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Chairman Murray, Ranking Member Burr, and Members of the Committee, thank you for the honor of addressing the Senate Committee on Veterans' Affairs. I served on active duty for 20 years as an internist and psychiatrist. My experiences have included deployment to the war zone, treating service members and their families at Walter Reed, and directing research to improve post-deployment mental health care. I also wrote a book for veterans and their families titled *Once a Warrior—Always a Warrior: Navigating the Transition from Combat to Home*, which Max Cleland described as “the guide to surviving the war back here.”

Ensuring that veterans have access to quality mental health treatment is a high priority. Of veterans who experienced direct combat in Afghanistan or Iraq, an estimated 10-20% struggle with PTSD, similar to rates after Vietnam. Depression, alcohol/substance abuse, suicidal behaviors, and other mental health concerns are also prevalent. In addition, large numbers of veterans experience readjustment challenges of a less severe nature (sometimes this is referred to as “PTS”). These problems can affect the veteran's spouse, children, and other family members, and can impact the ability to find meaningful work and enjoy life.

Access to care has been defined in various ways, and it is helpful to distinguish between an organization's ability to provide medical services, and the many barriers to care and recovery experienced by individuals in need of these services. In other words, even when an organization makes care accessible in the form of readily available appointments with qualified personnel and short wait times, this does not mean that individuals will be able to utilize these services or that the quality of care will be adequate to achieve recovery. My interest has increasingly been focused on the veteran's perspective and the many barriers veterans encounter navigating the transition home from the combat environment.

Mental health treatments have improved dramatically over the last two decades, and there are many more resources now that were not available to veterans of previous conflicts. Studies have shown that treatment for PTSD can be 70-80% effective, as long as individuals are able to access the care and continue with treatment long enough for it to be effective.

Unfortunately, the marked improvements in evidence-based treatments have been offset by continued gaps in access and other barriers to recovery. Despite extensive stigma-reduction efforts over 10 years of war, it is estimated that only approximately half of service members and veterans in need of mental health treatment seek these services out; of those who do begin treatment, many receive less than optimal care or leave before achieving recovery. The actual effectiveness of PTSD treatment is estimated to be closer to 40%, not 70-80%, because of high rates of withdrawing from care.

Stigma, negative perceptions of mental health care, and other barriers influence whether a veteran will initially access or continue to utilize services. Stigma is pervasive in society, not just in the military, and involves concerns of how others might view the veteran who seeks mental health care. Negative perceptions include lack of trust or confidence in mental health professionals, or considering mental health treatment ineffective, unhealthy, or a “last resort.” Other barriers include difficulty obtaining appointments, lack of availability of the same provider over time, poor coordination of care, distance from the treatment facility, transportation costs, or work or child care responsibilities that interfere with appointments.

The question is, how do we meet veterans where they are, and foster a climate that minimizes the many barriers they face to recovery? Here is a partial list of considerations grouped into broad categories:

Appointment Access

Appointments for veterans (initial and follow-up) need to be readily available at convenient times and locations, with options to assist veterans with evening or weekend appointments to minimize interference with work. This includes addressing any specific barriers that impede getting to appointments (e.g., transportation availability and costs). Outreach is essential to ensure that veterans are aware of available resources.

Stigma and Willingness to Seek Care

More research is needed to better understand and guide interventions to improve willingness to seek care when needed. There are numerous potential opportunities to affect change in this area, and I will comment on two that I have been particularly interested in: a) fostering greater understanding of PTSD from the warrior’s perspective to reduce stigmatizing attitudes, and b) veteran peer-to-peer initiatives to enhance transition and readjustment.

Considering PTSD from the warrior’s perspective within the military occupational context, rather than always from a medical perspective, is an important normalizing step for everyone (veterans, family members, health care professionals, and society at large). Warriors are professionals trained to work in some of the most inhospitable environments and they respond to combat events according to their training as part of cohesive teams. This is similar to other first responders (e.g., police, firefighters), and very different than the experiences of civilian victims of trauma. There is a paradox that responses that sometimes interfere with functioning back home (and may be labeled “symptoms”) can also be beneficial in the military occupational context, reinforced through rigorous training and deployment. For example, “hypervigilance” can equate to sharply tuned threat perception in combat. Anger and numbing of emotions can stem from skills the warrior developed in channeling anger and controlling other emotions to focus on accomplishing combat missions. These responses have a physiological basis. They are not “psychological” or “emotional” per se.

I think there is also a critical role for veteran peer-to-peer counseling, mentoring, readjustment, and outreach efforts, partnered with traditional mental health services, since many veterans report feeling much more comfortable talking with peers about their war-related concerns than

with others.

Negative Perceptions of Mental Health Care and Willingness to Continue with Treatment

No matter how good evidence-based treatments may be, they will not be effective if offered in ways that drive veterans away. Mental health care needs a makeover to correct negative perceptions which appear to be pervasive. Research is needed to better understand veterans' perceptions of their health care experiences, with feedback to ensure the health care system is responsive. Veterans frequently report dissatisfaction with care, and disconnect between their experiences as warriors and situations they encounter when they access the medical system. This can take many forms, such as: "I'm tired of answering the same questions over and over to different providers." "The doctor kept looking at the computer screen." "I felt misunderstood and judged." "The doctor only offered medications." "The doctor told me she understands what I went through, but never deployed." "The doctor said there were only two talk therapy options for PTSD supported by the VA, neither of which I want." "The doctor told me that I have to think differently about something that happened in combat that I don't want to see differently."

When a veteran takes the difficult step to overcome obstacles and seek mental health care, they are looking for a professional who is accessible, caring, competent, non-judgmental, and attentive to their concerns. Patient-centered care is important. Veterans should be provided with as wide a range of evidence-based treatment options as possible, and actively participate in selecting those they are most comfortable with.

Clinicians must know how to tailor the core components of evidence-based treatments to individual patient preferences. For example, in PTSD treatment, narration is one of the most therapeutic components, and research indicates that narration can be conducted in many different ways, including oral (past or present tense), written, as part of a life narrative review, or combined with specific eye-movements (as is done in a therapy called Eye Movement Desensitization and Reprocessing or EMDR). Clinicians must also have sensitivity and knowledge in attending to difficult military-specific topics, such as grief, survivor's guilt, ethical dilemmas from combat, and other unique transition and readjustment concerns. The bottom line is that one size does not fit all, and policies aimed at standardizing care across health care systems must not lose sight of this.

Structure and Coordination of Health Care

I am encouraged by efforts in both the DoD and VA to enhance mental health treatment in primary care, and build collaborative patient-centered systems within primary care that address all deployment health concerns. However, more research, particularly clinical trials, is needed in this area.

Health care should be structured with an understanding of PTSD as a physical condition that affects physical, cognitive, psychological, and emotional functioning, and co-exists with other health concerns. There is an unrealistic expectation that the physiological effects of combat can quickly reset upon return home, which is not how the body functions. The extreme physical stress of combat, sleep deprivation, injuries (including concussions/mild TBIs) and PTSD can all interact to affect health, including the functioning of the endocrine and autonomic nervous systems (the part of the nervous system that controls heart rate, breathing, digestion, and other

automatic or reflexive functions). Veterans with PTSD have significantly higher rates of physical health problems compared with veterans without PTSD, including chronic pain, headaches, sleep problems, concentration/memory problems, fatigue, cardiovascular problems, hypertension, and other concerns. Several of these problems are also linked to “self-medication” with alcohol or other substances.

This means that PTSD (and other war-related health concerns) cannot be treated in isolation or strictly within specialty clinics. Treatment needs to attend to all post-war health effects holistically, with careful coordination of services through primary care to avoid problems, such as adverse interactions between medications prescribed by different providers.

I believe there is also a role for complementary and alternative medicine modalities to help, for example, with modulating physiological reactivity, improving sleep, and assisting with pain control. Program evaluation and research is needed in all these areas.

Support for Families

Lastly, more attention needs to be given to supporting spouses, partners, and other family members who are the most important and healing connections that veterans have. Family members should be actively involved in the treatment process. Sometimes the most effective intervention the medical system can provide to veterans is to simply support and strengthen their connections with others.

Once again, I thank you for inviting me to share my perspective and for your attention to the critical topic of access to care, and I look forward to your questions.