Peer support often serves as a bridge to receiving treatment and is a positive first step. Military cultural competency is key in establishing trust with a veteran when beginning treatment for a mental health condition, and peer support is often the best tool for this purpose.

It is critical to underscore that a peer support specialist is an important member of a clinical care team, which should also include an appropriate array of qualified health and mental health care professionals.

Employing Evidence-based Treatments

Research shows that cognitive behavioral therapies, such as Cognitive Processing Therapy (CPT) and Prolonged Exposure therapy (PE), are among the most effective evidence-based treatments for PTSD. Although VA currently recommends cognitive

behavioral therapies as first-line treatments for PTSD, many VHA mental health providers have not been properly trained or do not administer them.

NAMI urges the Committee to consider exploring the option of mandating that each VHA mental health provider be trained and have the ability to administer at least one of these evidence-based therapies. Our nation's veterans deserve the best treatments available and VA should be leading the way in providing the top-notch mental health care that we know can make a significant clinical impact.

Treatment-resistant PTSD

NAMI remains concerned about veterans diagnosed with treatment-resistant PTSD and depression as first-line, conventional treatments do not make a positive clinical impact. While peer support, cognitive behavioral therapies and medication management are often effective in treating veterans with PTSD, VA must begin more intently researching and developing the clinical tools necessary to care for veterans with treatment-resistant PTSD and depression.

NAMI advises VA to work in coordination with the National Institute of Mental Health (NIMH) to develop a series of randomized clinically-controlled research trials on the effectiveness of innovative new approaches to these conditions including, but not limited to Ketamine treatments and Trans-Cranial Magnetic Stimulation therapy (TMS). The research trials should have safety protocols in place and be led by top-notch researchers who understand and value adhering to clinical safety guidelines.

While the research base for these treatments is currently underdeveloped and more conclusive research studies are necessary, it is incumbent upon VA to be a leader in pioneering the path forward to care for veterans with these conditions. Additionally, creating an evidence-base around these treatments could ultimately go a long way in meeting our shared goal in the reduction, and eventually elimination, of suicide among veterans.

Finally, it is NAMI's strong belief that in a time when science and innovation could be the key to unlocking many life-saving treatments for America's veterans living with mental health conditions, it is certainly not the time to cut any federal funding for medical research. We respectfully ask the Committee to broadly reject any cuts to funding for medical research and innovation where the Committee has jurisdiction.

As the Committee is aware, the signature wounds of the Iraq and Afghanistan wars are invisible. In a culture that demands strength, it is often difficult to step forward and seek help for an injury, such as PTSD, that remains unseen. For this reason, there is a much larger barrier facing America's veterans in accessing necessary mental health care services. NAMI encourages the Committee to remain vigilant on these issues and keep matters concerning mental health care for our nation's veterans at the forefront of all key policy discussions.

NAMI is grateful to the Chairman, Ranking Member, and the entire Committee for its commitment to improving mental health services for our nation's veterans. NAMI is committed to working with Congress, Secretary Shulkin, and our Veterans Service Organization (VSO) partners in continuing to improve mental health services within VA and through Choice program providers-ensuring that veterans, too have a community of hope and realize that recovery is achievable.

Thank you for inviting NAMI to submit written testimony on this important topic; we always appreciate being a resource on mental health matters at VA and in the veterans' community overall.

VETERANS OF FOREIGN WARS OF THE UNITED STATES (VFW)

STATEMENT OF KAYDA KELEHER, ASSOCIATE DIRECTOR

NATIONAL LEGISLATIVE SERVICE

Chairman Roe, Ranking Member Walz and members of the Committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, I want to thank you for the opportunity to present the VFW's views on the Department of Veterans Affairs (VA) efforts in treating veterans struggling with Post-Traumatic Stress Disorder (PTSD).

Public Private Partnership

Since the enactment of Public Law 114-2, Clay Hunt SAV Act, VA has entered into new relationships with many private sector organizations to address PTSD

within the veteran population as well as to combat veteran suicide. Some of these organizations include Bristol-Myers Squibb Foundation. This foundation has awarded over \$15 million in grants to veteran service organizations and academic teaching hospital partners working to develop and improve innovative models of community-based care and support to improve the mental health and community reintegration of veterans. The VFW is also among the many organizations who have signed on to partner with VA.

This past year, the VFW launched a Mental Wellness Campaign to change the narrative in which America discusses mental health. We teamed with Give an Hour providers, One Mind researchers, the peer-to-peer group Patients-Like-Me, the family caregiver-focused Elizabeth Dole Foundation, the nation's largest pharmacy Walgreens, and the Department of Veterans Affairs to promote mental health awareness, to dispel misconceptions about seeking help, and to connect more veterans with lifesaving resources. The goal of the VFW campaign is to de-stigmatize mental health, teach our local communities how to identify mental distress and what local resources are available to those struggling to cope with mental health conditions. To do this, VFW posts and VA employees from Richmond, Va. to Lakeside, Calif. and everywhere in-between, have held mental wellness workshops to spread awareness of VA's mental health care services, as well as how to properly identify a fellow veteran in distress. The VFW and VA talked with local veterans about the Campaign to Change Direction and their five signs of mental distress—personality change, agitated, withdrawal, poor self-care and hopelessness.

We know this campaign has saved lives, our members have told us so. Veterans have told us of how they were suicidal - gun in hand - but they put the gun down when they saw the pamphlet from the Campaign to Change Direction. Those veterans are still alive after they called the Veterans Crisis Line and received help. That is the power of the public private partnerships VA is continuing to develop.

With 14 of the 20 veterans who die by suicide every day not seeking care at VA, the VFW believes VA must continue expanding these partnerships with the mindset of providing better outreach to those who are not using VA services. By continuing to perform increased outreach to this vulnerable population, we will hopefully begin seeing a decrease in the veteran suicides.

Peer Support

The VFW has long advocated for the expansion of VA's peer support specialists program. VA peer support specialists are individuals with mental health or co-occurring conditions who are trained and certified by VA standards to help other veterans with similar conditions and/or life situations. They are actively engaged in their own recovery and provide support services to others in similar treatment at VA. Veterans who obtain assistance from peer support specialist value the assistance they receive.

The VFW urges Congress to make sure VA has the resources required to continue expanding on this effective, low-cost form of assistance to veterans in need. To ensure VA is offering a holistic approach in effectively addressing PTSD within the veteran population, VA must have the ability to provide peer specialists outside of traditional behavioral health clinics. Veterans overcoming homelessness, veterans seeking employment, veterans in mental health crisis going to the emergency room or urgent care center could all benefit from peer support services.

Aside from veterans receiving support from fellow veterans who have recovered from similar health conditions and experiencing the bond and trust veterans share, peer support specialists also greatly assist in destigmatizing mental health conditions such as PTSD. For a veteran to become a peer support specialist they must have actively gone through treatment, and are living a relatively healthy lifestyle. This allows veterans who may be struggling to see that their condition is treatable, manageable and not something that has to negatively impact or control their lives.

Women Veterans

Women veterans seeking treatment for PTSD often times face unique barriers or challenges. While people of all genders struggle with PTSD for the same reasons, PTSD linked to sexual violence affects women at a much higher ratio than others in the veteran population. As the population of women veterans continues to rise, it is of the utmost importance VA continues prioritizing their often overlooked health care needs.

The VFW urges Congress and VA to continue expanding telemental health programs. These programs are often invaluable to women veterans wanting to use group therapy for PTSD linked to sexual violence. In VA's where there may not be enough women to get a group therapy session started, telemental health provides this opportunity. The VFW also urges VA to do two things. First, begin more seri-

ously taking sex into consideration before prescribing psycho-pharmaceutical treatments. Medications have different effects between people of different sexes. The VFW asks VA to begin being on the fighting end as a good example in beginning to prioritize this. Second, VA must continue training mental health providers and employees on treatments and proper handling of patients with PTSD due to sexual trauma.

The VFW also urges the Committee to swiftly consider and pass H.R. 2123, the VETS Act of 2017, which would expand VA's authority to provide telemedicine. This important bill would improve the tele-mental health services VA provides women veterans.

Veterans Seeking Treatment

Veterans who seek treatment for PTSD at VA report that their treatment was effective. But this is not disregarding access to care issues VA has struggled with in the past. Veterans who choose to use VA for their health care must have access to treatment, particularly veterans struggling with mental health conditions such as PTSD.

The VA is the largest integrated mental health systems in the United States with specialized treatment for PTSD. The number of veterans seeking treatment at VA for PTSD has continued increasing as more veterans from Iraq and Afghanistan leave the military and transition to civilian life. This is part of the cost of war. Congress and VA must ensure those seeking these treatments are provided timely access to VA care.

Mental health staff members within VA have increasingly continued to receive training in areas such as prolonged exposure and cognitive processing therapy - which are the most effectively and empirically proven forms of known therapies for PTSD. Medication treatments are also offered, and thanks to Congress and the Clay Hunt SAV Act medications are being more closely monitored. Through VA's Opioid Safety Initiative, opioids are being prescribed on a less frequent basis for mental health conditions and are being monitored for addiction and other negative consequences.

With the number of opioid prescriptions decreasing and the number of providers receiving training on effective psychotherapies specific to PTSD patients increasing, the VFW believes VA is successful in their efforts to treat veterans within this population. This is not to say more work does not need to be done.

Throughout the years PTSD research has allowed doctors and researchers to understand and diagnose PTSD in ways never before possible. The VFW urges VA to continue this research to better understand biological implications for diagnosis to avoid misdiagnosing and treatment. The VFW also urges Congress to provide VA with the necessities required to continue hiring more mental health care providers. The VFW also urges VA and Congress to work together in providing new technologies and researching new and/or alternative forms of treatment.

VIETNAM VETERANS OF AMERICA (VVA)

SUBMITTED BY THOMAS J. BERGER, PH.D

EXECUTIVE DIRECTOR, THE VETERANS HEALTH COUNCIL

Chairman Roe, Ranking Member Walz, and Distinguished Members of the House Veterans Affairs Committee, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on "Overcoming PTSD: Assessing VA's Efforts to Promote Wellness and Healing". We should also like to thank you for your overall concern about the mental health care of our troops and veterans.

There is an unprecedented demand VA for mental healthcare because many veterans suffer from depression, isolation, anxiety, and substance abuse disorders. While the VA has made strides in increasing access to mental healthcare, it alone cannot address this crisis. Solving the veterans' mental health crisis requires partnerships and a commitment with/from many sectors: public, private, non-profit, and local communities. Otherwise the crisis will only worsen.

Starting with this premise, not the least of issues with VA mental healthcare begins with recognition of our veterans' age, gender and race, as many of the VA's mental health programs remain "one size fits all". This does not allow for addressing the specific needs of individual veterans, particularly our women veterans, even with recognition of the need for more clinicians and financial resources.

VVA also understands that some of our veterans are calling for holistic PTSD treatments (i.e., complementary alternative medicines or CAMs) such as yoga/meditation, art therapy, music therapy, nature-based recreational therapy, and various pet therapies. Yet VVA is not aware of any science-based comparative clinical research studies of these therapies that demonstrate clinical efficacy outcomes as stand-alone treatments for PTSD. As such, VVA cannot support adding these additional treatment programs to VA's mental health programs without the comparative effectiveness studies that both psychological and pharmacological therapies must currently undergo, including the training and certification standards for such VA providers. Therefore, VVA strongly recommends that VA R&D monies be allocated for/directed to science-based comparative clinical research studies of these therapies before wholesale adoption by the VA (see *reference below).

Furthermore, VVA recognizes that veterans' peer support programs can be effectively utilized to link people living with a chronic condition or common illness who are able to share knowledge and experiences - including some that many health workers do not have. As such, the VA currently operates a peer support program in mental health, but it's relatively unknown, not well understood within the veterans' community, and not well advertised. Thus, VVA calls for an independent evaluation of its peer support program for effectiveness.

In addition, in a May 29 The Hill op-ed piece by Maura C. Sullivan (former Assistant Secretary at the VA, former Assistant to the Secretary of Defense, and a U.S. Marine and Iraq Veteran), she notes "researchers have found that after U.S. forces began withdrawing from Afghanistan in 2011, death by suicide surpassed war-related deaths - making it the second leading cause of death, after accidents, among active service members in 2012 and 2013. Furthermore, the Department of Veterans Affairs (VA) estimates that up to 20 percent of U.S. military personnel who served in Iraq or Afghanistan, about 400,000 Veterans, have Post Traumatic Stress Disorder. To put this figure in perspective, that's nearly the equivalent of the population of Wyoming." Furthermore, the VA's own 2016 Suicide Report concluded that approximately 65 percent of all Veterans who died from suicide in 2014 were 50 years of age or older - which is of the gravest concern to VVA. But despite the significance of these data, other problems with the VA's Veterans Crisis Line (VCL) also surfaced about the same time and were clearly noted in the GAO's report of June 2016 which stated "GAO found that the Department of Veterans Affairs (VA) did not meet its call response time goals for the Veterans Crisis Line" and "reports of dissatisfaction with VCL's service periodically appeared in the media". The GAO then recommended that VA and SAMHSA collect information on how often and why callers reach Lifeline (i.e., a back-up service) when intending to reach the VCL, review this information, and, if necessary, develop plans to address the causes. VA and HHS concurred with GAO's recommendations and described planned actions to address them.

Now fast forward to the VA's OIG report issued on May 18, 2017 entitled "Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities" wherein the purpose of the review was to evaluate facility compliance at 28 VHA facilities with selected VHA guidelines from October 1, 2015 through March 31, 2016. This report noted that most facilities had a process for responding to referrals from the Veterans Crisis Line and a process to follow up on high-risk patients who missed appointments. Additionally, when patients died from suicide, facilities generally created issue briefs and, when indicated, completed mortality reviews or behavioral autopsies and initiated root cause analyses. However, the report also identified six system weaknesses and made the following six recommendations:

- Suicide Prevention Coordinators provide at least five outreach activities per month.
- Clinicians complete Suicide Prevention Safety Plans for all high-risk patients, include in the plans the contact numbers of family or friends for support, and give the patient and/or caregiver a copy of the plan.
- When clinicians, in consultation with Suicide Prevention Coordinators, identify high-risk inpatients, they place Patient Record Flags in the patients' electronic health records and notify the Suicide Prevention Coordinator of each patient's admission.
- A Suicide Prevention Coordinator or mental health provider evaluates all high-risk inpatients at least four times during the first 30 days after discharge.
- When clinicians identify outpatients as high risk, they review the Patient Record Flags every 90 days and document the review and their justification for continuing or discontinuing the flags.
- Clinicians complete suicide risk management training within 90 days of hire.

VVA asks how and when will the Secretary respond to these latest recommendations?

Finally, VVA eagerly awaits to hear the update from the VA on the implementation of the Clay Hunt SAV Act (PL 114-2), which requires (amongst other items) the VA to partner with non-profit mental health organizations on veteran suicide prevention and to arrange for an independent third-party evaluation of VA's mental healthcare and suicide prevention programs. VVA's Arizona State Council and chapters are participating partners in the state's pilot Be Connected program, working with all of the public and private sector key stakeholders, including the Arizona Coalition for Military Families, U.S. Department of Veterans Affairs, Office of Senator John McCain, Arizona Health Care Cost Containment System and Tri-West Healthcare Alliance among others. The program's goal is to increase access to, and use of, supportive resources and to decrease deaths by suicide within the Arizona veteran community.

VVA earnestly hopes that Congress can see there are many facets to addressing the issues that will be covered in today's hearing and we stand ready to assist in any way we can. Thank you for the opportunity to comment for the record.

*Reference —

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COHEN VETERANS NETWORK

Thank you for this opportunity to submit a statement for the record in connection with the hearing titled Overcoming PTSD: Assessing VA's Efforts to Promote Wellness and Healing. As the CEO and President of Cohen Veterans Network (CVN), and in my 30 years of military behavioral health experience, I've seen that community-based treatment programs and embedded providers near the military member units are ideal options for serving war fighters or veterans with post-traumatic stress disorder (PTSD) and other mental health conditions.

PTSD Background

PTSD is a clinically diagnosed psychiatric disorder that can occur following the experience or the witnessing of life-threatening events, including military combat, and is the most commonly occurring disorder that occurs after exposure to traumatic events. Symptoms of PTSD can include reliving the event or having flashbacks; avoiding situations that trigger the memories; losing interest in activities or feelings of fear, guilt, or shame; feeling anxious or always on alert for danger. Sufferers may have trouble concentrating or sleeping—a state called hyper-arousal. Other symptoms include panic attacks, depression, suicidal thoughts, feeling estranged and isolated, and not being able to complete daily tasks.

Among the military, nearly 20 percent of enlisted soldiers—approximately 300,000—who returned from Iraq and Afghanistan have reported symptoms of PTSD or major depression. Other factors in combat can add to stress and contribute to PTSD and other mental health problems, including the veteran's role in the war, politics surrounding the war, where it was fought, and the type of enemy the service members faced.

CVN Efforts

CVN is establishing accessible community-based mental health clinics across the country that align with the efforts of the U.S. Department of Veterans Affairs (VA) around mental health care. We are currently demonstrating that community access and engagement with the veteran population near where they work and live can reach those in need of services and get ahead of the crisis. Of the estimated 20 veteran suicides a day, 14 never make it to the VA. We believe that community providers like our Steven A. Cohen Military Family Clinics provide a desirable alternative option for veterans and their families.

As a result, CVN was established in 2015. The mission of CVN is to improve the quality of life for post-9/11 veterans and their families by focusing on improving

mental health outcomes, especially those associated with PTSD and related challenges. The primary way that CVN does this is through the direct provision of mental health care. Direct care is provided through a national network of Cohen Military Family Clinics (MFCs) for veterans and family members dealing with post-traumatic stress and other mental health conditions.

The Cohen MFCs provide a compassionate, individually-tailored, and holistic approach to outpatient mental health treatment for veterans and their family members. CVN defines a veteran as any individual who has served in the Armed Services (including the National Guard and Reserves) in any capacity, regardless of role or discharge status. Our clinics specialize in time-limited, evidence-based care. Grounded in the culture of veterans and military families, our clinics build trusting, confidential relationships with patients and maintain strong ethical and legal commitments to privacy and confidentiality.

The core areas of adult treatment for all MFCs are post-traumatic stress, depression, anxiety, sleep problems, substance abuse, bereavement, transition and re-integration issues, and family/couple discord. MFCs are also equipped to assess for (and, in some clinic locations, treat) mild traumatic brain injury. For children, MFCs provide diagnostic assessment and treatment for common childhood disorders such as depression, anxiety, family stress, and adjustment issues. Individual MFCs also provide specialized treatment in other areas beyond the identified core. CVN strongly advocates the use of evidence-based and evidence-informed treatments.

It is well-known that, despite the sacrifices veterans and their families have made in service to the nation, the mental health services provided to them by the Veterans Health Administration and civilian providers are often inaccessible or inadequate to meet the critical mental health needs that have emerged in recent years. Moreover, there are many veterans and family members who don't qualify for VA care, and the VA Choice program has been unsuccessful in fully addressing the issues with access and quality.

Our CVN clinics report that 20% of veteran clients are diagnosed with PTSD and they also face challenges like depression, substance abuse, and other transition issues. Community providers like our clinics also see a large percentage of female veterans and other than honorable discharged veterans, all with low wait times.

We believe in a true holistic, evidence-based approach as the best option to care for veterans, featuring a team of clinicians, case managers, and peer veteran outreach staff. These roles play an integral part in the 12 clinics we will have in operation by the end of 2017.

As this Committee examines whether the VA's current system of health care services and benefits effectively promotes wellness and supports veterans with PTSD in seeking treatment, as well as the importance of peer support and community-based treatment programs for veterans with PTSD, it is important to recognize that community providers such as CVN are well-positioned to support the VA's goal of expanding care options for mental health, while serving veterans in the most effective, timely manner.

As you move forward with PTSD-specific initiatives-as well as your overall efforts to extend and enhance the Veterans Choice Program-we look forward to serving as a resource and true partner in these important efforts. Do not hesitate to contact me directly if we can provide you with additional information or answer any questions. Thank you.

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Material Submitted For The Record

DAVID LYNCH FOUNDATION ATTACHMENT

ABOUT THE DAVID LYNCH FOUNDATION

The David Lynch Foundation (DLF) is a 501(c)(3) nonprofit organization, founded in 2005, with a mission to reduce the epidemic of trauma and toxic stress among at-risk populations through the implementation of the evidence-based Transcendental Meditation technique. DLF has served more than 500,000 children and adults worldwide, with a focus on underserved middle and high school students, veterans suffering from post-traumatic stress and their families, and women and children dealing with domestic violence and sexual assault. DLF also works with the homeless, prison populations, people living with HIV/AIDS, and others.

WHAT IS TRANSCENDENTAL MEDITATION?

Transcendental Meditation (TM) is a simple, easily-learned, evidence-based technique, practiced for 20 minutes twice a day, sitting comfortably in a chair. During TM, the body gains a profound state of rest and relaxation while the mind is deeply settled yet wide awake and the brain functions with increased coherence. More than 350 peer-reviewed studies verify the physiological and psychological benefits of Transcendental Meditation for reducing stress and stress-related disorders, including hypertension, anxiety, depression, and insomnia, while increasing creativity, energy, intelligence, and focus.

QUIET TIME

For schools in low-income, often crime-ridden neighborhoods, traumatic stress is a daily reality for millions of children growing up in an oppressive climate of poverty, violence, and fear. This stress impedes learning and undermines physical and mental health.

- 5% of teenagers suffer from anxiety disorders.
- Suicide is the third leading cause of death among teenagers.

DLF's Quiet Time program serves thousands of students in underserved communities, fostering and sustaining positive learning environments. Built into each school's curriculum and taught to the entire school community - students, teachers, administrators, and principals - Quiet Time has been shown to increase learning readiness, positively impact grades and graduation rates, and decrease student truancy and teacher burnout. Quiet Time is in schools in New York, Chicago, Los Angeles, and San Francisco.

A sample of Quiet Time results include:

- 70% experienced reduced stress.
- 87% reduced number of suspensions over first 3 years.
- 63% felt meditation increased their focus.

"Quiet Time is the most powerful and effective program I've come across in my 40 years as a public school educator for addressing the problem of stress in education, particularly in our inner city schools." -James Dierke, Visitacion Valley Middle School Principal (San Francisco, CA)

CORE PROGRAMS

OPERATION WARRIOR WELLNESS

Post-traumatic stress among veterans has reached epidemic proportions, with serious consequences.

Veterans commit suicide at the rate of 21 per day. Many returning veterans are unable to hold jobs, support their families, and maintain positive relationships. Transcendental Meditation has proven to be an effective tool with significant results. We provide scholarships so veterans and active duty personnel can learn TM for free at TM centers and veteran service organizations nationwide. In addition to serving veterans, we instruct active duty service members as part of a DOD-funded project at the Eisenhower Army Medical Center Traumatic Brain Injury (TBI) Clinic at Fort Gordon, and at Norwich University. In a clinical trial at Fort Gordon's TBI Clinic, 83.7% of those instructed in TM stabilized, reduced, or stopped using psychotropic medication within one month of regular TM practice.

Results from a recent partnership with Wounded Warrior Project showed that:

On average individuals experienced:

- 51% reduction in trauma symptoms
- 42% reduction in depression symptoms
- 25% improvement in sleep quality

*For details see accompanying trauma research document.

"Nobody should be angry before Cheerios in the morning! TM is making me a better man, father and husband. I want to take this opportunity to say thank you to [DLF]."

-Michael, Marine Corp Veteran with deployments in Iraq

WOMEN'S HEALTH INITIATIVE

The David Lynch Foundation launched the

Women's Health Initiative in 2012 to combat toxic stress and trauma among survivors of domestic violence and sexual abuse from within the military, college campuses, and at home. The program offers Transcendental Meditation as an evidence-based therapy to help heal and empower victims of abuse. The initiative partners with a variety of organizations including New York City's Family Justice Centers.

The Women's Health Initiative empowers victims of domestic abuse by building a sense of resiliency, confidence, and self-respect, improving resistance to stress to help victims heal from within.

Key findings from the Women's Health Initiative include:

- Average of 35% reduction in anger, anxiety, depression and fatigue
- Average of 51% improvement in quality of sleep

"I am a better person to myself. I love TM and this will be a lifelong practice. Before, I felt aggression walking down the street. Now I feel calm and at peace. I no longer need antidepressants and feel so happy and I quit taking sleeping pills."

-Domestic violence survivor, age 45

NATIONAL INSTITUTES OF HEALTH-FUNDED RESEARCH ON TRANSCENDENTAL MEDITATION

The National Institutes of Health (NIH) has granted more than \$26 million over the past 20 years to study the effects of the Transcendental Meditation program on cardiovascular disease and its risk factors. The following is a summary of findings from published research.

CARDIOVASCULAR DISEASE AND RISK FACTORS

1) Decreased Risk of Heart Attack, Stroke and Death

Circulation: Cardiovascular Quality and Outcomes, 2012; 5, 750-758 (American Heart Association journal)

Two hundred and one African American men and women with coronary heart disease were randomly assigned to Transcendental Meditation (TM) or health education (HE) and followed up over an average of 5.4 years. Results indicated that the TM group showed a 48% decrease in heart attack, stroke, or all-cause mortality (primary endpoint) compared to HE. A 24% decrease in the secondary composite endpoint of cardiovascular mortality, revascularizations, and cardiovascular hospitalizations was also found in TM participants compared to HE controls. The degree of regularity of practice of the TM program was positively associated with survival. Other findings indicated a reduction of 4.9 mm Hg in systolic blood pressure and a significant decrease in anger expression in the TM group compared to HE.

Research Field Site: Medical College of Wisconsin

National Institutes of Health - National Heart, Lung and Blood Institute Grant RO1HL48107

2) Reduced Carotid Atherosclerosis in Hypertensive Patients

Stroke, 2000, 31, 568-573 (American Heart Association journal)

Sixty hypertensive subjects were randomly assigned to Transcendental Meditation or health education (HE) control groups and completed posttesting after 6 to 9 months. The TM group showed a significant decrease of 0.098 mm in intima-media-thickness (IMT), as measured by B-mode ultrasound, compared with an increase of 0.054 mm in the control group. This reduction was similar to that achieved by lipid-lowering drugs and extensive lifestyle changes.

Research Field Site: Charles R. Drew University of Medicine and Science, CA

National Heart, Lung, and Blood Institute Grants HL-51519, HL-51519-S2

3) Reduced Carotid Atherosclerosis in Older Adults

American Journal of Cardiology, 2002, 89, 952-958

Fifty-seven older adults (mean age of 74 years) were randomly assigned to either a traditional medicine multi-modality program that included Transcendental Meditation, a standard health education program, or usual care, with a twelve-month intervention period. The primary outcome was intima-media-thickness (IMT), measured by B-mode ultrasound. Results showed significantly decreased IMT in the traditional medicine group compared to the other combined groups. Reductions were most pronounced in the subgroup of participants with multiple coronary heart disease risk factors.

Research Field Site: Saint Joseph Hospital, Chicago, IL

National Institutes of Health - National Center for Complementary and Alternative Medicine Specialized Center of Research Grant P50-AT00082-01 and National Institute of Aging AG05735-3

4) Improved Functional Capacity in Heart Failure Patients

Ethnicity & Disease, 2007, 17, 72-77

Twenty-three African American patients hospitalized with congestive heart failure were randomly assigned to Transcendental Meditation (TM) or health education (HE) control groups. For the primary outcome of functional capacity, the TM group significantly improved on the six-minute walk test from baseline to six months compared to the HE group. The TM group also showed improvements in mental health, depression, and disease-specific quality of life. The TM group had fewer re-hospitalizations during the six months of follow-up.

Research Field Site: Department of Medicine University of Pennsylvania

National Center for Complementary and Alternative Medicine Grant P50-AT00082-05

5) Reduced Metabolic Syndrome

Archives of Internal Medicine, 2006, 166, 1218-1224 (American Medical Association journal)

One hundred and three coronary heart disease patients were randomly assigned to Transcendental Meditation (TM) or health education (HE) control group. Over a four-month intervention period, the TM group showed a significant improvement in blood pressure and insulin resistance components of the metabolic syndrome as well as cardiac autonomic nervous system tone compared to HE. These results suggest that TM may modulate the physiological response to stress and improve coronary heart disease risk factors.

Research Field Site: Cedars-Sinai Medical Center

National Center for Complementary and Alternative Medicine and other National Institutes of Health Grants R01 AT00226, 1-P50-AA0082-02, 1-R15-HL660242- 01, R01-HL51519-08

6) Decreased Blood Pressure in Hypertensive Patients

Hypertension, 1995, 26(5), 820-827 (American Heart Association journal)

One hundred and twenty-seven hypertensive African Americans were randomly assigned to either Transcendental Meditation (TM), Progressive Muscle Relaxation (PMR) or education control (EC) groups and completed three-month posttesting. Results showed reductions of 10.7 mm Hg in systolic blood pressure (SBP) and 6.4 mm Hg in diastolic blood pressure (DBP) in the TM group; these reductions in BP were significantly different from changes found in the other treatment groups. The BP reductions in the TM group compare favorably to the effects found with antihypertensive medication.

Research Field Site: West Oakland Health Center, CA

Supported in part by National Institutes of Health Research Grant 5R01HL-48107

7) Reductions in Blood Pressure and Use of Hypertensive Medication

American Journal of Hypertension, 2005, 18, 88-98

One hundred and fifty hypertensive African Americans randomly were randomly assigned to either Transcendental Meditation (TM), Progressive Muscle Relaxation (PMR) or health education (HE) groups and completed twelve-month posttesting. Results indicated a decrease of 5.7 mm Hg in diastolic blood pressure (DBP) in the TM group, which was significantly different from changes found in the other treatment groups. A non-significant decrease of 3.1 mm Hg in systolic blood pressure (SBP) was observed. Women TM participants exhibited a significant decrease in both DBP and SBP compared to the other treatment groups. Use of hypertensive medication was also found to significantly decrease in the TM group in comparison to the other groups.

Research Field Site: West Oakland Health Center, CA

National Heart Lung and Blood Institute Grant 1R01HL48107 and National Center for Complementary and Alternative Medicine Grant 1P50AT00082

8) Lower Mortality in Hypertensive Older Adults

American Journal of Cardiology, 2005, 95, 1060-1064

Patient data were pooled from two published randomized controlled trials on high blood pressure that compared TM to other behavioral interventions (mindfulness, progressive muscle relaxation, mental relaxation procedures, health education) and usual care. A total of 202 older adults with pre-hypertension or hypertension were followed-up for vital status and cause of death over an average of 7.6 years. Compared with combined controls, the TM group showed a 23% decrease in all-cause mortality, the study's primary outcome. Secondary analyses showed a 30% decrease in the rate of cardiovascular mortality and a 51% decrease in the rate of mortality due to cancer in the TM group compared with combined controls.

Research Field Sites: The two published studies were originally conducted at the West Oakland Health Center, CA and Harvard University, MA.

Supported in part by National Center for Complementary and Alternative Medicine Grant 1P50AT00082

REACTIVITY TO PAIN

9) Lower Brain Reactivity to Pain

Neuroreport. 2006 August 21; 17(12): 1359-1363

Long-term practitioners of the Transcendental Meditation technique showed lower reactivity to thermally induced pain, as measured by functional magnetic resonance imaging (fMRI), compared to healthy matched controls. After the controls learned the technique and practiced it for 5 months, their response decreased by 40-50% in the total brain, thalamus, and prefrontal cortex, and to lesser extent in the anterior cingulate cortex. The results suggest that the Transcendental Meditation technique reduces the affective/ motivational dimension of the brain's response to pain.

Research Field Site: University of California at Irvine

National Center for Complementary and Alternative Medicine Grant P50-AT00082-05

BREAST CANCER

10) Improved Quality of Life in Breast Cancer Patients

Integrative Cancer Therapies, 2009, 8(3) 228-234

One hundred and thirty women were randomly assigned to either the Transcendental Meditation (TM) or education control (EC) group. Measures were administered every six months over an average 18-month intervention period. Significant improvements were found in the Transcendental Meditation group compared with controls in overall quality of life, especially emotional wellbeing, social wellbeing, and mental health.

Research Field Site: St Joseph's Hospital, Chicago

Supported in part by National Center for Complementary and Alternative Medicine Grant 1K01AT004415-01

GENE EXPRESSION

11) Increased Telomerase Gene Expression

PLOS/ONE 10(11): e0142689. doi:10.1371

Forty-eight African American men and women with stage I hypertension, who participated in a larger parent randomized controlled trial, volunteered for this sub-study. These subjects participated in Transcendental Meditation plus a basic health education or an extensive health education program. Both groups exhibited significant improvement in telomerase gene expression (hTERT and hTR) over a 16-week period. Reductions in blood pressure were also observed. These findings have implications for improving longevity and may provide a mechanism by which stress reduction and lifestyle modification reduce BP.

Research Field Site: Howard University Medical Center, Washington, DC

National Heart Lung and Blood Institute Grant HL083944

COLLEGE STUDENTS

12) Decreased Blood Pressure and Mood Disturbance and Improved Coping Ability

American Journal of Hypertension, 2009, 22 (12): 1326-1331

Two hundred and ninety-eight college students were randomly assigned to either the Transcendental Meditation (TM) program or wait-list control, with a three-month intervention period. Results showed significant improvements in total mood disturbance, positive coping, and anxiety, depression, anger/hostility. Significant re-

ductions in both resting systolic and diastolic blood pressure were also observed in the high-risk hypertension subgroup.

Research Field Site: American University

Supported in part by National Center for Complementary and Alternative Medicine Grant 1P50AT00082

13) Reduced Ambulatory Blood Pressure

International Journal of Neuroscience, 1997, 89, 15-28

Twenty-six mostly normotensive subjects randomly assigned to either Transcendental Meditation (TM) or health education (HE) groups, who completed baseline and posttesting on ambulatory blood pressure (ABP), were included in final analyses. Results indicated significant reductions in diastolic blood pressure in the high compliance TM group compared to controls over a four-month intervention period. No significant change was observed in cardiovascular reactivity assessment.

Research Field Site: University of Iowa Hospitals and Clinics

Supported in part by National Institutes of Health Grants 1R15HL40495 01A1, RR59

SCHOOL STUDENTS

14) Reduced Negative School Behaviors

Health and Quality of Life Outcomes, 2003, 1:10

Forty-five African American adolescents were randomly assigned to either Transcendental Meditation (TM) or health education (HE) control groups, with a four-month intervention period. Results showed significant reductions in absenteeism, rule infractions, and suspensions in the TM group compared to controls.

Research Field Site: Medical College of Georgia

Supported in part by National Institutes of Health Grant HL62976

15) Improved Cardiovascular Functioning at Rest and in Reaction to Stressors in Adolescents At-Risk for Hypertension

Journal of Psychosomatic Research, 2001, 51, 597-605

Thirty-five adolescents with resting blood pressure between the 85th and 95th percentile for their age and gender were randomly assigned to either Transcendental Meditation (TM) or health education (HE) control groups, with a two-month intervention period. The TM group exhibited a significant decrease in resting systolic blood pressure (SBP) compared to controls. Greater decreases in blood pressure, heart rate, and cardiac output reactivity to stressors were further observed.

Research Field Site: Georgia Health Sciences University

Supported in part by National Institutes of Grant HL62976

16) Reduced Left-Ventricular Mass Index and Maintained Body-Mass Index

Evidence-Based Complementary and Alternative Medicine, 2012, doi:10.1155/2012/923153

Sixty-two African American adolescents with high normal systolic blood pressure were randomly assigned to either Transcendental Meditation (TM) or health education (HE) groups. The study included a 4-month intervention period plus 4-month follow-up. Results showed a significant decrease in left-ventricular mass index (LVMI) after four months, which was maintained at 4-month follow-up. TM adolescents also exhibited less of an increase in body mass index (BMI) compared to controls at 4-month follow-up.

Research Field Site: Georgia Health Sciences University

Supported in part by National Heart Lung and Blood Institute Grant HL62976, HL05662

APPENDIX

1) American Heart Association Scientific Statement on Blood Pressure Reduction

Based on the above NIH-funded research on Transcendental Meditation and blood pressure reduction as well as other published studies, the American Heart Association, in its systematic review entitled "Beyond medications and diet: Alternative approaches to lower blood pressure: A scientific statement from the American Heart Association" conferred a "Class IIB Level of Evidence B recommendation in regard to BP-lowering efficacy. TM may be considered in clinical practice to lower BP. Because of many negative studies or mixed results and a paucity of available trials, all other meditation techniques (including MBSR) received a Class III, no benefit, Level of Evidence C recommendation." (Hypertension, 2013, 61, 1- 24, doi 10.1161/HYP.0b013e318293645f)

2) Department of Defense-funded Comparative Effectiveness Trial Comparing Transcendental Meditation to Prolonged Exposure and Health Education (in progress)

This is a randomized controlled trial with 203 veterans with documented posttraumatic stress disorder (PTSD) randomly assigned to Transcendental Meditation (TM), Cognitive Behavior Therapy-Prolonged Exposure (PE) or health education (HE) control groups, with a three-month intervention period. Outcomes include trauma severity as measured by Clinician Administered PTSD Scale (CAPS), PTSD Checklist-Military Version (PCL-M), and Patient Health Questionnaire (PHQ)-9 depression scale. Study hypotheses include: 1) non-inferiority: relative to PE the effects of TM will be comparable to PE on the primary CAPS outcome and secondary psychological outcomes; and 2) standard comparison: TM and PE both will show significant improvement on the primary and secondary psychological outcomes of the study compared to HE. The project is currently in its final phase of data analysis and write-up. (Study protocol is published in *Contemporary Clinical Trials*, 2014, 1-7, doi.org/10.1016/j.cct.2014.07.00) Research Field Site: San Diego VA
Department of Defense Grants W81XWH-12-1-0576, W81XWH-12-1-0577

research and evaluation on the effects of transcendental meditation on trauma and post-traumatic stress

Impact of Transcendental Meditation on Psychotropic Medication Use Among Active Duty Military Service Members With Anxiety and PTSD¹

This study included 74 active-duty service members with PTSD or anxiety disorder. Half the service members voluntarily practiced Transcendental Meditation regularly in addition to other therapies; half did not. In just one month after learning the TM technique, there was a significant reduction in psychotropic medication usage among the TM group:

- TM meditators: 83.7% stabilized, reduced or stopped using medication. 10.9% increased.
- Non-meditators: 59.4% stabilized, reduced or stopped using medication. 40.5% increased.

Meditation Programs for Veterans With Posttraumatic Stress Disorder: Aggregate Findings From a Multi-Site Evaluation²

This meta-analysis looked at several sites, one of which, the Michigan VA Hospital, implemented a randomized controlled trial of TM. All participants in the study were receiving mental health services. A total of 19 veterans learned TM with 24 treatment-as-usual controls. Trauma symptom severity significantly decreased in the TM group compared to controls. The TM group had a 36% reduction in PTSD assessment scores compared to an 18% reduction for the control group who received the standard VA therapy.

Reduced Trauma Symptoms and Perceived Stress in Male Prison Inmates through the Transcendental Meditation Program: A Randomized Controlled Trial³

This randomized controlled trial of 181 male prison inmates in Oregon found significant reductions in total trauma symptoms, anxiety, depression, dissociation, and sleep disturbance subscales, and perceived stress in the TM group compared with controls. The TM group had a 47% reduction in PTSD assessment scores compared to a 12% reduction for the control group.

Transcendental Meditation and Reduced Trauma Symptoms in Female Inmates: A Randomized Controlled Study⁴

This randomized controlled trial of 22 female prison inmates in Oregon found a significant effect of TM on total trauma symptoms with significant effects on intrusions and hyperarousal subscales. The TM group had a 45% reduction in PTSD assessment scores compared to a 22% reduction for the control group.

DLF Internal Evaluation of Veteran Outcomes⁵

In 2016, the David Lynch Foundation received pre-surveys from 233 veterans or active duty military personnel instructed in TM. Of those individuals, 77% completed at least one post-instruction survey (at 1, 3, or 6 months). Individuals experienced a 51% reduction in trauma symptoms, a 42% reduction in depression, and 25% improvement in sleep quality.

- Trauma: Before learning TM, 65% of individuals had PCL scores consistent with a provisional PTSD diagnosis. Of those who completed the 1-month post-test, approximately 70% were no longer in that range.
- Depression: Before learning TM, 88% of individuals had CES-D scores that put them at risk of clinical depression. Of those who completed the 1-month post-test, approximately 40% no longer scored at risk.

Department of Defense \$2.4 million PTSD Study at the San Diego VA

In this randomized controlled trial of 203 veterans with documented PTSD, participants were randomly assigned to one of three treatment groups:

1. Transcendental Meditation
2. Prolonged Exposure (PE) (the gold standard treatment for PTSD)
3. Health education control group

The treatment phase of this study has been completed. One of the researchers is planning to present the results at a scientific conference soon. We are optimistic about the results.

1 *Mil Med.* 2016 Jan;181(1):56-63. doi: 10.7205/MILMED-D-14-00333.

2 *Psychol Trauma.* 2016 May;8(3):365-74. doi: 10.1037/tra0000106. Epub 2016 Jan 11. This was measured by the Clinically Administered PTSD Scale, the gold standard for PTSD diagnosis. The scale ranges from 0-80. The TM group averaged a score of 73.5 before instruction (margin of error = 6.22.) The control group averaged 74.1 (margin of error = 4.92)

3 *Perm J.* 2016 Fall;20(4):43-47. doi: 10.7812/TPP/16-007. Epub 2016 Oct 7. This was measured by the Trauma Symptoms Checklist, which evaluates symptomatology in adults associated with childhood or adult traumatic experiences. In the prison studies, we used a modified version for the prison population which ranges from 0 to 90 in total score. The TM group averaged a score of 23.68 before instruction (margin of error = 13.11.) The control group averaged 30.12 (margin of error = 16.1.)

4 *Perm J.* 2017;21. doi: 10.7812/TPP/16-008. Epub 2017 Jan 17. This was measured by the civilian version of the PCL, an assessment used by the VA to screen for PTSD. PCL-C scores range from 17-85. The TM group averaged a score of 53 before instruction (margin of error 17.35.) The control group averaged 52.4 (margin of error 13.05.)

5 Trauma was measured using the PCL-5, which has a score that can range from 0-80 with a cut-point of 33. The group averaged a score of 39.3 before instruction. Depression was measured using the CES-D, which has a score that can range from 0-60 with a cut-point of 16. The group averaged a score of 26.8 before instruction. Sleep quality was measured using MOS Sleep Scale, which has a score that can range from 10-60. The group averaged a score of 34.2 before instruction.

