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P R O C E E D I N G S

MR. O'HANLON: Good morning everyone. I'm Michael O'Hanlon with the Brookings Institution, and we are pleased today to welcome you to an event that we are putting together with the Wounded Warrior Project, the state of America's veterans, and Wounded Warriors, and what can and still be done to take better care of them as a country.

We originally conceived the idea for this event when thinking about where we would be in the political cycle. And recognizing that while this year's election process is highly charged, and in many ways, rancorous, nonetheless, the reason we have elections in the United States is to bring big issues before the country, and hope that candidates will explain what they want to do to improve the situation facing the country and it's many, many citizens.

In this case, of course, with more than 20 million American veterans, not all of them wounded, and from many previous conflicts, but a large number of Americans fitting this bill, and also with tens of thousands actually been having been wounded in the wars of Iraq and Afghanistan, and the broader conflicts of the 21st century, there is a real responsibility to continue to bring these kinds of issues before the voters, and before candidates, to remind them of the importance, and ask them how they would address those needs that we have not yet figured out how to best address for our Wounded Warrior and veterans' populations.

So, with me today is Michael Richardson who had a long, distinguished military career before joining the Wounded Warrior project, and specializes there in mental health, which, by the way, will be one of our, or if perhaps not even our preeminent concern in today's discussion, although we don't intend to limit ourselves just to that topic.

We also have Brian Dempsey who is an attorney who has advocated for many individual Wounded Warriors and families over the years, and now works as well with the Wounded Warrior project.

And then Kayla Williams who is a well-known author and Army veteran herself, wrote a fantastic book, "Love My Rifle More Than You: Being Young and Female in the U.S. Army," and is now at the Center for A New American Security where she specializes in their military families' and veterans' work and projects, and joins us today with personal and well as professional interest in the topic at hand. We may also have a quick intervention by another colleague of mine, Elaine Kamarck.

But in any event, after my questions for the panelists, we will go to you through our email function, events@brookings.edu. And the questions that you're able to provide there, or through our Twitter hashtag, will get to me through a chat or a text and I'll be able to pose those to the panelists in the second half of today's hour long discussion. (audio drop).

MS. WILLIAMS: I think since he did warn us that --

MR. O'HANLON: There are issues --

MS. WILLIAMS: There we go.

MR. O'HANLON: Around the country, let me again thank everyone who contributes in important ways, and now post my first question to the panelists.

I know my internet may be acting up a bit so let me just get my question on the table and ask them to go in order -- Michael, Brian, and then Kayla.

And the question is really a big picture question of, how do we assess the overall state of how well we're doing of taking care of Wounded Warriors and military families, and veterans in the United States today?

Where have we made progress, but where do we still have work left to do? And Michael, over to you please.

MR. RICHARDSON: Yeah, again, Michael, and the Brookings Institute, I really appreciate to have this dialogue, and being joined by my colleagues Brian and Kayla, and I think today is going to be a great opportunity for a great dialogue as we look into the veterans' issues, which are a portion of the greater population of the United States and the issues that we're facing.

What I'd like to start with, though, is sometimes we have to put down the statistics and the data, and just have a conversation, especially to truly address the mental health and other issues that are facing our veterans and others, because there are a lot of stats out there that you can get lost in. It's very important to set the baseline to start the discussion.

What I'm starting to find is the ability to really have a human interaction conversation to really -- you hear the term, change the narrative, because what we're facing, specific to your point, we've come a long way but we have so much further to go in the plethora of issues that are facing our veterans and their families, and their other loved ones, as well.

And it really is a massive problem, and it requires an audacious solution, and we can't keep doing the same thing over and over again and expecting different results in just talking about it. I think it really has to be action.

I think Einstein defined that as insanity, and so, there's been a lot of work around the margins which have started to get at some of the issues that we'll talk about.

What we need to do is really take a public health approach to those issues that are facing our veterans, because not all veterans are the same.

We have 90-year-old veterans and we have 18-year-old veterans. The issues that each of them are dealing with in the whole spectrum are different. And so, it's not going to take one solution fits all.

So, what I would propose what we do is really look at a public health approach in a clinical, nonclinical, peer-to-peer support, places of worship, your gym, where every (inaudible) soaks (phonetic) and comfort and support, that in order to get in front of the issues that are facing our veterans -- be that employment, psychological wellbeing, resilience -- can all gear towards really living a life with real sense of purpose and mission so that -- you know, sadly our veterans and others take off this suicide suggestion as that as the solution, as not part of the solution.

So, what we need to do, again, is changing the narrative -- what I mentioned earlier.

And oftentimes what we find are -- what frustrates me, especially in the middle of mental and brain health space in which I've been working for a number of years now -- is that those professionals within that space, and also good intentioned other individuals not in that space -- also, are often more interested in comparing specific treatment types or delivery tactics to one another, as opposed to providing a more comprehensive and holistic approach to treatment and engagement.

So, for instance, is group therapy better than individual therapy, is beekeeping and meditation better than empirically supported evidence-based treatment therapies, and clinical interventions.

And it's not one or the other, it's the combination of it all. And if we really want to get out there, it's going to take an innovative approach, not what we've been doing on the margins, as I've mentioned in the past. I'll end this with, too, is hopefully we'll get some additional questions, while these

two positions may not be that sexy, they will absolutely transformative.

What we've learned in COVID as a result of this is the telehealth opportunity. Cross state licensures are a real barrier to care; barrier to access, barrier to quality, cultural competence to where we send Warriors from all over the country to one of our four active medical centers that we've partnered with, with our Warrior Care Network, Massachusetts General Hospital, Emery University, Rush University, and UCLA health, from all over the country, and when they go back home to Fargo, North Dakota, they can't continue that care because of antiquated licensure laws.

The other one that I point out is reimbursement. Now, that is not sexy but if we can start to look at regulation and policy change in the reimbursement for mental health, where right now it's pennies on the dollar from what it really costs to deliver that high-quality care.

Prime example, in the intensive operation program you get five hours of therapy a day -- some of it may be group, some of it may be individual -- you can only bill for one in most cases. That's archaic, that is old school of thought.

We need to really start to think about how can we change both licensure regulation in policy, and while policy is great, sometimes policy takes a long time to get enacted, but it also is the catalyst to change.

And so, I'm really interested to the discussion that we'll have today with our colleagues. So, thanks, Mike.

MR. O'HANLON: Thank you, Michael. And Brian, over to you.

MR. DEMPSEY: Thank you, sir. And thank you for everyone who's viewing the webcast today.

As a director of government relations for the Wounded Warrior Project, I can't look at this question without wearing a policy hat and say that heading into 2020 we really entered with a lot of momentum.

At the end of 2019, at about November, the House of Representatives passed the Deborah Sampson Act with just under 400 votes because we were addressing the question of what could we do to better serve the fastest growing and most diverse cohort of veterans in the country.

So, under the leadership of Congresswoman Brownley, the House has been using its

Women Veterans Task Force to really address those issues head on and come up with actionable policy solutions.

And then also as we entered 2020, we saw the Senate pass the Commander John Scott Hanon Veterans Mental Health Improvement act which, you know, really addressed the question that's on a lot of minds of people paying attention to veterans' policy, which is, how could we connect more veterans with better quality care in a timely manner.

And that's another bill, too, where, heading into the rest of the year, you've got half of the Senate chamber that stands in support of that bill.

And I'm also looking forward to the unveiling of the President's Prevents Task Force roadmap about how we're going to address veterans' suicide in a coordinated national scale level.

And of course, all of this is coming on the heels of some really eventful policy reforms over the last few years.

Specifically, I look to the VA MISSION Act of 2018, which really consolidated and improved the way that VA uses the non-VA clinical providers to expand their ability to meet the capacity to deliver care to veterans. And then also expanding the caregiver program to veterans who serves before 9/11. For the last several years it has been only just for post 9/11, so how do we get that right so that more deserving veterans can take advantage of that program, and their caregivers, as well.

Of course, just like many sectors in policy in economy, we had to take a -- not a hard stop, but really, adjust our expectations and priorities with the spread of coronavirus.

So, on the health side, it's how do we make sure that veterans are still getting the care they need, but in a safe manner. And then also, on the benefits side, how do we continue the process of applying for disability claims and making sure that those appeals are processed in a timely manner.

So, it's an interesting year thus far, and one where I think there's still a lot of momentum to get things done as we head into the summer and fall.

MR. O'HANLON: Thank you, Brian. And, Kayla, over to you for the same question, please. Just to take stock of how you see the overall challenge facing the country today in regard to what you work on there at CNAS with military veterans and society.

MS. WILLIAMS: Sure, and thanks so much for having me, it's a pleasure to be part of

this discussion.

Pulling back and looking at the past, say, 15 years or so, I've seen tremendous improvement in the state of how we're able to provide care for service members, veterans, and their families. The transition process is significantly improved.

We've seen tremendous improvements in public/private coordination so that there is a better relationship now between organizations like VA, and organizations like Wounded Warrior Project, to be able to get folks where they need to be to get the care (audio drop) like licensure across state lines.

One of the challenges that's looming in the future is that we just have too few providers. Fifty percent of counties don't have a single mental health practitioner. And so, if we want to be able to get care to veterans everywhere, we have to find more innovative ways to do it.

And this coronavirus is, as Brian mentioned, really forcing some more forward leaning behaviors in making sure that we bridge some of those gaps.

I think we also need to continue to think about and acknowledge the ways in which some groups may be disproportionately affected by challenges compared to others. And just as we need to take a public health approach, we need to really understand the extent to which some of the social determinates of health can come into play here.

So, when we have folks who are dealing with other challenges in various aspects of their lives, it's going to affect their mental health, it's going to affect their physical health; so, we have to bear in mind that some groups are being affected more strongly than others by economic crises, by the problems and challenges of systematic racism, and other problems that affect groups in our country.

Veterans come back to our communities and are affected by the same challenges that others are. Thanks.

MR. O'HANLON: Thank you very much for that framing, to all three of you.

And let me now, maybe in reverse order - so, we'll stay with you Kayla -- while you've got the microphone, so to speak, and ask about some of the next steps that you would consider to be most important at this juncture.

And you sort of hinted at, at least one, which was, I think, allowing providers to essentially provide services remotely. Or, if they relocate geographically, to be able to more quickly relicense in a

new jurisdiction, if I understand you correctly.

But maybe you could start with that and suggest any other policy reforms or initiatives that you think would be particularly salient and helpful at this juncture. Thanks, and over to you.

MS. WILLIAMS: Sure, thank you. And I'll let Michael dig into that a little bit more deeply, if he has very specific understandings about that.

But I'll say one of the things I think is really important, is that we make a very structured effort to tackle disparities.

So, we know that at the Department of Veterans' Affairs there are some policies that are explicitly discriminatory against women, against LGBT individuals. So, eliminating those policy barriers, I think, is incredibly important.

And then also, it's tremendously urgent that we go beyond just those policy and systemic barriers, and also get at some of the more nuanced and harder to address cultural problems.

So, one in four women that goes to VA for healthcare experiences sexual harassment by male patients in a healthcare setting. This is going to be a tough challenge to overcome and one that we need our male allies to step up and help us address. But we're not going to be able to provide truly equitable care in a situation where that is going on.

I think it's also important that we, when we're thinking about these policy solutions and how are we going to handle them into the future, that we rethink how we calculate the cost of war.

So, it's just within the past couple of weeks that the last person drawing a pension due to her parent's civil war service passed on and died. So, when we think about how expense our todays' wars is going to be, that's the tail of the cost that we have to consider.

So, before we go to war, we have to make a real accounting for what the cost is going to be and how we're going to pay for it. And in my opinion, the current system of just passing the cost on to our children and grandchildren is not adequate, and we have to think about, in very real terms, how can we pay for the cost of the wars that we're in, and the tail cost of those wars that our veterans and their families will be bearing for many, many years to come.

MR. O'HANLON: If I could just pick up on that myself, and I'm going to have one follow-up for you before going to Brian and Michael, but I want to give a shout out to the Watson Center at

Brown University, which I think has been a real leader in doing exactly what you said, in trying to calculate the long-term inevitable cost of veterans' care as part of war costs.

Some of the methodologies that the Watson Center uses in their reports are debatable and require a certain amount of interpretation. You know, what would have happened to oil prices if we hadn't invaded Iraq? Things like that.

But in terms of the demographics of what we know is going to be a certain sized veterans population going forward, we don't know exactly what healthcare will be available, but we know how much it costs today, we have some sense of knowing how fast it tends to grow in cost per year -- at least in the past, and can project that into the future.

And as you say, when you bring in these costs you often are adding hundreds of billions of dollars at a minimum to each of the two conflicts -- Iraq and Afghanistan -- which is otherwise each estimated at roughly a trillion dollars in costs, but when you bring in the longer term veterans' care, you're looking at hundreds of billions of dollars additional costs; at least another 50%, so I'm glad you brought that up.

But I also wanted to see, Kayla, if you wanted to make any remarks, or at least any brief references, to employment opportunities for wounded warriors and veterans. Also, to the way in which we help families, including spouses, including children.

I know some benefits are transferable, but there may or may not be psychological and counseling services, there may not be compensation in all cases when a spouse leaves a job to go care for a wounded spouse from military service.

So, I was just hoping for a little bit of reflection on sort of the broad question of employment, and where we stand with that in the veterans' population as well, if you have a word to add there.

MS. WILLIAMS: Sure, absolutely. And I'll first mention that in addition to the cost of war injuries, both physical and psychological, the cost of toxic exposure is another area that I think we're not nearly accounting for enough.

Also, the cleanup that is going to have to happen at military installations domestically.

So, these huge looming costs that we have just not accounted for, and we have to figure

out a way to manage that for the health of our communities all over the country. And I know the Wounded Warrior Project as actually been doing some great work on toxic exposures, as well.

When it comes to employment, I think if you had asked me this question six months ago, I would have had a very different answer (laughter), because veteran unemployment had gotten to be so low -- nationwide unemployment was so low, veteran unemployment was even lower than the national average -- so, things were really looking very good.

There had been intense partnerships between the public, private, and nonprofit sectors that were paying tremendous dividends, and I was arguing in every session like this that it's time to focus on things like retention and job satisfaction, and not so much just pure employment, with the exception of military spouses, who's unemployment at that point was already, DOD estimated, at 26%, and underemployment a significant problem in that population, as well.

However, now that coronavirus has hit, it is an entirely different situation for everyone. The early data that I've seen from the Department of Labor, I think showed that for veterans overall, we hadn't been quite as hard-hit, though some sub-populations still hit harder than others.

But right now, I just feel like it would almost be unconscionable of me to focus too much on veteran unemployment when we have unemployment at the national level just at such tremendous levels, because of this absolute crisis.

And so, resolving this is going to be something that takes work far outside of our community and really is beyond our problem, but it's really a national problem.

MR. O'HANLON: Thank you, and well said. Brian Dempsey, over to you, please, with again, the most pressing and important policy agenda -- the forward-looking agenda -- that you would want to advocate and ask candidates to think about advocating; over to you.

MR. DEMPSEY: Of course, thank you Michael. And I think I'll pick up right where Kayla left off. I mean, it's hard to take ourselves out of the current landscape that we have in front of us with coronavirus, so, not look at the impact that is having and what policy decisions we're making moving forward.

So, what I would really focus on -- and, actually, three things I think have been underscored by current events.

Number one is telemedicine. We've seen a dramatic surge in use through the VA system. You know, they were averaging about 20,000 appointments per month before coronavirus, now it's up to 20,000.

Of course, VA has some very favorable telehealth rules. But one of the stark realities we've got to face is that roughly only a third of veterans are enrolled in the VA system and using it.

So what are the strengths of that system that VA has built up that perhaps can be replicated in the private system to ultimately reach more Americans, because I think Mike and Kayla have both mentioned, a lot of veterans issues are American issues. So, how do we improve health through telemedicine.

Another one that I think has been really underscored, is really looking at VA as continuing its leadership in the field of PTSD treatment.

And I want to focus there on precision medicine, and biomarker research, and how can we create more targeted therapies through that. And in fact, VA has been moving forward over the last couple of years with some reforms that are making it a much more attractive place for clinical researchers to get involved.

And I think a couple of things that the coronavirus has sort of brought to light, number one, the amount of trauma that frontline health workers are facing in treating this disease. And then in addition to that, just the fact that VA has been highly involved in clinical trials for coronavirus therapies.

So, you know, how can we leverage the largest integrated health system in America to be a leader in certain components of healthcare. And, of course, in the veterans' context, looking at the mental health challenges that so many veterans are facing, it really makes sense to focus in on there.

And lastly, I'd really focus on something that has become part of the discussion in mental health as we pivot towards a public health approach, you know, fresh off of the MISSION Act, and how VA has been leveraging the clinical landscape to better serve veterans, is really looking at how can we use the nonclinical support structures across the country through nonprofits, state and local governments, to really reach more veterans in the communities where they live, and really focus on upstream interventions that can prevent crisis before it happens.

There's been, I think, a lot of stress on nonprofit organizations, just like many other parts

of the economy, to really keep their lights on. And a lot of that even dates back to a lot of tax reforms recently, and legislation that is popular in Congress right now is looking to expand those partnerships through VA -- not to be a lifeline to those organizations, but to recognize that there is so much more than clinical intervention that can be done to support veterans and their mental health.

So, those are three areas that I would urge people to focus on.

MR. O'HANLON: That's excellent. Can I just clarify one thing before going to Michael, and Kayla, you may want to comment on this too?

If I understand the sum total of what you both said correctly, it sounds like in terms of available benefits, we have made a lot of progress and things are pretty good. But, there may not always be adequate access, especially in certain parts of the country.

There may not be sufficiently rapid access for people who are in crisis and we want to get to them as soon as we can. And that may mean broadening the network beyond Wounded Warrior Project and the Veterans' Affairs Department, and trying to enlist people who don't work for those kinds of organizations, but are still mental healthcare professionals and may be closer to a veteran or a Wounded Warrior in a given part of the country.

And also, to the extent we need benefits themselves to expand we need to actually access those, or make it possible to access those for toxic exposure, which Kayla, if I understood you correctly, right now the available benefits may not be adequate and may not always be quickly available through a sort of veterans benefit, because there's still contention about whether and how to qualify for those sorts of benefits, and whether they're always tied back to military service?

Am I correct in more or less putting all those pieces together that access has come a long way in general, but there are people who are in remote locations, and also people who may have had toxic exposure, and they need more help with access even today? Is that sort of the right summary?

MS. WILLIAMS: I think you summed it fairly well. And it's not just access, to me, but navigation.

Folks don't necessarily know where to go, so it's really important that organizations have this "no wrong door" approach, and if they are not the right organization to solve a particular need, that they take the initiative to adequately route folks to organizations that can fill that need, instead of just

saying, sorry that's not our problem, that's not what we do.

And we have some folks who are really thriving as veterans, and we have other folks who are dealing with multiple problems at the same time. So, they need help managing homelessness, and unemployment, and mental healthcare altogether. And those cases are really complicated and need really significant resources to knit together a whole continuum of care.

And absolutely, when it comes to toxic exposures we have some hints about what may be looming in the future, but additional research still needs to be done to have a full understanding of the potential long-term health consequences, and how we can best support those who may suffer the results of those exposures.

But also, again, cleaning up the domestic sources of those toxic exposures, is something that we have barely begun to scratch the surface of, thanks.

MR. O'HANLON: And Brian, I'd like to ask you that same question, by follow-up.

MR. DEMPSEY: Of course, and you know, I can't help but take this question in the context of veterans' suicide, unfortunately.

You know, the numbers have been adjusted slightly in terms of how we track it, but one that has always stuck out in my mind is, of the 20 veterans a day that we are losing to suicide, 14 of them have not been enrolled in VA, or haven't used the system in the last two years.

So, while VA has built up tremendous capacity and care is excellent once you are in the system, so to speak, we need to do more to draw veterans into that system.

It's a model that Wounded Warrior Project has followed where often the first interaction that we're having with the warrior isn't to help them with their mental health, it's to become more connected in their community, or it's to help them access simple benefits for what might be a back or knee injury that they had in service. But we see that mental health program referrals are the leading referral once they are a part of the Wounded Warrior Project roster.

So, I think in many ways that's a model that VA can replicate through stronger partnerships with the community, whether it be clinical or nonclinical.

MR. O'HANLON: Just to drive the point home, and then we'll go to Michael, since we may have some people watching right now who are in that boat of not knowing which right door to go to,

Kayla, or not knowing how to begin to access the system, Brian, can we give a warrior a suggestion about how somebody who senses they need help, but doesn't yet know where to turn, where do they begin?

Maybe each of you can say a word on that, and then I'll go to Michael, please. Brian?

MR. DEMPSEY: That's a great question. I think part of what the PREVENTS Task Force is looking at is how do you make sure that there is no wrong door. And a lot of that is leveraging awareness on a much broader scale.

You know, there are support lines that can be called through VA, but there's also just resources in the community. I would say Wounded Warrior Project is a great one, but I think there are a lot of access points.

I think knowing that there's a greater appreciation now for the struggles that many veterans have. Many are well adjusted and don't encounter these issues, but for those who do, I think that there's a healthy network of support that's ready to step in.

MR. O'HANLON: Kayla?

MS. WILLIAMS: I totally agree, and it's important to get engaged early on and have social support and more.

But in this situation, I also think I'd be remiss to not mention the Veterans Crisis Line. If anybody is in crisis, that number is 1-800-273-TALK; veterans press 1, thank you.

MR. O'HANLON: 1-800-273-TALK, and then press 1, thank you. And then, of course, we could also -- for less immediately crisis -- Brian, you mentioned some of the call-in lines, one could google Veterans' Affairs Access, or Veterans' Affairs Call Line, or just contact the Wounded Warrior Project through your website.

I'm assuming that's what you meant when you said the Wounded Warrior Project could be a reference?

MR. DEMPSEY: Absolutely.

MR. O'HANLON: Great, thank you. Over to you for the future policy agenda and your recommendations, please.

MR. RICHARDSON: Sure, I was actually just going to start woundedwarriorproject.org for our website, and we do have a resource center.

It's not a crisis center, but we do have a resource center that has typical hours from, I think it's like 8 in the morning until about 8 at night, to various resources from across the country. So, there are a couple of resources for folks who are struggling out there.

A lot of interesting points that were just brought up from calculating the cost of war, to involvement of increased effort focused on women's issues in the VA, as well as navigating the space and additional barriers to care.

I've been actually pretty impressed with the Deborah Sampson Act looking at Women Veterans Task Force; that's a great initiative that's been put out there. As well as, of course, Brian had mentioned Commander Hanon that's in the process, that act, the mental health improvement act is moving forward.

We need to make sure we keep those moving forward. That's number one. And that's a short-term fix.

Talking about the actual cost of war, I really appreciated bringing that up because you often forget because we're in the today, what does tomorrow look like? And so, that is also the same for the psychological cost of war.

It is steep and it is inevitable, but it is treatable, and some would argue, curable, if I can be a little provocative and through that out there as well for a discussion point, of where could we go.

And again, the next piece I'd like to bring up is something that we touched upon, but specific to toxic exposure, and that is the long-term care needs. But it's not just for toxic exposure.

The traumatic brain injury impact on our Warriors and their families, indirectly, is huge. Early onset of Alzheimer's disease, Parkinson's, and all of the -- when we have Warriors that are in their 40s but they're really physically, and because of the increased challenges of traumatic brain injury (audio drop) then you put toxic exposure in there, are so much more older physically than what they are chronologically.

And so we don't know what that will really be, so we need to be focused on the long-term care of the Warriors that we are caring for today, not only in being a part of the treatment of today, but the solution of tomorrow. And Brian mentioned it, that's research.

We have to break down the research walls, publish or perish in (inaudible) medical

centers, or academia, we gotta get on that, we gotta get into sharing data, sharing best practices much better than what we've ever done in the past. And there are some great examples of that happening out there now.

So, I think if we're able to break down our own internal myopic parochial views, and kind of open it up, not just for veterans, but our nation at large relative to all of the issues that we have just mentioned, will go a long, long way in getting in front of the challenge before they become a real challenge and we won't have solutions for that.

But I'd also like to highlight womens' (phonetic), that a real focus within the Warrior Project right now.

So, interestingly enough, when we went to -- because of COVID as Brian has mentioned -- a lot of things changed, one was telehealth.

Last summer the Wounded Warrior Project started an easing with a couple of telehealth entities out there because we knew that was a (inaudible) care, and we wanted to partner with someone as we did. So, we were poised to exponentially increase our investment in the space, very important (phonetic) and we've already had a role in that for that.

We also did that with a number of our programs, our individual, whether it was social connected programs, our physical health and wellness programs, our financial wellness programs, when you see the massive increase in the number of women veterans that are engaging in our virtual programming.

And so, a lot of great lessons learned are coming out of this real challenging time that will live on for quite some time as we engage populations that may have found themselves more isolated than before.

Another example is those that might not have been ready for a two to three week intensive outpatient program, or a face-to-face program, and we're now able to drive virtual programming and virtual mental health curriculum, to get them ready to take that next step.

Great lessons learned as a result of the challenge that we've risen through.

So, I'll end on this, relative to the telehealth, relative to (inaudible), relative to virtual, we can't go back to the way it was. We have to learn from what we've done and really catapult us into the

future.

The last thing I would like to add is that there are some great lessons learned from the Department of Defense and VA medicine relative to prosthetics and burns. We need to start asking harder questions (inaudible) and more answers relative to mental and brain health.

And why not leverage the lessons learned in treating our veterans with mental health, in the innovative assets that we've done, so we can help the civilian population as well, just as we've done with prosthetics and burns.

And so, there is a lot of great (inaudible) with the sale of admission over the last 15 years, but we have a long way still to go. And it's opportunities like that this that give us that chance.

Again, put down the data, put down the stats, let's have a conversation with real human interaction and dialogue of what the challenges are and figure out who's actually able to act on them. So, again, thank you, Mike.

MR. O'HANLON: That's great, Michael. I have one follow-up for you too, and then I'd like to start referencing and quoting the questions from the audience.

But Mike, the question for you has to do with sharing of research information, and I remember 6 or 8 years ago having a conversation with retired General Peter Chiarelli, who I believe continues to work in this space of trying to promote sharing of research data. And I'm a little distressed to hear you imply that maybe there hasn't been a lot of progress in that area.

Could you please maybe explain a little more the nature of the problem, and whether thee is any progress towards changing whatever academia, or professional, or legal barriers might exist to a rapid, more real-time sharing of research information across different universities, and companies, and so forth?

Could you just explain a little bit more the nature of the challenge, and the proposed solution, please?

MR. RICHARDSON: Sure, interesting about General Carelli, I actually heard him personally speak on this issue a number of times, and he's absolutely spot on that there is still a problem.

There are pockets of success that we've seen. And I'll just give one example, and that's the selective medical centers that make our (inaudible) Wounded Warrior Project in the VA that make up

our warrior (inaudible). There's massive (inaudible).

And that was one of the things that when we brought the four AMCs together, we demanded collaboration. We have a data sharing agreement where all of their de-identified data feeds into a central data system in the Wounded Warrior Project.

That's an example of an acting medical center who decide, though there are parochial views, and they are working together in doing publishing now.

We're actually looking at what is better relative to a two or three week CPT (inaudible) cognitive processing therapy or bone exposure, and what type of supportive therapies around that, because of the rich data that we have in our Warrior carrier network, and enacting officers that I mentioned are all willing to share that.

That's a challenge but they I still hear occasionally publish or perish, I mean, you've got to protect your publication before it gets out so somebody else doesn't do it. That's an antiquated way of thinking of data sharing especially given the plethora of data out there.

The other piece that we need to start looking at is social media data. There are a lot of opportunities there to be predictive as opposed to reactive relative without then someone is in crisis.

And so, I'll just kind of throw this out there that it's going to take kind of a human interaction of looking for those pockets of successes and catapulting those successes to the masses.

MR. O'HANLON: Excellent. So now I'd like to start going to some of the questions that we have from the kind viewers and participants now in the discussion.

I'm just going to maybe put two at a time before the panel, one comes from Derek Coy, who's a New York State health foundation professional, and he asks about Indigenous and African American populations, do they have special needs that are distinct from the general veterans population, and is there anything that is required for all of us to do better so that we can help them more specifically with their particular needs; again, for Black and Indigenous veterans, in particular.

And then a second question from Jeffrey Kathey of the Bank of America, asking about whether we see any measurable correlation between the operational tempo and deployment patterns of troops on the one hand with their emotional wellbeing, and also their mental health more generally,

So, I guess, one implication would be, if the military today is slightly less busy -- still quite

busy, but slightly less busy than it was a decade ago -- can we hope that we will maybe see a somewhat reduced frequency of mental health care problems.

Clearly, we would hope to have fewer physical injuries, traumatic brain injury, fewer people running into explosives in Iraq and Afghanistan than used to be the case, but the question here is about operational tempo, and deployment patterns and their effects on emotional wellbeing.

So, with those two questions, maybe I could start with Kayla, and then come back to Michael and Brian.

MS. WILLIAMS: Sure, thank you so much. We do know that certainly for Native Americans who live on reservations, many reservations are still facing substantial challenges in terms of having adequate access to even basic things like electricity or running water sometimes -- Wi-Fi is a big challenge there. So, in terms of being able to access mental health care, some of the advances in telehealth that we're talking about may not go as far in serving that population.

And so, again, trying to address some of the underlying existing disparities in American society, those are also going to affect veterans, and we have to tackle those.

We also know -- and I swear Derek is not a plant -- but we did some research for New York State Health Foundation on minority veterans and their needs, and in some of the focus groups we conducted, we heard from African American veterans that they did not always feel that providers had adequate cultural competence to address their needs and help them overcome different types of barriers to care-seeking.

And so going on to continue to do work within VA and nonprofits to be sure that they're able to work towards greater equity and addressing not just military cultural competence, that we know is lacking in the civilian sector, but also other types of cultural competence within the care setting to be able to meet the needs of all veterans is deeply, deeply important. Thanks.

MR. O'HANLON: Thank you. Michael, I want to go to you next, then we'll come to Brian, on one or both of those two questions.

Again, Kayla has already addressed the question about Black and Indigenous populations, but you may talk about that. There's also the operational tempo and emotional wellbeing question.

MR. RICHARDSON: I'd just like touch on Kayla, great (inaudible) always a great response on the multicultural challenge.

So, not being a multicultural psychologist, but a good friend of mine is, a colleague, and he talks about this often. There's absolutely (inaudible).

One thing that frustrates me in the area that we (inaudible) very, right. As we mentioned when we were opening this discussion, is that our veterans come from multicultural, socioeconomic differences, all of the above, and we can't just blanket them all into one bundle.

And so I really appreciated the opportunity to bring up the dialogue of, what do our African American veterans need, what do our Indigenous veterans need, what do our women veterans need, what are the plethora of catch-up (phonetic), and we need to address that specifically, and what we need to learn from our multicultural psychologists is, where do we approach this?

And the interesting point is that -- it isn't out there yet -- but we did commission a substance use work study landscape and we saw significant differences in those minority groups in their response to certain types of treatments. So, that will help us focus on where we are moving toward project goals in the future for substance abuse disorder treatment. Not just talking about it, actually treating it.

Talking about the slightly less busy op tempo, while it's true, sadly, what will happen -- again, the long-term effects, both psychological as well as the physical injuries -- it will take a while for some folks to start to manifest the post-traumatic stress, the anxiety from depression as they get older, and their lives are in transition.

So, yes, we're seeing less but we still have over 3 million that are deployed, that are coming back and are still wrestling with the psychological effects of war. The multiple deployments and the relentless mortar attacks as well as the countless patrols. They're still coming back so we have a lot of veterans and family members that we still need to help.

And yeah, if we never go back to war, sure there will be less and less, but it doesn't mean it's going away for those who have experienced it.

MR. O'HANLON: Thank you, Brian over to you.

MS. WILLIAMS: Oh, I'm sorry.

MR. DEMPSEY: Kayla, I'm happy if you wanted a quick point to throw in, by all means.

MS. WILLIAMS: Thank you. I was just going to say that there is, when we think about op tempo and deployments, there's a substantial amount of research that shows that there's not a linear correlation between deployments and say suicidality, suicide attempts, and suicide completions.

So, it's an assumption that a lot of folks make that clearly it has to be going to war that leads to this type of outcome, but that's not very clear.

The last time I looked, over half of the suicides within the military were among folks who had never deployed, and so we have to take a more holistic look at things and not just assume that once op tempo everything is going to be sunshine and roses. We're still going to have challenges that we need to address for folks.

MR. DEMPSEY: And Kayla, you actually took one of the first points I was going to make about how in the mental health space, a lot of it is just challenging assumptions that a lot of people have.

You raised one of the points I was going to make which I believe your records being correct, it was about 40% of suicides from active duty were from those who had never deployed.

And the other statistic I was going to put out there is in the veterans' space, that the largest count amongst demographics in suicide is actually older veterans in the 55 to 74 range. So, it's not even necessary proximity to combat either.

So, I think in the policy community, before we can address some of the, I think, deeper and harder to grab at discussions about the nature of recruitment or maintaining an all-volunteer force, is really just focusing on treatment and how to make sure that the clinical and nonclinical supports are there.

MS. WILLIAMS: Sorry for stepping on your toes.

MR. DEMPSEY: No, it's great. I appreciate the conversation.

MR. O'HANLON: Yeah, I'm glad to hear some of these points emphasized and reemphasized because I think in a conversation like this, again, where it's really useful to pound home the 2 or 3 or 4 consensus areas where we know that we can do better.

So, I very much welcome for my own education, and perhaps for some of the other people watching, the occasional emphasis by more than one of you on the same question or point.

And let me now go to two more questions. Blake Sorenson from the Bramer Group asks

about outside community care facilities -- something that you've already touched on -- but whether you wanted to add a specific suggestion. For example, Brian, you were making the point earlier about how in rural communities sometimes there may be a non-VA, non-Wounded Warrior, non-military provider who's the most proximate, and maybe you could add some specificity in response to Blake's question.

And then a question from Kristy Park of Jefferson Business Consulting, about opioid prescriptions and whether we are seeing the Veteran Ferrer system handle opioids more responsibly than many healthcare professionals did in the decades when we developed this opioid crisis in the United States. Are we seeing the VA take important steps to address the over-prescription of opioids?

So those are the next two questions, and this time, why don't we start with Brian, then Michael, and then Kayla.

MR. DEMPSEY: Thanks, and I'm not sure I have the exact nature of the first question, but I think what it might underscore is what has entered this debate about VA grants to the community to help them reach veterans in rural areas, for instance, or just different parts of the country where that connection might not be as strong.

I think that there is a reasonable debate to be had, and in fact, it is being had right now in Congress about whether or not grants in that kind of a program should go to those who can provide clinical care.

I know at Wounded Warrior Project, we believe that there should be no wrong door to a veteran who needs care, and that grants should absolutely be made available to those who can provide clinical.

It's not being offered to compete with VA. In our annual Warrior survey, VA has consistently been rated as the number one mental healthcare resource for veterans who use it, and we absolutely want to see more veterans get into the VA system.

But, you know, if the first appointment happens to be, within that example, the best doctor on main street in a small town in Montana who's not part of VA's community care network, we want to make sure that the veteran, nonveteran, whoever needs help is able to get it there.

And this community pilot program, at this point, that VA is exploring is one that is being carved out to at least potentially have grants for those who can provide care in emergent situations. But,

you know, the debate we are trying to have in this public health approach, is how do you get upstream against all of that.

MR. O'HANLON: Could I follow-up on that before we go to Michael and Kayla with the other questions, too, because I thought that the VA Choice concept had now made it possible to walk into that doctor's office in Montana already. But you're making me think that there may be limitations on just how much this sort of private option has progressed.

MR. DEMPSEY: Well, they need to be part of the network and they are building out that network.

You know, part of what the MISSION act did was it consolidated the Choice Program and about a dozen others, into one, to make the process more efficient and easier to access, to eliminate the amount of questions, both on the veterans side and on the administration end.

The reality is that not everyone, every provider, is quick to enter the network, and just the same as new third party administrators are building out their own networks that you don't necessarily start with contracting everyone and then whittling down until you sort of found the sweet spot, but it's actually building up the capacity.

So, VA is doing a great job. They are extremely committed to making the system work for veterans and I think that more and more are getting connected to quality care on a timely basis.

And I think the community at large is extremely enthusiastic about all the potential that it holds, but there's still work to be done. So, I think I'd leave it at that.

MR. O'HANLON: Thank you. Michael, over to you please, including the question on opioids if you wish to address that.

MR. RICHARDSON: Sure, thank you. I'd just had one thing to Brian, is that the Choice Act and the MISSION act are a great start, but there were raw (inaudible), from referral, acceptance, to payment; it's still a challenge. But, again, it's moving in the absolute right direction.

If we go back to utilizing the communities for care, (inaudible) both health approaches, get your care where you are as opposed to having to travel somewhere to get that care. That talks about access to the quality of care, there's not enough providers out there -- Kayla had mentioned that earlier -- and then again, there needs to be reimbursement in place.

There needs to be a much better effective and efficient flow from referral, to treatment, to reimbursing. But they're on the right road with this. I truly believe that, and a lot of lessons learned there.

And I applaud the VA for actually when they first went into the Choice Act, we need to work very quickly, a lot of lessons learned, we need to do get into the MISSION Act, and I think the next phase of this is to improve from what it was, but it's still got a long way to go.

On the opioid side, (inaudible) a few years ago when this really came to the forefront of the discussion it was rampant, there was no doubt about that.

I have not looked at any of the research in the last year or so, but there has been significant research in showing different approaches to not prescribing opioids, even in organizations that were supplying are looking at other alternative means as opposed to opioid being more of the access. I can't speak to the current stats within the VA, though, sorry.

MR. O'HANLON: Kayla?

MS. WILLIAMS: And I will note that I still have some reservations about the push to enhance access to community care.

Certainly, I think that reducing some of the bureaucratic hassles when it is necessary is a huge improvement in making it less complicated. With the huge variety of programs there use to be, this is a step in the right direction.

But I really think it's important to reaffirm that VA provides high quality, evidence-based, culturally competent care, at lower cost.

And I think it's incredibly important that we protect the VA system. It is the largest integrated health system in the country, and I do have some concern that there is an ongoing effort to dismantle what has been an incredible successful system, and that we should be focused on pushing back on any efforts to get rid of VA because as has been mentioned -- as Brian mentioned even in their surveys -- it is where veterans are getting great care and we want to make sure that that is not threatened at all.

VA also -- to the opioid question -- has been rolling out enhancements to their whole health program, and complimentary and alternative medicine, to try to provide patients with other types of pain management as part of the solution, after acknowledging that they were, no doubt, part of the

problem that swept the entire country with over-prescribing.

So, again, to our earlier point that veterans are part of American society, so a lot of these challenges that affect everyone are also going to affect us. But I do think VA is trying to be a part of the solution on that, as well.

MR. RICHARDSON: Michael, if I could just add one point.

MR. O'HANLON: Yes, please.

MR. RICHARDSON: To the Kayla's point about dismantling the VA. I couldn't agree with you more in that aspect.

So, we've treated over 2,000 Warriors in our intensive outpatient programs in our Warrior Care Network, and most have an appointment back at their VA before they leave one of the four active network centers. So, we see that as an absolutely connection to getting back into the VA system if they hadn't been. Or, if they were once and they no longer are, reinitiating them into the VA care system.

At each of the active medical centers we have a VA employee who's is the VA liaison, full time FTE, from the VA, paid for by the VA in each of the AMCs, helping to coach, teach, and mentor, and refer back into the VA.

So, really, we thought they were going to be helping us get medical records for quality of care, they turned into a Swiss Army knife of resource for us in briefings, education, in helping our Warriors to make a really informed decision about the VA, as opposed to potentially just negative perceptions.

But I just wanted to join in, I couldn't agree with you more.

MS. WILLIAMS: I, also, am not a disinterested observer. My husband went through the Home Base Program that Wounded Warrior Project funds and is part of your Warrior Care Network, and it was tremendously beneficial. I can't speak highly enough of it. But I do really still affirm the importance of -- as you just mentioned -- having a strong VA.

We have ongoing challenges here in the D.C. area. It isn't necessarily possible to get community care using either TRICARE dollars or VA dollars. The capacity just isn't there within a lot of the systems that exist.

So, finding ways to increase the number of qualified providers, and figuring out ways that we can make sure that all of our service members, veterans, military families are able to get the care that

they need through any door that they approach is an ongoing challenge.

MR. O'HANLON: And that leads to the last question, which is another dimension of this. And so, I'll pose it to each of the three of you, please, and then also thank you, again, for being part of this very helpful discussion today.

The question comes from William Negley of Sound Off, and he's interested in those veterans who do not seek help even though they might need it, because of a stigma, of what it means to ask for mental health. Of course, this again, as Kayla has been emphasizing, is a broader societal challenge as well.

But also, because of potentially legitimate professional concerns that if you are seen by an employer as having mental health problems, you may be accorded less responsibility, or you may not be hired in the first place. In other words, people worry about stigma and they worry also about real professional damage to their career opportunities because they have been seeking help.

I guess maybe part of what William might be hoping is that you can disabuse some such people of those kinds of concerns but let me let you answer the question.

Again, of the roughly half of all veterans and service members who may have PTSD or major depression not seeking help because of stigma or professional concern, how do we get them to ask for the help they need?

MR. RICHARDSON: Sure, if you'd like, I'll start. Or, Kayla, if you'd like to start?

MS. WILLIAMS: No, go ahead.

MR. RICHARDSON: Sure, obviously one of the huge barriers to care is stigma, and what we're talking about is two different types, right. Societal stigma from the workforce side and the other parts of society, as well as individualized stigma. How we are feeling; you're not "strong"?

The big part -- again, going back to changing the narrative -- is how do we talk about this? How do we showcase that apt treatment absolutely works, you're not alone out there, if you see something, say something.

And sadly, even some of our movies stereotype the impacts of post-traumatic stress syndrome on our veterans, our "Warrior" type of situation.

So, what we have to do is really start to manipulate that to showcase the greatness that

treatment is. We have to address it shows immense strength to seek the care, not weakness, just the absolute opposite.

And what we're seeing is veterans who are getting the care and getting better are telling their buddy about it. That's normalizing mental health and we need to keep that and never let our foot off the gas on breaking that stigma. That is one of the number one barriers to care and there's no doubt about that.

MR. O'HANLON: Thank you, Michael. Kayla, over to you and then we'll finish with Brian.

MS. WILLIAMS: I think especially for folks on active duty, there is legitimacy to some of those concerns still to this day, though efforts have been made to tackle some of those challenges. But certainly, there can still be problems, especially for certain populations, like pilots, for example.

So, finding ways to allow folks to get confidential care is incredibly important. And if people aren't necessarily willing or able to engage in a full, evidence-based treatment program, I would encourage folks to look for anything that will help them out; whether that's an APP, whether that's peer support and social support; anything to get them started on this journey.

I will also just mention that I know a lot of folks who've said, "Oh, I tried therapy once, it didn't work so I'm never going back." And look, if you tried toothpaste and didn't like the flavor you wouldn't quit brushing your teeth. You would buy a new flavor.

So, I really encourage people to think about therapy the same way. If you didn't click with your first therapist, try a new one. If you didn't like a certain type of therapy, go on and look for another one.

But I think that can add to the stigma. It's like, "Oh, I tried it once and I wasn't immediately better, so forget it, I'm done."

Keep trying. Keep finding other ways to engage and if confidentiality is important, there are confidential ways that you can get care. Thanks.

MR. O'HANLON: Excellent. Very good point, thank you very much. Brian, to you for the last word.

MR. DEMPSEY: And I just quickly round out with perhaps a plug for what the U.S. Chamber of Commerce is doing through their Hiring Our Heroes initiative.

As part of the PREVENTS Task Force, they have a line of effort looking at mental health wellness in the workplace, and really brining in employers to the discussion as part of that national conversation about mental health and normalizing the conversation.

It will be part of the roadmap that will be released hopefully very soon. Of course, this is part of a public health educational campaign, and as we as a country deal with coronavirus, extremely hard to break into the dialogue of something that's as critically important as ending veteran suicide. But there is going to be a lot of great resources and initiatives coming out of that.

MR. O'HANLON: Well, let me just thank all three of you, as well as everyone who contributed with their questions and their participation, and their attendance today. And, most of all -- and I'm sure everybody here agrees with me on this -- I want to thank military veterans and their families, and military active duty, and the wounded who are trying hard to move on and heal.

I want to just thank everyone who served, and does serve, and supports them, and thank you all again, for being part of this today. So, over and out, best wishes.

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