Testimony of Commissioner Loree Sutton, MD, Brigadier General (ret. US Army)
New York City Department of Veterans' Services

Oversight Hearing – Veteran Suicide and Mental Health

Committee on Veterans
Committee on Mental Health, Disabilities, and Addiction
16th Floor Committee Room, 250 Broadway, New York, NY
Tuesday, February 26, 2019, 1:00pm

Good afternoon, Chair Deutsch, Chair Ayala and the esteemed members of the Committee on Veterans and the Committee on Mental Health, Disabilities, and Addiction. Thank you for the opportunity to testify before you and all who have gathered here today to discuss the critically important issues concerning veteran mental health and suicide. I am joined by fellow psychiatrist and Assistant Commissioner, DOHMH Bureau of Mental Health, Dr. Myla Harrison, MD.

Our community

New York City's military service member and veteran population is estimated to be approximately 210,000. This includes of course the veterans of all services and components, as well as the men and women still serving on active duty, National Guard or the Reserves, including the roughly 9,000 veterans serving in City government.

Yet this figure doesn't reflect the entire picture of our military and veteran community. Even if each military service member or veteran has just one family member – a spouse, partner or child – this brings our total constituent population is closer to half a million.

Spouses, partners caregivers, survivors and children also require vigilance and support regarding their mental health concerns. At DVS, we link veterans and families with peers and mentors, whose considerable influence can often provide the impetus and encouragement needed to seek the clinical care, holistic services and community resources they have earned.

While many veterans are thriving; many are also struggling and remain reluctant to reach out for help. For example, recent research documenting increased rates of suicide among all veterans demands our urgent attention and focused action; further, women and LGBTQ veterans, many of whom struggle with moral injuries, complex PTSD, other trauma-spectrum disorders and/or substance use disorders, are dying by suicide at staggeringly high rates.

Today, I'll provide some background information about veteran mental health as well as a brief review about recent trends in veteran suicide. This will be followed by a description of the innovative approach DVS employs to empower veterans and their families to overcome mental health challenges, enabling them to pursue healthy, fulfilling, and purpose-driven lives. As I look around the room, I am heartened to see so many members of our community – veterans,

family members, community service providers, clinicians, researchers, advocates and allies – joined today through individual and collective concern for these vitally important topics.

Veteran Mental Health Overview

As the United States enters its 18th year of combat in the Middle East, there has never been a more urgent need for new interventions to mitigate the effects of post-traumatic stress disorder (PTSD) and other mental health concerns. In recent years, PTSD rates have risen steadily among US veterans, and research indicates that deployment length, frequency and prolonged exposure to combat are major factors driving this increase. In fact, veterans who served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) have faced greater number of days deployed than those during previous eras of conflict.

Additionally, the effects of traumatic brain injury (TBI) from improvised explosive device (IED) explosions are especially concerning due to the nature of warfare typical to this era of conflict. It is estimated that, of the over 3 million service members deployed to these regions, 10 to 20 percent return with post-concussive symptoms. Data also indicate that one-third of returning OEF and OIF service members have reported symptoms of mental health or cognitive problems.

Overall, veterans with combat-related TBI report higher levels of symptoms relating to PTSD and depression which, if left untreated, can often can lead to substance abuse issues and have adverse effects on sleep, relationships, employment and other aspects of everyday life.

Many older and/or disabled veterans also still struggle with mental health and general health issues, often exacerbated by age, retirement, financial hardship, social isolation, substance use and family issues. As an example, recent research has found that a large number of Vietnam veterans show symptoms of PTSD as well as the aftermath of toxins and other service-related conditions; in fact, 37% of Vietnam veterans with PTSD also suffered from major depression. No matter the era of service, during times of war or peace, all veterans have earned our support.

When dealing with PTSD and other psychological injuries, social support is vital, and can mean the difference between recovery and growth versus despair and isolation. Approximately 70-80% of soldiers, even those who endure the most stressful ordeals of war – becoming wounded, ill or injured; killing or witnessing the death of an enemy soldier; or, toughest of all, having a friend die – will experience post-traumatic stress (PTS) yet eventually recover their ability to function as a contributing member of society, retooling their capacities for continued service to others, especially their veteran sisters and brothers. Despite the painful aftermath of experiencing the horrors of war, many will also find a path through their suffering to experience what is known as 'post-traumatic growth' – enhanced compassion and empathy for others; deeper faith and commitment to service; gratitude for being alive or a heightened sense of purpose, to name a few examples – as a positive dimension of their experiences, however harrowing.

To all veterans and families, our message is simple but powerful: PTSD and the unseen wounds of war are real; treatment works (and is getting better all the time!); the most effective intervention starts early with peers, families and communities; and reaching out is an act of real strength and courage. These are timeless truths: isolation kills; community heals.

We know that war changes everyone; our challenge is to intervene early through a continuum intervention starting with conducting community outreach and peer/family education to peer skills training and counseling programs offered by Vet Centers and other community-based organizations to VA/other clinical treatment programs and other essential services such as housing, employment, benefits eligibility, legal services, disability claims, financial counseling and education. While PTS/D can pose daunting challenges, it is by no means the only issue facing veterans as they transition from military service and begin the journey of reintegration.

Veteran & service member suicides

As the 10th leading cause of death in the United States, suicide is a national health concern that affects all Americans, whether or not they have served in the military. According to the VA National Suicide Data Report (2018), veteran and non-veteran adult suicide rates increased 26% and 21%, respectively, during 2005 to 2016.

This represents a 22% higher overall risk of suicide among veterans compared to non-veterans. Broken down by gender, veteran males are 19% more likely to die by suicide than non-veteran males; women veterans are 2.5 times as likely to die by suicide than non-veteran females. Other key findings include:

- **Rates increasing:** More than 6,000 veterans died by suicide every year from 2008-2016; the age-adjusted rate (per 100,000 person years) for all veteran suicide deaths increased from 26 to 35 deaths per 100,000 person years. Also, it is important to keep in mind that 65% of the estimated 20 veterans dying daily by suicide are over 50 years old.
- **Younger veterans:** Death by suicide disproportionally affects younger veterans -- those aged 18-34 – and especially in recent years. From 2006 to 2016, the suicide rate among this age group increased from 27 to 39 deaths per 100,000 person years. The military group at highest risk for suicide are those who served in the military for less than a full enlistment, with a 63% higher suicide rate following termination from service.
- **Women veterans:** Women veterans are increasingly at risk for death by suicide: from 2001 to 2014, the suicide rate for women veterans increased from 10 to 14 deaths per 100,000 person years. While fewer women veterans die by suicide in comparison to their male veteran counterparts, this rate of increase is three times higher than their male counterparts during this same time period.
- **Active Duty Service members:** Death by suicide is also increasing among active-duty service members across the military service branches. Recent studies show that the Army reached a 5-year high in total active duty suicide deaths in 2018; in the Navy and Marines, death by suicides among active-duty service members hit a 10-year high.
- **Former Guard & Reserve Service Members**: Between 2005 and 2016, suicide deaths have increased by over 25% for former Service members who were never federally activated National Guard and Reserve members. In recognition that these individuals and families have limited access to VA benefits and services under current laws and regulations, DoD and VA are now expanding outreach and suicide prevention activities.
- **NY veteran suicides:** Statewide, veteran suicides numbered 153 deaths in 2016, out of 1,615. In NYC, there were 552 deaths by suicide in 2015; City veteran data is not

available. The veteran suicide rate in New York State (19 per 100,000 person years) was significantly lower than the national veteran suicide rate (35 per 100,000 person years), but higher than the national overall suicide rate (18 per 100,000 person years).

Clearly, suicide prevention is a national, state and local imperative for all Americans, whether or not they have served in the military. Every lost life is one too many.

About *VetsThriveNYC*

As part of the pioneering *ThriveNYC* mental health initiative, *VetsThriveNYC* is a program aimed at increasing help-seeking behavior and social engagement, moving the front lines of healing from clinic to community. The program is comprised of two parts: (1) the Engagement and Community Services Outreach Team; and (2) the Core4 Whole Health Model™.

VetsThriveNYC recognizes that social determinants of health – including social engagement, housing, nutrition, education, employment, transportation, financial and legal stability – are vital for wellbeing. To this end, DVS uses a collective impact framework, featuring its coordinated care network, VetConnectNYC, that ensures veterans & their families can access whole-of-life services through expanded access and connection to care, services and resources.

Veteran Outreach Team Expansion

The Engagement and Community Services (ECS) Outreach Team is committed to community engagement with New York City veterans and their families in the context of a peer-based community and social support model. DVS supports all veterans regardless of discharge status, military/veteran caregivers, and their families. The multi-pronged outreach approach is designed to engage the full scope of the veteran's life. Outreach activities, and the corresponding *ThriveNYC* guiding principles they support, are listed below.

- **Mental Health First Aid**: Aligned with the *ThriveNYC* guiding principles, the team focuses on ***Changing the Culture*** by encouraging individuals to have an open conversation about mental health. Through our outreach we train the community in both the Adult and Veteran/Military Family Mental Health First Aid courses. The Outreach Team focuses on increasing awareness of mental health concerns and connection to services through education.

- **NYCWELL (1-888-NYC-WELL):** Through public engagement and community interaction the Outreach Team ensures that veterans and their families ***Act Early*** to identify mental health challenges and that families are aware of and connected to available resources and mental health services. NYCWELL is a 24/7 service, featuring trained counselors who can assist callers with finding the right mental health resources, VA or City, and ensuring a warm handoff. Further, veterans and their family members contacting NYCWELL or 3-1-1 who identify as such may also gain direct access to the Veteran Crisis Line (800-273-TALK). This is also accomplished through a direct referral in *VetConnectNYC*, DVS's vetted network of service providers (1-833-VETS-NYC).

- **Military/Veteran Caregivers:** As a member of the Senator Elizabeth Dole Foundation's *Hidden Heroes* Initiative, the Outreach Team ensures that our New York City military and veteran caregivers ***Partner with Communities*** and are aware of and connected to comprehensive mental health services tailored to their needs. DVS is also poised to become a contributor to the "Military Families and Caregivers Network," a social networking site dedicated to supporting military families and caregivers.

- **Community On-Site Engagement:** The ECS Outreach Team conducts multi-pronged outreach in numerous locations across the City, including our Veteran Resource Centers. Direct interaction with veterans in the communities in which they live increases our visibility of critical needs and enhances our ability to ***Partner with Communities*** and ***Close Treatment Gaps***, providing veterans and their families in every neighborhood with equal access to care that works for them, when and where they need it.

- **Underserved Veterans:** The *VetsThriveNYC* Program focuses on addressing the mental health needs of underserved veterans, including women veterans, immigrant veterans and members of the LGBTQ community, working to ***Close Treatment Gaps*** to reduce the disparities in care that underserved veterans face regarding mental health concern related to military service.

Core4 Whole Health Model™

The Core4 Whole Health Model, the 4-tiered pyramid illustrated below (Figure 1), is designed to foster hope, healing and wholeness through informed access to clinical treatment, community holistic services, peer/family/community social support and cultural initiatives and the arts. Every veteran, transitioning service member and family member has unique strengths and struggles, requiring an individualized approach which incorporates family engagement and support. While access to clinical treatment is vital, healing and hope must begin at the front lines of communities, where veterans and their loved ones live and work. Not surprisingly, countless generations of veterans have relied upon peer, family and community support as the most powerful influences affecting their health and well-being, often bolstering their courage to overcome the stigma of seeking clinical care, holistic services and community resources.

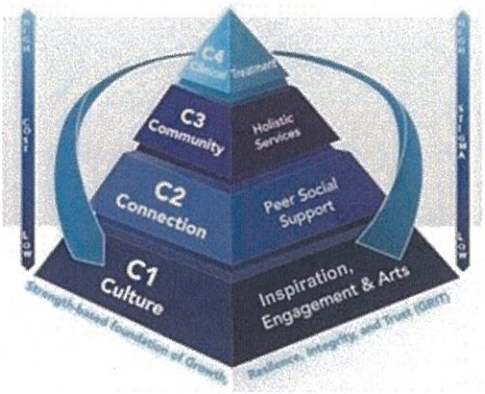

Figure 1: Core4 Whole Health Model

To further augment the impact of our outreach, DVS has deployed *VetConnectNYC*, a one-stop shop for services for veterans and their families. With over 80 vetted service providers and a coordination team dedicated to connecting veterans and their family members to the right services, such as health, recreation, legal services and education, *VetConnectNYC* takes the hassle out of navigating resources and benefits. We urge veterans and their families to learn more about *VetConnectNYC* at www.VetConnectNYC.org or call 1-833-VETS-NYC.

Closing

In closing, please know this – the unseen wounds of war are real; treatment works; early intervention is best; and, finally, reaching out is an act of real strength and courage.

To those who have served their country in uniform and the families who have served beside them, we are here today to tell you, you are not alone. Just as you have served and continue to serve us all, we stand ready to serve you. There simply is no greater privilege.

To this end, Team DVS stands ready to assist any service member, veteran or family member -- one-on-one at a convenient location. Just call 212-416-5250, email **info@veterans.nyc.gov**, message us on Facebook or Twitter @nycveterans, find a satellite site in all five boroughs at our website **www.nyc.gov/vets,** or visit us in person at our main hub at 1 Centre Street, Suite 2208.

Immediate 24/7 help is also available through NYC Well at 1-888-NYC-WELL (1-888-692-9355) and the Veteran Crisis Line at 1-800-273-TALK (8255).

Thank you for your continued leadership and collaborative teamwork in bringing awareness to these critical issues concerning NYC veterans and their families. At this time, I welcome your thoughts, questions and concerns.

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Community
Healthcare Network

Testimony of Dorothy Farley
VP of Behavioral Health, Social Services & Care Coordination
Community Healthcare Network
New York City Council Committees on Veterans and Mental Health
Tuesday, February 26, 2019

Thank you Chairperson Deutsch and members of the Committee on Veterans and the Committee on Mental Health, Disabilities, and Addiction for the opportunity to speak today. My name is Dorothy Farley and I am the Vice President of Behavioral Health, Social Services, and Care Coordination at Community Healthcare Network (CHN). CHN is a network of 14 federally-qualified health centers, including two school-based health centers and a fleet of medical mobile vans. We provide affordable primary care, behavioral health, dental, and supportive services to 85,000 New Yorkers annually throughout Manhattan, Queens, Brooklyn, and the Bronx.

At CHN, we strive to treat the whole patient. Our model of integrated care allows patients to access any number of health and social services when they walk through our door. This model extends to populations currently or formerly involved in the military, including active duty service members, veterans, and their families – regardless of discharge status. CHN's Military Health and Wellness Family Program recognizes the need for timely, culturally-informed care among military populations and draws on the strength of a wide variety of health professionals to deliver these services. In our medical-legal partnership with the Urban Justice Center's Veteran Advocacy Project – or VAP, CHN offers case management, linkage to legal and social services, and comprehensive healthcare for individuals seeking care outside the Department of Veterans Affairs (VA) system.

CHN offers four "Centers of Excellence" in military care at our health centers in Harlem, Long Island City, Sutphin Boulevard, and the South Bronx. Staff at these centers are trained by the Veteran Advocacy Project to provide comprehensive, culturally-informed care to military populations. Over the next year, CHN plans to designate two more health centers – in Brooklyn and the Bronx – as military health "Centers of Excellence." These centers are the core of our Military Health & Wellness Family Program. Individuals

referred to the program – through VAP, Help USA, VetConnectNYC, or internal staff – are paired with a member of our social work team and are screened using a veterans-specific intake form, including a validated depression questionnaire.

Since its inception, CHN's Military Health & Wellness Families Program has taken on 199 unique patients – with generous support from the City Council, led by Chairman Deutsch. A significant portion of these patients are referred to behavioral health services after initial screening. This trend reflects a wealth of research and anecdotal evidence supporting a link between traumatic military service and behavioral health needs. However, not all patients coming through this program feel comfortable or ready to access behavioral health services – or even at all. At CHN, we meet patients where they are at – and we do so in stigma-free, integrated setting. In addition to a team of highly-skilled social workers, psychiatrists, mental health therapists, and substance abuse professionals – we offer services in primary care, dentistry, pediatrics, podiatry, nutrition, wellness, and sexual and reproductive health. Our integrated approach supports the link between physical and mental health, and the understanding that treatment of one often benefits the other.

For today's hearing, we offer the following considerations:

Importantly, not all veterans prioritize care at the VA. In fact, a sizable portion of veterans are ineligible for VA services due to their military discharge status. To that end, it is imperative that military populations have alternatives to the VA and that these alternatives extend to their families. Our military health program focuses on the whole family with the understanding that the impact of military service extends beyond the active or former service member. Additionally, while many organizations *do* operate

military health programs outside of the VA, these programs are not always visible to military populations. We applaud the Veterans Committee for releasing a Veterans Resource Guide earlier this year and support ongoing efforts to increase visibility of – and communication among– health resources among military communities.

We integrate primary and behavioral health care for military-affiliated families. While there have been great efforts to de-stigmatize mental health care, both internal and external stigma continue to dissuade individuals from seeking out behavioral health services, especially among military populations. We have found that the co-location of behavioral health and primary care services has benefited regular engagement in care, including transition into behavioral health therapy, if needed and desired. Thus, communication and collaboration between behavioral health and primary care services oriented towards military populations benefits the health and wellbeing of military-affiliated patients.

We have also recognized the importance of having programs that accept veterans' insurance Tri-Care – government-managed health insurance for military members and their families. CHN accepts veterans insurance as well as virtually all other insurances. We have found, however, that many of our patients have experienced challenges accessing services at other locations where Tri-Care is not accepted. To that end, we support greater visibility around insurance as part of ongoing efforts to advertise military health resources.

Finally, we note the importance of having staff that are trained to meet the needs of military families, without making these populations feel singled out. We have found great success in our partnership with

VAP and are continually improving our military screening template to better link patients to the right resources.

We thank the Chairpersons and Committees for the opportunity to speak today and look forward to continuing our work alongside city legislators and community-based organizations to better serve the military community throughout New York City.

Statement of Vadim Panasyuk
Sr. Veteran Transition Manager, Policy Liaison & VA Benefits Lead
of
Iraq and Afghanistan Veterans Of America
before the
New York City Council Joint Committee on Veterans & Mental Health

February 26, 2018

Chairman Deutsch, Chairwoman Ayala and distinguished members of the Joint Committee, on behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members, I would like to thank you for the opportunity to testify here today. I am a New Yorker, a Ukrainian expatriate, a naturalized citizen, and a US Army veteran having served two tours of duty with the 3rd Infantry Division in Iraq. At IAVA, I am a masters-level social worker serving as a Senior Veteran Transition Manager (VTM), VA Benefits Lead, with our Rapid Response Referral Program - or "RRRP" for short.

RRRP is a high-tech, high-touch referral service for veterans and their families with a comprehensive case management component. We assist veterans of all eras, regardless of discharge status, worldwide in confronting significant challenges like unemployment, financial or legal struggles, homelessness, and mental health related issues. To date, RRRP has served over 9,000 veterans and family members nationwide, and over 1,000 in New York City alone, providing critical support and resources to ensure that this city's veteran's needs are effectively met.

The campaign to combat suicide among troops and veterans is an extremely important issue to IAVA and remains number one among our Big 6 priorities, which also include Support and Recognition for Women Veterans, Reforming the VA for Today's Veterans, Defending the GI Bill, Support for Injuries from Burn Pits and Toxic Exposures, and Support for Veteran Cannabis Use.

For nearly a decade, IAVA and the veteran community have called for immediate action by our nation's leaders to appropriately respond to this crisis of 20 military and veterans dying every day from suicide. Thanks to the courage and leadership of veterans, military family members and our allies, there has been tremendous progress. The issue of veteran suicide is now the subject of national conversation, increased media coverage, a reduction in stigma and a surge of government and private support. In 2015, IAVA and our partners jump-started a national conversation. But the flood of need continues nationwide – and continues to rise. In our latest

Member Survey, 65% of IAVA members know a post-9/11 veteran who attempted suicide. 59% know a post-9/11 veteran who died by suicide, and 77% believe that we as a nation are making progress in combating military and veteran suicide. Every day, we are losing more of our brothers and sisters to suicide. This is not the time for America to let up. Instead, this is a time to redouble our efforts as a nation and answer the call to action. And IAVA will continue to maintain our leadership on that charge.

One of the ways that IAVA will maintain our leadership on this issue is through RRRP. In 2018, we provided nearly 130 connections to mental health support for veterans and family members around the country, ensuring that those in need of help can easily access the quality support they need. Importantly, we have a memorandum of understanding with the VA's Veterans Crisis Line (VCL) which allows us to provide a warm handoff with a trained responder at the VCL, where the at-risk veteran is never left alone or hung up on, literally preventing veteran suicide. In 2018, RRRP connected 39 veterans to the VCL, which means that about every week and a half VTMs connected a veteran that was either currently suicidal or at-risk of suicide with lifesaving support. RRRP relies on this critical partnership with the VA to keep veterans and families safe by ensuring that our clients who are in crisis are connected with VCL responders to prevent suicide. IAVA's Rapid Response Referral Program and the VCL have been in partnership since RRRP launched in 2012, and has connected nearly 240 veterans to this lifesaving resource.

Members of the Joint Committee, thank you again for the opportunity to share IAVA's views on these issues today. I look forward to answering any questions you may have and working with the Committee in the future.

City Council Committees on Mental Health, Disabilities, and Addiction and Veterans
Oversight: Veteran Suicide and Mental Health
Veteran Advocacy Project testimony by Coco Culhane
February 26, 2019

VETERAN ADVOCACY PROJECT

Good afternoon members of the Committee on Veterans and the Committee on Mental Health, Disabilities, and Addiction. My name is Coco Culhane and I am the director of the Veteran Advocacy Project. We provide free legal services to veterans and their families, with a focus on those living with Post Traumatic Stress (PTS), Traumatic Brain Injury (TBI), and substance use disorders. Thank you for the opportunity to testify today on veterans and mental health services.

Most veterans make a successful transition back to civilian life. The road is not always easy and when mental illness or injuries are involved, it can be the hardest battle they face. New York can be an overwhelming place, particularly for those who have experienced trauma. Too many veterans forgo physical and mental care because they are struggling against complex benefits systems or fighting to maintain income and housing in a city losing affordable units every single day. Our goal at the Veteran Advocacy Project is to confront these issues for veterans and their families, to remove the barriers to recovery, by ensuring access to housing, health care, and income. In short, we fight the systems so they can spend time getting well.

Recent studies show that the rate of major depression among veterans is five times as that of civilians; intermittent explosive disorder is six times as high; and PTS is nearly 15 times as high.[1] When left untreated these conditions can become debilitating and the toll on family members is serious, with high rates of secondary trauma and severe depression for spouses and even children.[2] If a family is facing an eviction or can't put enough food on the table because their benefits have been cut off, that becomes the only priority. Mental health and wellness are quickly sacrificed.

The most shocking statistic, one that must not be ignored: VA data shows that 20 veterans die by suicide every day, only 6 of whom access VA services. All of these veterans are our concern as a community, but the 14 outside of VA care are our responsibility. We must do more for all veterans but especially for those not getting the expert treatment they need. Some do not want to receive care from a government that sent them to war, particularly our Vietnam veteran generation, while other veterans cannot receive care at all. Despite being wounded either psychologically, physically, or both, they are unjustly denied benefits and health care because of their discharge status. (Members of the military leave service with one of six discharge statuses that determines the benefits and health care they are entitled to receive as veterans. Far too many servicemembers face discipline for acts of misconduct that are actually symptoms of invisible wounds: post-traumatic stress and traumatic brain injury. Without an understanding of their symptoms, charges of misconduct can lead to administrative proceedings or courts-martial that result in less-than-honorable discharges.) Less-than-honorable discharges, known as "bad paper," prevent veterans from accessing the VA and healing.[3] Plainly put, veterans are being cut off from care because of the very conditions they need treated.

The rate of mental illness among veterans with less-than-honorable discharges is staggering. Of all the servicemembers diagnosed with PTSD or TBI who were discharged from 2011 to 2015, *only 4 percent received an Honorable*.[4] Servicemembers should not be punished for their wounds. Many accept an administrative "other than honorable" discharge, allowing them to go

home, instead of facing court-martial. Yet the consequences of that discharge can be dire. An involuntary discharge—either by administrative boards or courts-marital—leads to a **suicide rate that is nearly three times that of other veterans.**[5] Moreover, bad paper discharges are the second highest predictor of homelessness.[6] Veterans with bad paper are incarcerated at higher rates; a 2012 study by the Bureau of Justice Statistics showed that 55% of incarcerated veterans had been diagnosed with a mental health disorder and 23% of incarcerated veterans have been diagnosed with PTSD. We know from the DOD statistics that 96% of those veterans, likely more, have a bad discharge.

VAP serves these men and women, fighting for the benefits and health care they earned. But it is a long process.[7] We work to ensure veterans have other benefits, housing, and treatment in the meantime. Nearly all of our clients, regardless of discharge, don't want to feel weak or vulnerable; and they have a difficult time asking for help. However, they will make the call when they get a marshal's notice. As we build trust with the client we can make information available about seeking health care. We serve our clients holistically through extensive collaboration. We work closely with two organizations that have VA homelessness prevention grants, Jericho Project and Services for the UnderServed, and our Medical Legal Partnerships (MLPs) are absolutely key to our clients' successful recovery and to wining their DoD and VA matters. In all of our MLPs, we coordinate with providers who produce crucial medical evidence for discharge upgrade and disability cases. Together with all of our partners, we serve some of New York's most vulnerable individuals and families. By combining the efforts of doctors, nurses, social workers, and lawyers to address social determinants of health, we improve health outcomes and ensure that clients achieve the long-term stability needed to thrive.

We have three formal partnerships with VA Vet Centers in Brooklyn, Queens, and the Bronx. Vet Centers are community based clinics where combat veterans and their families can receive counseling, financial coaching, and adjustment and transition services. We also partner with a network of federally qualified health centers, Community Healthcare Network (CHN). These centers have culturally competent, integrated primary and behavioral health care; and with 14 locations across the city, veterans and their families can choose the center they want to use. They can receive care in their own neighborhood. CHN's program, developed in partnership with VAP with veterans who cannot use the VA in mind, is the only one of its kind in New York. It is the only alternative to the VA for culturally competent comprehensive health care. That should not be the case and we hope that as CHN's outreach grows, so too will the model.

I testified at a similar hearing in 2011, 2012, then in 2013, and numerous other times over the years. I was desperate to convey a sense of urgency over the need for community based veterans' mental health outreach and services in New York. I told client stories. I recited statistics. I read a letter a veteran wrote his congressman before killing himself. One year I started by saying: *I could just read the testimony I wrote the first time I spoke on this topic, years ago, because nothing has changed.* I am thrilled to say that that is no longer true. Most of the resources available to veterans have developed out of private organizations but the city is funding more of these resources and they are connecting with the Department of Veterans' Services to join efforts. This is an excellent investment in our future as a community.

Where we had no plan, we now have what mental health experts call a *brilliant* model for healing: the Department of Veterans' Services Core 4 Whole Health Model. DVS is a connector and is growing their reach every day. Yet it seems veterans may be able to find more information about the idea of the model than the services.

As someone not involved in the model, such as, say, a veteran new to New York, it can be difficult to find the community that Core4 talks about. For culture, the broadest layer, the website features Theater of War. What else can a veteran get involved in when it comes to finding community through the arts? Where else could a veteran go for that information? Does it exist beyond that? I'm not doubting it does but we need to make it known. If I can't find the info, a vet probably can't either. The other cores' web pages say to contact a peer and lead you to the online contact DVS form. Where targeted referrals are involved this makes sense. Yet, I sit on the advisory board of the Veterans' Mental Health Coalition, led by the designated Core4 community point person, and I don't know what Core4 actually entails. Are there core providers in VetConnect? Do they have joint outreach? Are they sharing best practices? What is it? No one has been able to explain it. We have a way to go when it comes to making information about connection and healing easily accessible.[8] Any of us could go through any program and find these small flaws; I point them out today only because when it comes to veterans' mental health and wellness, we can't have a system that relies on veterans digging for connection—in any way, on any web page.

We all have more work to do to let veterans and their families know about the community services available to them. We continue to build pathways out of isolation and toward the many resources in New York City. Veteran Advocacy steps in when things go wrong but we connect veterans that can make things right; and through our legal services we make sure that vets can spend their time on healing and rebuilding their lives. The city has made tremendous progress and we have incredible expertise when it comes to wellness. Let's make sure every veteran in New York, regardless of discharge, service era, or mental health condition, can find that expertise and thrive.

Thank you for the opportunity to speak today.

[1] Kessler, R. C., et al. (2014). Thirty-day prevalence of DSM-IV mental disorders among nondeployed soldiers in the US Army: results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *JAMA psychiatry*, *71*(5), 504-513.

[2] Dekel, R., Levinstein, Y., Siegel, A., Fridkin, S., & Svetlitzky, V. (2016). Secondary traumatization of partners of war veterans: The role of boundary ambiguity. *Journal of Family Psychology, 30*(1), 63-71. *Available at*: http://dx.doi.org/10.1037/fam0000163.

[3] For more information on how VA regulations shut veterans out of care, beyond congressional intent by statute, see: *Underserved: How the VA Wrongfully Excludes veterans with Bad Paper*, Harvard Veterans Legal Clinic, Legal Services Center of Harvard Law School, March 2016. *Available at*: https://law.yale.edu/system/files/area/center/liman/.../underserved_liman_program.pdf.

[4] *Actions Needed to Ensure Post-Traumatic Stress Disorder and Traumatic Brain Injury Are Considered in Misconduct Separations*; GAO-17-260: Published: May 16, 2017.

[5] Bryan, CJ. *On Deployment and Military Suicide Risk. JAMA Psychiatry.* 2015;72(9):949–950. *Available at*: doi:10.1001/jamapsychiatry.2015.0671.

[6] Homelessness risk factors have been analyzed in a number of studies. *See, e.g.*: Gundlapalli AV, Fargo JD, Metraux S, et al. *Military Misconduct and Homelessness Among US Veterans Separated From Active Duty, 2001-2012. JAMA.* 2015;314(8):832–834. *Available at*: doi:10.1001/jama.2015.8207.

[7] Gathering military records, extensive medical evidence, and witness affidavits can take month, but the wait at the boards I once an application is submitted is what makes the cases take years: one board just quoted to VAP that they are at ***850 days*** from submission receipt to the day they even look at the packet.

[8] Last year in trying to connect the city with CHN's new Military Families Health and Wellness Program I spent weeks hitting walls and finally gave up. I introduced CHN to the Institute for Veterans and Military Families who brought them into the NYServes, now VetConnect, system. A year later they still are not part of the web site.

Samaritans
SUICIDE PREVENTION CENTER

New York City Council Committee on Veterans with the Committee on Mental Health, Disabilities and Addiction

Testimony Presented, February 26, 2019

My name is Elaine Hunter and, on behalf of Samaritans Director, Alan Ross, I want to thank the NYC Council Committee on Veterans and the Committee on Mental Health, Disabilities and Addiction, for the opportunity to present testimony today based on our experience operating NYC's longest-running Suicide Prevention Center.

You certainly don't need us to tell you that suicide and self-harming behavior are on the rise in New York and across the nation. And though we are here to address the needs of veterans and those with mental illness, you are also well aware that the issues and problems related to suicide are experienced on a daily basis by people of every age, race, culture, sexual identity and socio-economic standing.

Working in collaboration with city, state, and federal health experts to prevent suicide these past 35 years has led Samaritans to extend our focus beyond the confines of "at-risk" populations—which we believe can limit our perspective in developing effective prevention strategies—and remind ourselves, **nobody is just one thing!**

No one is a "veteran" or an "immigrant" or a victim of bullying or someone with a health problem. People are unique and complex and possess their own distinct combination of more thoughts, beliefs, behaviors, traits, life experiences, perceptions, etc. than we can possibly imagine.

A veteran is not just an active or retired soldier, as important as that may be. Rather, he or she is also a parent, a spouse, a son or daughter; someone who may be deeply religious or have no spiritual conviction; who is financially sound or unable to make ends meet. They may also be gay or lesbian, an immigrant, someone who struggles with substance abuse, a victim of trauma, sexual assault or child abuse or more things than we can possibly imagine.

We murder when we dissect, said Wordsworth, who could easily have been referring to our age-old preoccupation with trying to quantify and qualify issues we are confronting that don't have simple answers, and can make us feel powerless and overwhelmed.

As current "burden research" points out, it's not "who" is at-risk, but where the greatest number of people who are at-risk can be found; and ultimately provided with the support they need. And that is more a matter of recognizing the complexity of modern life, how each person copes with their problems and is comfortable seeking help.

This is the lesson the military taught us over 20 years ago when the US Air Force implemented what is still to this day the most comprehensive, and effective, suicide prevention program in this country's history.

What they found was that the more "points of access" for help available to members of the military who were in distress, the more likely they were to seek that help. And often, the help accessed was an alternative to official, government-run programs. The current federal legislation examining the effectiveness of the Veterans Hotline proves this.

It does take a village, what Samaritans calls "caring community," a cross-section of clinical, medical, humanistic, volunteer and other programs and services that cover the entire gamut of ways people *are comfortable* seeking help; often, the very community and volunteer health agencies that are consistently overlooked when decisions are made on how to respond to ever-increasing demands for services.

Samaritans and numerous non-profits that have historically provided these services are still waiting for our Mayor, who frequently states how important it is to reduce self-harming behavior, to restore the cuts to community groups, like Samaritans hotline, that were enacted when Thrive was launched. In our case, this resulted in the hotline going from responding to 89,000 calls four years ago to 75,000 last year.

So, as you seek to improve and increase the help and support available for those in distress, please remember: Bigger is not always better. New is not always improved.

Strengthen NYC's Safety Net. Support NYC's 'caring community' agencies. Because when people need help, we're there!

Thank you.

Alan Ross
Executive Director
Samaritans Suicide Prevention Center

Written Submission to the New York City Council Veterans Committee, Committee on Mental Health, Disabilities, & Addiction

Amanda Spray, PhD
February 26, 2019

We are all aware of the alarmingly high rates of suicide amongst veterans; nearly 22 veterans die by suicide each and every day. The impact of war and military service on service members and their loved ones is long lasting; mental health struggles are not uncommon. Yet they are often left unaddressed, potentially leading to unemployment, loss of housing, damaged relationships, and at times – tragic loss of life by suicide. Families of veterans may face mental health risks of their own, especially those who play a caregiving role. These can include declines in mental health, increased behavioral problems among children, higher divorce rates, and increased risk of suicide themselves. Timely and high quality mental health care is crucial and can potentially be lifesaving. Yet, mental health resources available for military family members as well as some veterans are limited.

The Veterans Administration Medical Centers are doing their best to address the issue, but they simply do not currently have the bandwidth to address the issue alone. The Steven A. Cohen Military Family Center at NYU Langone Health was founded in 2012 to fill in the gaps in services available to veterans and their families in NYC area in a complementary way to the VA. Our Clinic's mission is to address mental health challenges by providing accessible, high quality, integrative treatment to veterans and their family members. We strive to remove barriers to care through a number of ways: By providing our services completely free of charge; by offering our services to veterans regardless of their discharge status, combat exposure, or era served; by opening our services not only to veterans but their family members who we define very broadly; and by offering our services not only face to face but also through a telehealth platform that allows providers to reach individuals who are unable to come in person due to geographical, emotional, or other challenges.

The Cohen Military Family Center addresses a wide range of mental health concerns including posttraumatic stress, traumatic brain injury, depression, anxiety, readjustment difficulties, alcohol and substance use, relationship problems, along with a variety of other challenges military families may experience. The services we provide include individual, couples, family, and group therapy, parenting training, psychiatric evaluations and medication management, neuropsychological assessments and interventions, among others. Our highly skilled clinicians have deep appreciation for and sensitivity to military culture and its unique strengths and challenges and are passionate about helping veterans and military families.

Mental health services such as those provided by the Steven A. Cohen Military Family Center at NYU Langone Health save lives. We have delivered these crucial services to over 2,000 veterans and their family members, filling gaps in what the VA is able to provide. We are very grateful to the New York City Council for their support of our program as we work closely with the VA, the Department of Veterans Services (DVS), and other veteran service organizations to address veteran suicide together.

Additional Information - Specialty Programs

Dual Diagnosis Program
Our Dual Diagnosis Program offers flexible, integrative care for veterans and their family members struggling with addiction and comorbid mental health problems. Our harm reduction approach provides flexibility in setting treatment plans and goals, which may vary between patients. Goals may include reduced harm associated with use or full abstinence, and treatment may include individual therapy, group therapy, and medication management.

Traumatic Brain Injury Program
Approximately 300,000 veterans sustained a TBI as a result of serving in the recent wars in Iraq and Afghanistan; 57% were not evaluated or treated for TBI. Our TBI Program, funded by NYC Council, is offering services to fill this gap in treatment. We offer neuropsychological evaluations for TBI as well as cognitive training to develop strategies to work around cognitive difficulties and to learn problem solving, organizational strategies and memory and attention techniques.

Child/Family Program
Military children are faced with unique stressors related to relocation, parental separation, family reunification, and reintegration. These stressors may result in disrupted relationships, behavioral problems, and academic difficulties. Many children struggle to adjust to their parent's combat injury or deal with a parent's death. Our Child and Family Program provides individual child therapy, parent-child therapy, family therapy, and parenting training. These services are offered to veterans and their families, as well as families of the fallen.

Telemental Health Program
Our Telemental Health Program provides mental health care to veterans and their families in every part of New York City and New York State who are unable to regularly commute to therapy. Services are provided via computer or tablet and can be done in the privacy of one's home. This program offers additional flexibility in the ways our services are delivered to the veterans and their families.

Contact:

To contact the clinic, interested individuals call our intake line at (855) NYU-4677 or e-mail us at: militaryfamilyclinic@nyumc.org. Visit our website at: http://nyulangone.org/locations/steven-a-cohen-military-family-clinic

The Columbia Protocol: A Policy Tool to Detect Those at Risk for Suicide, Empowering Communities Across the Globe
Saving Lives Among Veterans, their Families and Communities
Kelly Posner Gerstenhaber, Ph.D.

I am grateful for the opportunity to discuss a solution to one of the most intractable problems of humanity. Make no mistake, suicide is not a Veteran problem, it is a human problem. Taking more fire fighters than fire, more police than crime, more soldiers than combat, even more lives than car accidents. Suicide, and depression – its biggest cause – actually, are the number one cause of global disability and cost humanity more than anything. And these are just the costs we can calculate. Suicide touches everyone: for every suicide death 135 people are affected and these effects linger across generations because of the silence that often follows.

I say this to empower you because we are not trapped by this history. Suicide IS preventable and we know what to do.

Did you know that 50% of people who die by suicide see their primary care doctor the month before they die? We need to ask like we monitor for blood pressure or do vision testing, otherwise we will not find the people suffering in silence. But even that's not enough. The Undersecretary of Defense and the VA had the critical recognition, reflected in an urgent memo (attached), that we had to go beyond the doctors' office, signaling a tectonic shift away from the narrow medical model; understanding that those suffering in silence would not come to us, we needed to go and find them, where they live and thrive.

The Columbia Protocol is the nationally and globally adopted common language - the standard of care and minimum standard for National Regulatory agencies from schools to health care – even noted as such in a State Supreme Court Brief – a few simple questions to identify who needs help, finding who is at imminent risk, and connecting them to care. The protocol is helping saves lives worldwide and has unprecedented science to support it. The preventative power of the Columbia Protocol is in empowering everyone to be able to ask.

The head of American Psychiatric Association called the Columbia the next antibiotic. Why? Over the last 50 years, we've made dramatic gains in preventing some of the most pernicious deadly diseases, heart disease and cancer, with up to 50% reductions in mortality. Not suicide. "Because of stigma, because of a lack of a ready easy- to-use method by which to detect it and then take action to try to prevent it."

States have said that since implementing the Columbia Protocol as a policy tool (from policeman to teacher to primary care doctor) they have lowered their suicide rates, in the first state example reversing an upward trend over the past 10 years. The DOD turned this vital need for a public health approach into action. The Marines achieved a 22% suicide reduction after giving the tool to everyone-financial aid counselors and legal assistants; the Air Force, where it is in every airman's, every spouse's, clergy member's, dentist's hands, was the only service to reduce suicide last year.

The head of Tennessee Suicide Prevention services said that the statewide adoption of the Columbia as the crisis assessment tool "has catapulted a transformation of practices by ensuring professionals and family members who come in contact with an individual who may have thoughts of taking their own life receive the help they need before it is too late". First responders not only use it in their job helping to connect those in need to life-saving care but to save their own lives.

Only 6 out of 20 Veterans access VA services and the majority will not seek ANY help; like most community members who will never access behavioral health. We must go find them where they live where they suffer in silence.

This urgent need has been brought to life countless times: a vet who died by suicide and the only person he spoke to was the janitor – not the doctor. Now there is a state policy for custodians.
The Columbia is top down policy throughout VHA medical care, like most health care systems- from Sloan Kettering to Kaiser but perhaps even more importantly it will soon be put in every non-medical hand. Just last week an attorney interacted with a veteran at risk and saved his life and now with along with the VA secretary and the General council we will make this sustainable - we'll give the Columbia to every lawyer and volunteer legal partner across America.

And the national tragedy of gun deaths, 2/3 of which are suicides. That person who goes up to the counter to end their life does not want to die, they just do not know there's help. In 2016 nearly 70% of Veteran suicides were from a firearm. U.S. nearly 50%. 90% of shooters have suicidal issues; Deputy Secretary of Education (Jim Shelton) under President Obama said these questions can keep our 64 million children safe. Ryan Petty, a Parkland father whose daughter was one of the 17 victims, said "we found another big piece of the school shooting puzzle – an antibiotic for suicide." I said to the senate hearing on school safety that we need more policy to get this critical threat assessment tool in everyone's hands.

In NYC, I have seen homeless veterans asking their peers, worked with all our local communities, but we have many more lives to save and we CAN do this but will take more policy. These questions can become the cornerstone of public health campaign posted near water coolers, for bus and taxi drivers, parking lot workers and neighbors.

I dare say we have a moral imperative to do so and it is easily achievable.

Following a training to VA Commissioner's' office, THRIVE and other city officials, Vets on campus can be the emissaries bringing this tool to their peers, peer-to-peer suicide prevention, giving these Vets a sense of purpose and meaning that is so often lost after they return home and helping them save lives in a new way.

The Columbia Protocol is more than just a method to identify when someone is at risk. It is a framework for normalizing the tough conversations that can make a difference. It reduces the stigma around talking about suicide and promotes connectedness. At its heart, the message of the Columbia protocol is simple: Just ask. You can save a life.

At one point in history learning to wash hands began saving lives. Now, as we put these questions in the hands of every veteran, families, and their communities, we will save lives today and tomorrow.

In Israel, In Every Teachers Hands, Helping Reduce Suicide "And Changing the Way We Live Our Lives" Through Policy:

The C-SSRS has been rolled out top-down (from the IDF to school teachers) and is an integral piece of the Israeli National Suicide Prevention Program. Directors of the Israeli Suicide Prevention Program said, *"**This work is not only saving millions of lives but in Israel it is literally changing the way we live our lives. Breaking down barriers that have been built up over thousands of years, it is quite amazing to see the Israeli doctor asking these questions to an Arab child or a third-generation holocaust survivor who would never speak and now has a voice or the Ethiopian...But we are just one nation and every nation deserves this extraordinary lifesaving tool.**"*

Dr. Kelly Posner Gerstenhaber and the C-SSRS

The Columbia Protocol is saving lives in 45 nations on 6 continents. The President of the American Psychiatric Association noted this work "***could be seen as really a watershed moment, like the introduction of antibiotics.***" **The U.S. Department of Defense called it "*nothing short of a miracle,*"** central to their National Strategy, and stated **the "effective model of improving the world will help propel us closer to a world without suicide**." The CDC **noted that this work is "changing the paradigm in suicide risk assessment in the US and worldwide**."

Dr. Posner was recently awarded **The Secretary of Defense Medal for Exceptional Public Service** for her work helping communities save lives with the Columbia Protocol, a powerful symbol of the impact of this public health approach.

The Protocol has been noted in a **keynote speech at the White House and has been presented to Congress**. Through Dr. Posner's advocacy, this work has changed local, national and international policy, which in turn has helped achieve reductions in suicide across all sectors of society.

Her policy work with the C-SSRS helped the state of Utah achieve its **first decrease in suicides in years**, reversing an alarming trend, and has helped the **U.S. Marine Corp achieve a 22% reduction in suicide,** through putting it in everyone's hands. Israeli government officials said her work "is not only saving millions of lives but in Israel it is **literally changing the way we live our lives**." A former leader in the U.S. Department of Education said that the Columbia Protocol **"has the potential to keep the 64 million children in our schools safe** physically and mentally by helping prevent school violence."

Dr. Posner was commissioned by the FDA to develop this scientific approach that **has become the gold standard** for suicide monitoring and is **ubiquitous across the U.S and many international agencies**. The C-SSRS has been adopted or recommended by the CDC, FDA, DoD, and NIMH. A lead article in *The New York Times* called this work **"one of the most profound changes of the past sixteen years**."

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PERSONNEL AND READINESS

MEMORANDUM FOR DEPUTY ASSISTANT SECRETARY OF THE ARMY FOR MILITARY PERSONNEL/QUALITY OF LIFE
DEPUTY ASSISTANT SECRETARY OF THE NAVY FOR MILITARY PERSONNEL POLICY
DEPUTY ASSISTANT SECRETARY OF THE AIR FORCE FOR RESERVE AFFAIRS AND AIRMEN READINESS

SUBJECT: Use of the Columbia-Suicide Severity Rating Scale

Suicide is a complex problem that requires a multi-strategy public health approach for prevention. While psychotherapeutic and pharmacologic interventions administered by medical and mental health professionals housed in hospitals and clinics are critically important our data and surveillance points toward the majority of Service members never choosing to access behavioral health. As a result, a broader-scale, public health approach to suicide prevention is warranted. A public health approach addresses the problem of suicide from a community perspective. It involves training of multiple gatekeepers on how to identify risk factors and warnings signs for suicide, and to assess for suicide risk.

The Defense Suicide Prevention Office (DSPO) supports the use of the Columbia-Suicide Severity Rating Scale (C-SSRS)- Screening Version for use within military communities, and more specifically, with military commands, community counselors, Sexual Assault Prevention and Response victim advocates, chaplains, law enforcement, firefighters, first responders, attorneys, peers, and other gatekeepers. The C-SSRS is already in wide utilization across all branches of the military.

The Centers for Disease Control has adopted the Columbia definitions in the context of their Self-Directed Violence Surveillance Uniformed Definitions, and the National Institutes of Mental Health has acknowledged the C-SSRS's capacity to identify those most at risk for suicidal behavior.

For more information on the Columbia-Suicide Severity Rating Scale- Screening Version, please visit the following website: http://www.cssrs.columbia.edu. Please see http://www.cssrs.columbia.edu/psychometric_cssrs.html for information on the Columbia's psychometric properties.

For further questions about Suicide Prevention tools, please contact DSPO at 703-614-8840.

K. Franklin

Keita Franklin, PhD, LCSW
Director
Defense Suicide Prevention Office

Operation Warrior Shield

"Healing the Hidden Wounds"

Tax ID 81-1268470 501C3 IRS Certified

My name is CMSgt (ret) Ed Schloeman and I have been involved with the epidemic of veteran/military suicide since 2010. To equate that in lives lost, using the common number of 22 Veterans a day taking their life, that adds up to 64,284 families destroyed. These families now are subject to TRAUMATIC GRIEF which leads to many disorders.

But we are here today to discuss New York Veterans. I have provided you with the most recent NY State Veteran Suicide Data Sheet 2015 and what it shows is; 152 NY Veteran suicides with two struggling aged groups;

92 suicides over 55 years old and 42 between 35-54 years committed suicide that year.

I have been attending many Veteran events throughout these years and most of the time, veteran service groups outnumber the veteran attendees. And throughout all of these events, I find not too many veterans in the troubled age group—over 55. Causes for their suicide could be—loss of a spouse, cancer, or finally PTSD, which has been with them since The Gulf War, Vietnam—and maybe Korea.

Where are you finding these age groups?---In the Department of Veterans Affairs Medical Centers because NYC has always had a great relationship with these medical centers. But, the process is laborious and difficult. Letting Veterans see their own doctor is one of the answers.

Operation Warrior Shield, which I am Chairman/CEO, have been working with three great organizations to combat the epidemic; The David Lynch Foundation,Tournesol Wellness and NYC's Department of Veterans Services. All supporting VAMC and our Veteran community.

We provide the non-religious modality of Transcendental Meditation and Community Based holistic services to the NYC VAMC's and "off-the street" veterans. First—what is TM

- TM is a simple method of relaxing the mind and body, reducing stress, improving psychological and physical health, and enhancing cognitive functioning. Over the last five years, it has been taught to 2,625 veterans and military personnel. (544 in NYC alone.) More than 380 peer-reviewed studies have been conducted over the last 40 years illustrating that TM has wide-ranging physical and mental health benefits. The National Institute of Health have awarded over $26 million to research the effectiveness of TM for reducing stress and stress-related issues.

  I HAVE ATTACHED MEDICAL DATA TO SUPPORT ABOVE

Our other partner in this fight against PTSD and Suicide is Tournesol Wellness, located in midtown. TW is an interactive medical center and healing arts community who empowers people with tools and strategies to achieve balance in the face of life's challenges.

YOGA, VIBROCOUSTIC SOUND THERAPY, PSYCHOTHERAPY AND MUCH MORE.

The Vietnam Veterans Wall in DC is a testament to the horrors of war. For all the names that are imprinted on that wall—58,318---there are untold numbers of veterans who made it through combat only to fall to the battle within their minds. And in my opening statement, since I have been doing this work, there are 68,284 more who did not make it.

So far, Operation Warrior Shield is treating veterans from the VAMC's and recently from VetconnectNYC. What shall prevent us from doing ALL THAT WE CAN== **funding.**

Boro-Presidents have grants that support capital growth in their boroughs – millions of dollars available.

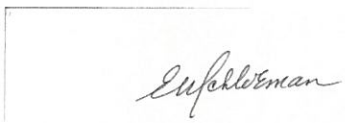
What can the city council commit to that can prevent a veteran suicide?

I remember seating here a few years ago when you asked the Director of MOVA , Mr. Holiday, how much do you need to insure all NYC Veterans are being taken care of. To my knowledge, he never gave you a number.

I would like for you to ask me that same question.

You have made it possible to have the nation's Best Department of Veterans Services in our country under the leadership of Commissioner Sutton.

Can we ask one more time for help from you? That help can come by establishing set aside funding which could be allocated to qualified foundations, like mine, that provides, free of charge, to your veterans the services which we have been doing for 10 years.



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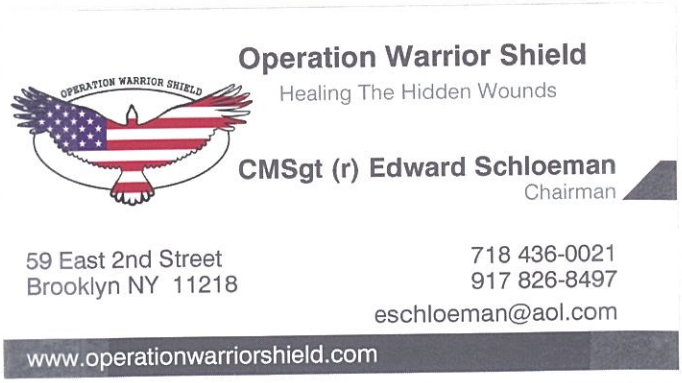

Summary of Research on PTSD

The Transcendental Meditation Technique

Transcendental Meditation (TM) is a simple method of relaxing the mind and body, reducing stress, improving psychological and physical health, and enhancing cognitive functioning. It has been taught to more than three million Americans in many corporate and institutional settings, ranging from Fortune 100 companies to homeless shelters, from social service agencies to hedge funds. Over the last five years, it has been taught to more than 1500 veterans and military personnel. More than 380 peer-reviewed studies have been conducted over the last 40 years illustrating that Transcendental Meditation has wide-ranging physical and mental health benefits. The National Institutes of Health have awarded over $26 million to research the effectiveness of TM for reducing stress and stress-related illness.

Key features of the practice include:

- Easy to learn and practice
- Results begin immediately with learning the technique
- Non-religious
- No negative side effects
- Cost-effective compared to other PTSD treatments
- It is portable and veterans can practice on their own wherever they are

Current Studies on Transcendental Meditation in Veteran Populations

Wege Grant (87 veterans, not all with PTSD)

- Average PTSD symptoms for the whole group decreased by 42% as measured by the PCL-5 test instrument in one month
- Of the 60 veterans with scores above the threshold for PTSD, 63% dropped below the PTSD threshold after one month of TM practice, 82% had a clinically significant drop in PTSD score (10 points or more).
- Improvements on specific components of PTSD:
    - 48% improvement in sleep
    - 46% increased ability to concentrate,
    - 46% reduction in strong negative feelings
    - 39% increase in capacity to experience positive feelings, such as happiness and love.

Wounded Warrior Project Grant (169 Veterans, not all with PTSD)

Results are both clinically and statistically significant

- 48% drop in PTSD levels in one month (average drop 19.5 points on PCL-5 scale)
- for veterans above the clinical threshold for PTSD, there was a 51% drop in PTSD levels in one month (average drop 26 points on PCL-5 scale)
- 65% of veterans scoring above the PTSD threshold at baseline dropped below the PTSD threshold in one month
- 42% reduction in depression in one month as measured by CES-Depression Scale
- 94% of veterans reported improved sleep after learning TM and there was a 25% improvement in sleep in one month on MOS Sleep Scale
- 34% of those on prescription medications reported a reduction of use in the first month

Published Research on Transcendental Meditation and Veterans

A study at the Army's Traumatic Brain Injury Clinic at Fort Gordon, Georgia examined 74 active-duty service members with PTSD or anxiety disorder. 83.7% of meditators in the group stabilized, reduced or stopped using medication (10.9% increased usage.) Among non-meditators, 59.4% stabilized, reduced or stopped using medication (40.5% increased.) [Military Medicine, 2016, 181: 56-63]

A randomized control trial of 18 Vietnam veterans compared TM to psychotherapy. The TM group improved significantly on 8 of 9 measures (depression, anxiety, emotional numbness, alcohol consumption, family problems, difficulty in getting job, insomnia, overall PTSD symptoms.) The Psychotherapy group did not have statistically significant improvements on any of the measures. [Journal of Counseling and Development, 1985, 64: 212-215]

A study on five veterans showed a 44% reduction in PTSD scores in two months as measured by the Clinician Administered PTSD Scale and 53% drop in depression, as measured by the Beck Depression Inventory. [Military Medicine 176 (6): 626-630, 2011]

Video links to veterans talking about their experience with TM

https://www.tm.org/tm-for-vets

New York
Veteran Suicide Data Sheet, 2015

The 2015 state data sheets contain the most up-to-date Veteran suicide information for all 50 states, the District of Columbia, and Puerto Rico. These sheets reflect the U.S. Department of Veterans Affairs' expanded analysis of suicide rates and include data that has become available since the release of the 2014 state data sheets.

This New York Veteran Suicide Data Sheet is based on a collaborative effort among the U.S. Department of Veterans Affairs (VA), the U.S. Department of Defense (DoD), and the National Center for Health Statistics (NCHS). The statistics herein are derived from multiple data sources, including the VA Office of Enterprise Integration, the VA Serious Mental Illness Treatment Resource and Evaluation Center, VA Post-Deployment Health Services, the VA Center of Excellence for Suicide Prevention, and the Defense Suicide Prevention Office. Cause of death was identified through the NCHS National Death Index (NDI). For additional information, please email Dr. Megan McCarthy, National Deputy Director for Suicide Prevention, VA Office of Mental Health and Suicide Prevention, at megan.mccarthy@va.gov.

New York Veteran Suicide Deaths, 2015

Sex	*Veteran Suicides*
Total	152
Male	140–150
Female	<10

Because some of New York's Veteran populations are relatively small, suicide deaths are presented in ranges rather than precise counts to protect confidentiality.

Northeastern Region

Connecticut
Maine
Massachusetts
New Hampshire
New Jersey
New York
Pennsylvania
Rhode Island
Vermont

New York, Northeastern Region[a], and National Veteran Suicide Deaths by Age Group, 2015[b]

Age Group	*New York Veteran Suicides*	*Northeastern Region Veteran Suicides*	*National Veteran Suicides*	*New York Veteran Suicide Rate*	*Northeastern Region Veteran Suicide Rate*	*National Veteran Suicide Rate*
Total	152	663	6,115	18.1	22.2	29.7
18–34	18	75	785	25.7*	32.1	39.1
35–54	42	192	1,777	23.0	30.4	34.8
55–74	62	251	2,310	17.6	19.5	26.0
75+	30	144	1,241	12.9	17.3	27.1

* Rates calculated from suicide counts lower than 20 are considered unreliable.

After accounting for differences in age, the Veteran suicide rate in New York was significantly lower than the national Veteran suicide rate[c].

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Mental Health and Suicide Prevention

New York Veteran and Total New York, Northeastern Region[a], and National Suicide Deaths by Age Group, 2015[b]

Age Group	New York Veteran Suicides	New York Total Suicides	Northeastern Region Total Suicides	National Total Suicides	New York Veteran Suicide Rate	New York Suicide Rate	Northeastern Region Suicide Rate	National Suicide Rate
Total	152	1,614	5,912	42,790	18.1	10.4	13.3	17.3
18–34	18	398	1,420	11,452	25.7*	8.3	11.0	15.4
35–54	42	602	2,254	15,687	23.0	11.5	15.1	18.7
55–74	62	487	1,775	11,940	17.6	11.6	14.2	17.4
75+	30	127	463	3,711	12.9	9.8	11.9	18.4

* Rates calculated from suicide counts lower than 20 are considered unreliable.

After accounting for differences in age, the Veteran suicide rate in New York was significantly higher than the national suicide rate[c].

New York Veteran and Total New York, Northeastern Region[a], and National Suicide Deaths by Method[d], 2015

New York Veteran Suicides ***New York Total Suicides*** ***Northeastern Region Suicides*** ***National Suicides***

Data presented herein is based on the U.S. adult population age 18 or older. National and regional statistics presented include the contiguous United States, Alaska, and Hawaii. The total state, regional, and national counts and rates presented are for the general U.S. population, which includes both Veterans and non-Veterans.

Suicide rates presented are the number of suicide deaths in 2015 divided by the estimated population, multiplied by 100,000. Veteran suicide data was obtained from the VA/DoD Joint Suicide Data Repository (SDR), and counts of suicides among the general U.S. population were obtained from CDC Wide-ranging ONline Data for Epidemiologic Research (WONDER)[f]. Veteran suicide rates are calculated using the Veteran Population Projection Model 2016 (VetPop2016) population estimates[g]. General U.S. population rates are calculated using the U.S. Census Bureau American Community Survey (ACS) one-year estimates[h]. Age-specific counts may not sum to the total counts because a small number of deaths with unavailable age information are included in the total counts and rates, but are not included in age-specific counts, age-specific rates, or age-adjusted rates.

Rates are marked with an asterisk (*) when the rate is calculated from fewer than 20 deaths. Rates based on small numbers of deaths are considered unreliable because a small change in the number of deaths might result in a large change in the rate. Because suicide rates based on fewer than 20 suicide deaths are considered statistically unreliable, any comparisons between age-adjusted rates and underlying age-specific rates based on fewer than 20 suicide deaths should also be interpreted with caution. Significance testing is based on the direct age-adjusted rates, using the 2000 standard U.S. population[i].

Suicide deaths for this data sheet are based on the underlying cause of death listed on the state death certificate as recorded in the SDR. Underlying cause of death, based on the International Classification of Diseases 10th revision (ICD-10), is defined as (a) the disease or injury that initiated the train of events leading directly to death, or (b) the circumstances of the accident or violence that produced the fatal injury[j]. The ICD-10 codes used to define suicide deaths are X60–X84 and Y87.0. For the percentages of suicide deaths by method, when the number of deaths in any one category is lower than 10, the categories with the smallest numbers are combined until a minimum count of 10 is reached.

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[a] Northeastern Region includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

[b] Rates presented are unadjusted rates per 100,000. To protect privacy, and prevent revealing information that may identify specific individuals, counts and rates are suppressed when based on 0-9 people. Rates calculated with a numerator of less than 20 are considered statistically unreliable, as indicated by an asterisk (*).

[c] Suicide rates presented in the tables are unadjusted for age. Age-adjusting suicide rates ensures that differences in rates are not due to differences in the age distributions of the populations being compared. In some cases, the results of comparisons of age-adjusted rates differ from those of unadjusted rates. Comparison of rates based on the rate ratio of adjusted rates, significance determined based on a p-value <0.05.

[d] Methods are based on ICD-10 codes X72 to X74 for firearms, X60 to X69 for poisoning (including intentional overdose), and X70 for suffocation (including strangulation). "Other Suicide" includes all other intentional self-harm, including cut/pierce, drowning, fall, fire/flame, other land transport, struck by/against, and other specified or unspecified injury. In cases where the number of deaths in any one of the categories was lower than 10, the categories with the smallest numbers were combined until the minimum count of 10 was reached, to maintain confidentiality.

[e] "Other Suicide" refers to all methods of suicide death apart from firearms, suffocation, and poisoning. "Low-Count Methods" refers to methods used in fewer than 10 deaths in a given state or territory. In states or territories with fewer than 10 firearm deaths, suffocation deaths, or poisoning deaths, those data are represented in the "Other and Low-Count Methods" category to protect the privacy of individual suicide decedents.

[f] National, regional, and state total suicide counts are obtained from the CDC WONDER online database. For more information on CDC WONDER, please refer to http://wonder.cdc.gov/ucd-icd10.html.

[g] Veteran Population Model 2016 (VetPop2016), Predictive Analytics and Actuary, Office of Enterprise Integration, Department of Veterans Affairs.

[h] U.S. general population estimates used for rate calculations are obtained from the U.S. Census Bureau, 2015 American Community Survey one-year estimates.

[i] Klein, RJ, and Schoenborn, CA. Age adjustment using the 2000 projected U.S. population. Healthy People Statistical Notes, No. 20. Hyattsville, Maryland: National Center for Health Statistics. January 2001.

[j] World Health Organization, Manual of the International Statistical Classification of Diseases, Injuries, and Cause of Death, based on the recommendations of the Ninth Revision Conference, 1975; Geneva, 1977.

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I am a Veteran. I am not special. Many have done far more than I. Like many who witnessed their country, and this city attacked, I answered the bugle's call and enlisted. We courageously faced the demons that haunted your nightmares. While the demons eventually left your nightmares to be replaced with dreams of ice skating at Rockefeller center, or having a first kiss in Central Park, that evil infected us and became a part of our daily nightmare upon our return.

On the early hours of Christmas 2006, less than 2 months after my return from Iraq, after being turned away by a church and a hospital, loaded a Beretta 9mm, put it to my temple and pulled the trigger. The gun misfired. Each day, twenty-two veterans have a similar experience and are not as lucky as I was. They were buried under the flag of the country they loved and were willing to die to defend. They volunteered to give their life for this country, they just never realized they would die by their own hand on America soil far from the battlefield. One such Veteran is SFC Danny Smith who on Saturday took his life after returning from a deployment. He was discovered by his son.

After my 5th and final attempt that should have been successful, I was snuck a note by an intern at the VA that saved my life. It said "Google MDMA/PTSD.

Exactly 8 years from my return from Iraq on November 22nd, 2014 I took MDMA for the first time as part of an FDA/DEA approved clinical trial conducted by the Multidisciplinary Association for Psychedelic Studies (MAPS). I didn't think it would work. I didn't think it would help. It was a miracle. I no longer have suicidal ideation, depression, or PTSD. I literally went from being in a VA mental ward to working as Sen Rand Paul's National Veterans Director on his presidential campaign.

At their 12 month follow up, 68% of participants no longer had PTSD. This is accomplished using psychotherapy under the influence of MDMA. 3 sessions, 3-4 weeks apart with 12 integration sessions. Unlike other treatments I went through, to include 42 pills a day, CBT, Exposure Therapy, etc., MDMA therapy allows the Veteran to actually deal with the root cause and trauma, rather than treating the symptoms. This is one of the reasons that when traditional treatment stops, whether Zoloft or cannabis, the symptoms return. This treatment is different. I was healed 4 years ago. I am better now than when I completed my treatment. It has also made me more resilient to future trauma.

This treatment has given me a 4th chapter to my life. This treatment is the reason my stepson has a father instead of a folded flag as SFC Smith's son will receive.

SGT(R) Jonathan M. Lubecky
USMC 1995-1999
Medically Retired Army 2003-2009

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MAPS
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Media Highlights

maps.org/media

TIME

Ending America's War on Drugs Would Finally Unleash the Therapeutic Potential of Psychedelics
Written by Rick Doblin,
May 30 2018

Medium

MDMA Helped Me Recover from War
Written by Jonathan Lubecky,
May 28, 2018

The New York Times

Treating PTSD With MDMA? You Might Have Some Questions.
Written by Dave Philipps,
May 2, 2018

Coming Back to Life: My Story of MDMA-Assisted Psychotherapy for PTSD
Written by Rachael Kaplan,
MAPS *Bulletin*
Winter 2017

TIME

Ending America's War on Drugs Would Finally Unleash the Therapeutic Potential of Psychedelics

Written by Rick Doblin

May 30, 2018

It was only after U.S. veteran Jonathan Lubecky pulled the trigger on a loaded gun aimed at his head and it misfired that he finally decided to seek help. He had tried to commit suicide five times, after struggling with post-traumatic stress disorder (PTSD) as a result of 12 years in the Marines and the Army, including service in Iraq.

Like many ex-servicemen and women experiencing mental health issues, Lubecky went to the Department of Veterans' Affairs (VA). But none of the treatments offered there worked for him. The only two drugs approved by the Food and Drug Administration for PTSD, Zoloft and Paxil, were more effective in women than in men, and didn't work for combat-related PTSD. Out of desperation, he volunteered as a subject in an experimental study of MDMA-assisted psychotherapy for chronic, treatment-resistant PTSD in veterans, firefighters and police officers.

The study was sponsored by the non-profit research and educational organization I founded, the Multidisciplinary Association for Psychedelic Studies (MAPS), and funded entirely by private donations. Because of the stigma associated with illegal drugs—MDMA is what the party drug, ecstasy contains, though the pills are often impure—MAPS was unable to get grants from the Department of Defense, the Veterans Administration or the National Institute of Mental Health, despite there being over 868,000 veterans with PTSD receiving monthly disability payments from the VA at an estimated cost of $17 billion per year.

The treatment being tested by the study involved three day-long administrations of MDMA about a month apart, and 12 sessions of psychotherapy within a three-and-a-half-month process.

After his treatment with MDMA-assisted psychotherapy, Lubecky managed to heal from his PTSD to the point that he became National Veterans Director for Senator Rand Paul's 2016

presidential primary campaign. His recovery is not unusual. On May 1, *The Lancet Psychiatry* published a scientific paper about the study Lubecky volunteered for; it reported that two-thirds of the 26 veterans, firefighters and police officers treated no longer qualified for a diagnosis of PTSD one month after their second MDMA session, with their reduction of PTSD symptoms lasting over time.

If Big Pharma were to try to create from scratch a drug optimized to treat PTSD, MDMA would be that drug. Big Pharma, in the form of Merck, did invent MDMA in 1912, but had no idea what it had created. Merck tested MDMA in animals in 1927 and again in 1959 but the research gave no clues about MDMA's therapeutic potential. MDMA is now out of its patent restrictions, another reason for MAPS' non-profit drug development efforts.

PTSD changes people's brains, increasing activity in the amygdala, where fear is processed, and reducing activity in the prefrontal cortex, where rational decision-making takes place. MDMA does the opposite, decreasing activity in the amygdala and increasing activity in the prefrontal cortex. MDMA also stimulates the release of the hormones prolactin and oxytocin, associated with bonding, affiliation and love, facilitating the therapeutic alliance between patient and therapist and increasing the effectiveness of psychotherapy. MDMA also stimulates the release of the neurotransmitters serotonin, dopamine and norepinephrine, producing a complex symphony of effects that help the drug enhance psychotherapy.

The organization is also sponsoring research into the use of four different kinds of smoked cannabis (THC, CBD, THC/CBD combination and a placebo) in 76 veterans with chronic, treatment-resistant PTSD. This study took seven years to obtain all the approvals, is funded by a $2.15 million grant to MAPS from the State of Colorado, and enrollment is about 75% completed. Unlike MDMA-assisted psychotherapy, marijuana for PTSD is usually self-administered on a daily basis to control symptoms, and is used for months or years, with symptoms often returning after cessation of use. Marijuana is reported by many veterans to be helpful for PTSD, but MAPS' study is the first double-blind, placebo-controlled study ever conducted.

U.S. and global drug prohibition has for decades delayed medical research into the healing properties of Schedule 1 drugs. Now that this research is finally being conducted, we're learning that enormous suffering and many suicides could have been prevented over these decades. It's long past time for the mainstreaming of the medical use of psychedelics and marijuana, and for replacing prohibition and criminalization with public health approaches to reducing drug abuse. In a post-prohibition world, we'll finally recognize that.

MDMA Helped Me Recover from War

Written by Jonathan Lubecky

May 29, 2018

I served in the military twice: first in the Marine Corps as a loadmaster on C-130s and C-9s from 1995 to 1999, and then as a sergeant in the Army. I deployed with my artillery unit to Iraq; we were there from October 2005 through October 2006.

My unit was on Balad Air Base, in the center of the Sunni Triangle, in the middle of the sectarian violence during Saddam's trial. That was probably either the worst time in Iraq or second worst, after the initial invasion. The base got mortared so often it was known as Mortaritaville.

The base I was on had a concrete plant, and we needed a lot of gravel delivered. Every morning, there was a giant lineup of about 200 dump trucks waiting to get on the base and drop off gravel. One morning, we opened the gate for everyone to come in, but none of the trucks moved. So we sent out a team and went truck by truck, and every single person had been shot in the head.

That was a bad day.

In April 2006, I got blown up in a porta-john. A mortar landed and threw shrapnel through the walls while I was using the toilet in the middle of the night—I'm actually alive because I was tired and sat down to pee. All the shrapnel missed me, but I was knocked out for a little bit. That's probably where my traumatic brain injury came from.

When I came home from the war, I watched every single person in my unit go to somebody—a parent, a child, a sibling, a girlfriend, a wife. My wife's not there. I go out into the rain, turn on my cellphone for the first time in a year, and call her. There's no answer. I end up having to take a taxi to my house, which is empty. My dog's gone. My motorcycle's gone. She apparently moved in with someone else two weeks earlier.

Christmas Eve 2006, I went to a bar that I frequented in Raleigh. I had two drinks and heard the church bells for midnight mass. I thought, "I don't need to be in a bar on Christmas. I need to go there." So I went to a Catholic church in downtown Raleigh, and they said, "We're full, come back in the morning." By this time, I've got tears streaming down my face. I'm like, "I just got back from Iraq. I really just need to go in there. I'll stand in the back." They're like, "No, we're full. The fire marshal will get us in trouble. Go away."

So I went to sit on the war memorial on the state capitol grounds in downtown Raleigh for about an hour, coming up with new and inventive ways to end my life. The Army kept giving us briefings that said if you were thinking like this, you should go to the hospital. So I got in my car and drove to Womack Army Medical Center at Fort Bragg, and I told them, "I'm going to kill myself."

They asked if I have guns. I said, "Yes, a lot."

They said, "Do you have ammo for those guns?"

I said, "Yes, a lot."

They said, "Okay, here are six Xanax. Don't take them all at the same time because it'll kill you. When you get home, give your guns to a neighbor and come back after the holiday."

So I went back to my house, chugged a fifth of vodka, and loaded a Beretta nine millimeter. I put it to my temple and pulled the trigger. As the hammer fell, it was the most peace I had felt in my whole life. But it was a squib load—there wasn't enough gunpowder in the bullet, so it didn't go all the way down the barrel.

That was the first of five suicide attempts that should have been successful.

For eight years, that was my life. Every second of every day, I was either thinking of killing myself or planning to kill myself.

During that time, I tried exposure therapy, cognitive behavioral therapy, all kinds of antidepressants. Nothing worked. Employment-wise, I had been trying to do what I did before I

deployed: transportation logistics. But that requires a lot of math ability and mental acuity that kind of got blown away in the porta-john. So I kept getting jobs and getting fired. Mental health issues didn't help.

I started working on legislation to improve VA benefits, and I went to school at the Citadel to begin a political career. I met Rand Paul when he came to speak there, and he noticed the bandages on my wrists. He asked what happened, and I said, "Oh, a week ago I tried to kill myself and I cut my wrists." He pulled me aside and said, "Forget I'm a senator. I'm also a doctor. I want to know what's going on right now." We talked for 20 minutes, and at the end of it, he gave me his right-hand man's cellphone number and said, "If you ever feel that way again, I want you to call that phone number, and we will use the full weight of my office and the federal government to fix whatever problem you have." (Two years later, I ended up working for his presidential campaign.)

I kept going to the VA. One day, I see an intern instead of my regular psychiatrist. She tells me, "Because I'm an intern and they quiz me on all this stuff, I've probably read your file more than anybody." She slides a piece of paper across the desk and says, "I want you to open that when you leave the VA. I'm not supposed to tell you about that, so just stick it in your pocket." We finish up the meeting, I walk outside, I pull out the note, and it says, "Google MDMA PTSD."

So I did. Through the organization MAPS, I learned about a study using MDMA-assisted psychotherapy to treat PTSD. I ended up being a part of it. For me, it was three treatments from Thanksgiving 2014 to spring break 2015. Each time, in a house retrofitted as a medical center, I started with a dose of 125 milligrams, with a 62.5-milligram booster four hours in. I took the MDMA, and then I took part in a psychotherapy session.

It's really hard to explain to people who have never done psychedelics what it's like to do psychotherapy under psychedelics. It's not just tripping on ecstasy, and it's not just psychotherapy—it's a synergistic effect between the two. It's like going to a regular counseling session, except you're being hugged by the person who you know loves you the most on this planet while being buried in fuzzy puppies licking your face.

In my first session, a big chunk of the beginning was just me going, "This is awesome." Then the psychiatrists ask questions like, "So, what was the weather like in Iraq?" It's the most innocuous question, but you start talking, and you keep talking. The MDMA is suppressing your fight-or-flight response in the amygdala, so you can address things that might otherwise make you panic. I talked about things I hadn't talked about with anyone else before.

And it fixed me.

I had my last treatment in 2015. One year following the study, my PTSD symptoms were dramatically reduced—I do still technically have PTSD. Depression was reduced by 60 percent, and suicidal ideation went away. Before my treatment, I was on 42 pills a day at one point. Now I take Concerta so I can concentrate and Ambien so I can sleep.

PTSD is a kind of like autism: It's a spectrum. Some people can deal with it by going to church or the gym. There are people for whom a Zoloft a day will keep the doctor away. Then there are people like me. The VA says that for 30 percent of people with PTSD, they have no effective treatment.

We need options. Right now there's just a cookie-cutter mold of PTSD treatment, and if you fall outside that mold, you live your life in misery. That's what I did for eight years. I'm angry that I have friends still in misery who don't have access to this treatment. I'm angry I had to wait eight years to get it.

Veterans are strong—we can survive three years of hell if we know there's a light at the end of the tunnel. The problem is a lot of veterans don't see that light, so they choose the only freedom they know, and that's a bullet to the head.

The New York Times

Treating PTSD With MDMA? You Might Have Some Questions.

By Dave Philipps

May 2, 2018

The drug known by the street names Ecstasy or Molly could be a promising treatment for post-traumatic stress disorder, according to a new study.

Research published Tuesday in the British journal The Lancet Psychiatry found that after two sessions of psychotherapy with the party drug, officially known as MDMA, a majority of 26 combat veterans and first-responders with chronic PTSD who had not been helped by traditional methods saw dramatic decreases in symptoms.

The improvements were so dramatic that 68 percent of the patients no longer met the clinical criteria for PTSD. Patients taking the drug also experienced "drastic" improvements in sleep and became more conscientious, according to the study.

The results, which mirror those of similar, small-scale studies of the illegal drug in recent years, come as MDMA is about to enter larger, Phase 3 trials this summer. Based on previous results, the Food and Drug Administration has given MDMA breakthrough therapy status, which could speed approval. If large-scale trials can replicate safety and efficacy results, the drug could be approved for legal use by 2021.

"I was finally able to process all the dark stuff that happened," Nicholas Blackston, 32, a study participant who had been a Marine machine-gunner in Iraq, said in an interview. "I was able to forgive myself. It was like a clean sweep."

But the possible legalization of a widely abused party drug raises a lot of questions.

How might MDMA therapy work?

No one goes home with a bottle of Ecstasy.

If approved by the F.D.A., MDMA would only be administered by a licensed therapist. First, a patient goes through three sessions of psychotherapy. In the fourth session, the patient takes a pill.

After taking the drug, the patient lies on a futon amid candles and fresh flowers, listening to music. Two therapists — one female, one male — sit at the patient's side as guides. That session lasts eight hours.

"We encourage them to set aside all expectation and agenda and be open. Experiences tend to be very individual," said Dr. Michael Mithoefer, one of the principal researchers.

The drug floods the brain with hormones and neurotransmitters that evoke feelings of trust and well-being, users report. Researchers say this allows patients to re-examine traumatic memories.

In follow-up psychotherapy, patients process emotions and insights brought up during the MDMA session. The current protocol calls for patients to take MDMA two or three times, each a month apart, interspersed with psychotherapy.

"The MDMA alone or the therapy alone don't appear to be as effective," Dr. Mithoefer said. "The MDMA seems to act as a catalyst that allows the healing to happen."

What do patients say about it?

"I was actually able to forgive myself," said Nigel McCourry, 36 a Marine veteran who was deployed in 2004 to Falluja, Iraq, whose experiences mirrored those of three other patients interviewed.

Mr. McCourry came home from war unable to escape scenes of an explosion that nearly killed him, and haunted by the memory of two young girls he accidentally killed in a fire fight. He struggled to sleep. He drank to forget. Rage eroded most of his relationships.

He tried help at a Veterans Affairs hospital, but couldn't let his guard down enough to benefit from standard psychotherapy. A handful of medications meant to help left him feeling like a zombie, and he gave them up. He was contemplating suicide when he tried MDMA.

"When it kicked in, it was like an epiphany," he said. "I could see all these things from combat I was afraid to look at before, and I had a totally new perspective. I relived the parts of me I had lost. I realized I had viewed myself as a monster, and I was able to start to have some compassion for myself. It was a turning point, and for the next year I continued to get better."

"There are also still some challenges I have to face from time to time related to the PTSD," he added. "But now I am able to work through them without getting stuck."

But does it actually work?

That's an open question.

Large-scale trials, which will include up to 300 participants at 14 sites, may not be able to replicate the success of previous trials, which were limited to a few dozen patients. But so far, results are encouraging. Nearly all patients saw clinically significant reductions in symptoms, and a majority saw such drastic reductions that they no longer met the criteria for a PTSD diagnosis. In the 12 months after MDMA therapy, PTSD symptoms generally continued to decrease.

Side effects, including anxiety, headache, fatigue, muscle tension and insomnia, were generally minor and limited to the days following the MDMA sessions.

Other researchers, intrigued by the results, are starting their own studies of MDMA therapy, including the Department of Veterans Affairs.

Seems risky. Isn't there something better?

Not really, said Dr. John Krystal, who heads the Neurosciences Division at the Department of Veterans Affairs National Center for PTSD. He described the current lack of effective therapy as "a crisis."

"The problem is that we don't have many treatments and what we have doesn't work that well," he said.

Only about one in three combat veterans with PTSD are effectively treated, he said.

Doctors often use a combination of off-label drugs to try to manage patients' nightmares, flashbacks and depression, but the drugs do nothing to treat the underlying condition, and can have negative side effects.

Psychotherapy also has limitations. Though many patients find it helpful, others find it too traumatizing or ineffective and quit therapy. In some studies, dropout rates were as high as 40 percent.

Who is behind these studies?

Not big pharma. The research is organized by a small nonprofit called the Multidisciplinary Association for Psychedelic Studies, or M.A.P.S., which was created in 1986 shortly after MDMA was outlawed.

"No one else would touch this, so we had to do it," said the founder of M.A.P.S., Rick Doblin, who has a doctorate in public policy from Harvard and has made legalizing MDMA his life's work.

The Phase 3 trials are expected to cost $27 million.

Where does the money come from?

It's all donations. And they have come from an odd array of sources. David Bronner, the vegan C.E.O. — that's Cosmic Engagement Officer — of Dr. Bronner's Magic Soaps and an unapologetic evangelist for psychedelics has given $5 million.

But also in the mix are the archconservative Mercer family, who typically fund right-leaning institutions including Cambridge Analytica and Breitbart News; the late Richard Rockefeller, a champion of public health; and an anonymous donor known only as Pine, who transferred $5 million in Bitcoin.

Does this mean people can just self medicate with MDMA?
People already are. The National Survey on Drug Use and Health found that in 2014 more than 17 million Americans reported using MDMA. While many are likely doing it purely for recreation, word of the therapeutic uses has spread, and combat veterans are trying it illegally at home.

But street Ecstasy is dangerous. Doses of the street drug can be an unknown mix of other stimulants and hallucinogens, and an overdose can be fatal. High frequency use of MDMA can also damage the brain.

Who cashes in if MDMA becomes legal?

M.A.P.S. would at first. MDMA was originally patented by pharmaceutical giant Merck in 1912, but it was never marketed and the patent lapsed. The F.D.A. grants temporary "data exclusivity" to groups that show new uses for drugs with expired patents. That would give M.A.P.S. a five-year monopoly in the U.S. After that, other companies could make it.

M.A.P.S. plans to spin off sales to a for-profit benefit corporation, which would then funnel the money back into clinical research on the use of MDMA with other disorders.

Is MDMA therapy new?

Yes and no. MDMA is an illegal drug and has never been approved for any use by the F.D.A. But for about a decade before it was outlawed in 1985, it was used as an aid in psychotherapy, especially on the West Coast.

At the time, academics were beginning to argue that it and other psychedelic drugs could be a useful ally in psychotherapy. The idea failed to gain traction then, but now a number of prestigious researchers are studying the potential therapeutic uses of LSD, psilocybin and MDMA.

Correction: May 1, 2018
An earlier version of this article misspelled the surname of a Marine veteran who said he tried MDMA therapy to treat his post-traumatic stress disorder. He is Nigel McCourry, not McCoury. The article also misstated the amount that an anonymous donor known as Pine transferred in Bitcoin to the Multidisciplinary Association for Psychedelic Studies. It was $5 million, not $4 million.

Rachael Kaplan

Coming Back to Life: My Story of MDMA-Assisted Psychotherapy for PTSD

RACHAEL KAPLAN

As I SIT IN A FIELD of tall green grasses, feeling the earth beneath me and listening to the songs of meadowlarks, I am overwhelmed with gratitude for not only being alive but for finally wanting to be alive. I am overwhelmed with gratitude for often feeling a sense of peace in my self and feeling connected with myself, with others and the world. These are all new experiences for me that I never believed where possible until now, after being a participant in the MDMA-assisted psychotherapy study in Boulder.

This last year, after integrating the healing that happened in my MDMA-assisted psychotherapy sessions, has been a drastic contrast to the rest of my life. For the majority of my life I prayed to die and fought suicidal urges as I struggled with complex PTSD. This PTSD was born out of chronic severe childhood abuse. Since then, my life has been a journey of searching for healing. I started going to therapy 21 years ago, and since then I have tried every healing modality that I could think of, such as bodywork, energy work, medications, residential treatment and more. Many of these modalities were beneficial but none of them significantly reduced my trauma symptoms. I was still terrified most of the time. I would have flashbacks that would leave me debilitated, having nightmares, dissociated, and self-harming, and I fought to keep myself alive each day. I had some of the best therapists, but I was so terrified from childhood trauma that my system would not let down its guard enough to let anything from the outside affect it. I was desperate for healing, and felt trapped by my level of fear.

It was this desperation to heal that lead me to enroll in the Boulder MDMA-assisted psychotherapy study. I was terrified to take a medicine that would put me in an altered state, but it was more terrifying not to try it, because I knew that if I did not find a way to heal then I would not have the will to keep living.

In my first MDMA-assisted psychotherapy session I was surprised that the MDMA helped me see the world as it was, instead of seeing it through my lens of terror. I thought that the MDMA would alter my perception of reality, but instead it helped me see if more clearly. As I sat with my two incredible therapists in my MDMA sessions it was the first time that I could really let in love, first time that I felt completely safe, respected and fully seen. I was blessed to have two therapists who were authentic, truly cared, and felt love for me. The MDMA allowed me to hone in on the real feelings of care that they had. For the first time in my life, I felt safe enough to let their love and respect into the core of my being. I had the felt experience of being completely vulnerable and seen while at the same time being loved, safe, and respected. This

planted the seed in me that it is actually safe to let in love and be seen by other trusted people as well as to let in my own love towards myself. This in itself has transformed how I am in relationships with other people and how I am in relationship with myself. The first couple MDMA-assisted psychotherapy sessions organically ended up being about understanding safety from the inside out, and learning that it was safe to connect to others. After the safety was deepened, I naturally began to process traumatic memories.

For the majority of my life, I had suppressed my memories of trauma and only understood fragments of it through my flashbacks and body memories. I hated myself for having such horrible memories and believed that I was psychotic and just making the memories up. I did this because it was easier to blame myself then to face the pain that these horrible things actually happened. This left me in a state of hating and not trusting myself, which only added to feelings of shame and depression. When I would go to therapy to try to talk about the memories, I would immediately become numb, and leave my body. In some cases, I would black out and end up curled in a ball, screaming. The MDMA session was the first time that I was able to stay present, explore, and process what had happened to me. This changed everything.

A life-changing moment happened at the beginning of my third MDMA session.

NYC Veterans Alliance

www.nycveteransalliance.org

www.ourveterans.nyc

Testimony by

Samuel Molik
Director of Policy and Legislative Advocacy
NYC Veterans Alliance

Joint Committees on Veterans and Mental Health, Disabilities & Addiction
Oversight: Veteran Suicide and Mental Health

February 26th, 2019

Good afternoon and thank you to the Committee Chairs for the opportunity to testify today. My name is Samuel Molik and I am the Director of Policy and Legislative Advocacy for the NYC Veterans Alliance, a member-driven, grassroots policy advocacy and community-building organization that advances veterans and their families as civic leaders.

On behalf of our members and supporters, I first would like to thank the chairs of both committees on holding this hearing today and bringing attention to the crisis of suicide and mental health within the veteran community. This is an issue our members have consistently brought forward as a top priority, and we have brought this before the Council numerous times, in addition to addressing this in our nation's Capitol alongside House Veterans Committee Chair Mark Takano and Iraq and Afghanistan Veterans of America. Veteran suicide is a national crisis, and one that requires marshaling all available resources within state and local governments to address the complex risk factors and find real solutions. Our nation needs veterans to continue to lead, serve, and make our communities better—we cannot continue to tolerate these preventable deaths.

The U.S. Department of Veterans Affairs publishes suicide statistics each year, and the data only becomes more alarming over these many years of conflict abroad and the advancement of veterans of many generations into categories that increase their risk. The VA's data shows an ongoing crisis, even as the VA itself has failed to expend its designated budget for suicide prevention. Yet we have many reasons to believe the VA's data does not capture the full extent of veteran suicide; it reports only veterans who have died showing a clear action or intention to die by suicide. The data does not capture overdoses or high-risk behaviors resulting in death unless this clarity of intention can be established. Countless veterans who have died after giving up hope of living go uncounted in these figures. We must do better as a community in tandem with our partners in government to avert this crisis.

Last year's VA report on suicide identified a national average of 20 current or former service members who die each day by suicide—a rate more than twice the rate of our civilian counterparts. Rates of suicide were highest among veterans under the age of 34, while the larger population of veterans aged 55 and older accounted for more than 58 percent of recorded veteran deaths by suicide. The rate of suicide of younger veterans continues to rise, as does the percentage of suicides resulting from firearms. In the State of New York, veteran deaths by

suicide are lower than the national average, but still represent a rate nearly double that of our civilian counterparts in our state.

The suicide crisis is increasingly getting attention, but less attention has been paid to the risk factors. The top three risk factors are as follows:

1 - Lack of VA Healthcare. Nationwide, the VA has identified that more than 2/3 of veterans who die by suicide did not receive recent VA healthcare. Despite recent reforms and expansion of VA care, there remains a critical staffing shortage at VA[1] and we've seen service reductions locally[2] because of staffing shortages, inoperable equipment, or inadequate facilities. Veterans who received discharges not listed as "honorable" have historically been unable to access VA care, and are more likely to encounter homelessness, incarceration, legal problems, substance abuse, and to die by suicide.

2 - History of Homelessness. Veterans with homeless histories were nearly 8 times more likely to have attempted suicide than veterans who have never been homeless and lifetime homelessness was independently associated with lifetime suicide attempts in veterans.[3]

3 - Chronic Pain. High risk factors for suicidal ideation are prevalent among individuals living with chronic pain[4], although it is difficult to identify when overdoses are intentional versus accidental. Recognizing a history of over-prescribing opioids, the VA has placed strict limits opioid prescriptions since 2014[5], but VA community care providers may not be adhering to these new standards.[6] These limits have also adversely affected many of the patients they were intended to help; as the VA's opioid prescriptions have decreased, overdose deaths have only continued to rise.[7] Limiting prescriptions has perhaps reduced the number of veterans becoming newly addicted to opioids, but those who have found themselves struggling with opioid addition have sought out other sources, including heroin[8] and fentanyl.[9][10] The fact remains that veterans are twice as likely as non-veterans to die from overdoses of opioids.[11]

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[1] https://www.military.com/daily-news/2018/09/04/no-clear-plan-fill-more-45000-job-vacancies-va.html
[2] http://www.nycveteransalliance.org/brooklyn_va_town_hall
[3] https://jech.bmj.com/content/early/2019/01/02/jech-2018-211065
[4] https://academic.oup.com/painmedicine/article/12/suppl_2/S43/1918150
[5] https://psmag.com/news/va-prescribing-fewer-opioids
[6] https://www.va.gov/oig/pubs/statements/VAOIG-statement-20171115-missal.pdf
[7] https://www.nytimes.com/2016/05/21/health/opioid-prescriptions-drop-for-first-time-in-two-decades.html
[8] https://psmag.com/social-justice/why-west-virginias-heroin-overdose-rate-doubled-after-it-mandated-doctors-use-the-state-drug-monitoring-database
[9] https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm

Other high risk factors must also be addressed. Veterans with a history of incarceration and ongoing legal issues are at high risk for dying by suicide. Veterans with untreated substance abuse histories are at high risk. Veterans with untreated PTSD are at high risk. Despite there being a clear correlation between military sexual trauma (MST) and depression, PTSD, and self-harm[12], a recent report showed that the VA wrongfully denied more than 1,300 veteran claims of MST within a 5-month period last year[13], keeping them from receiving services and benefits to which they should otherwise be entitled. This points to larger systemic problems with the processing of MST claims by the VA.

We strongly urge the Council to work with the advocacy community to develop and strengthen policy solutions attacking the complexities of each of these risk factors leading to veterans dying by suicide. We recommend the Council and the Administration take a more proactive approach to working with local VA Medical Centers and Vet Centers to ensure quality care is available and that veterans feel welcome to seek that quality care. We recommend continued efforts to move homeless veterans into permanent housing, and targeted efforts to ensure veterans can find and maintain affordable housing through historic preferences in lotteries and waitlists. We recommend the Council and Administration to work with Veterans Treatment Courts in each borough to ensure they receive the resourcing and support needed to divert veterans away from incarceration into programs that help them restore their lives. We recommend the Council continue to support efforts to provide free and confidential mental healthcare to veterans and family members outside of the VA as well, to include our community partners at the NYU Langone Military Family Clinic and NY Presbyterian Military Family Wellness Center.

Our list of recommendations is long, and more will be included in the Policy & Legislative Agenda we will release next month. We applaud the Council for holding this hearing, and we look forward to the work ahead in reducing the risk factors of veteran suicide. Thank you for the opportunity to testify today. Pending your questions, this concludes my testimony.

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[10] https://addiction.surgeongeneral.gov/

[11] https://www.reuters.com/article/us-usa-veterans-opioids/opioid-abuse-crisis-takes-heavy-toll-on-u-s-veterans-idUSKBN1DA1B2

[12] https://www.scopus.com/record/display.uri?eid=2-s2.0-85027944777&origin=inward&txGid=8dafa7dd305500b9e240fbc103a5e6c7

[13] https://www.stripes.com/news/lawmakers-advocates-call-for-change-after-va-mishandled-military-sexual-trauma-claims-1.544677

Veterans Mental Health
Coalition of NYC

administered by
V!brant
Emotional Health

New York City Council

Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

Honorable Diana Ayala, Chair

Jointly with:

The Committee on Veterans

Honorable Chaim M. Deutsch, Chair

T2019-3777T - Oversight - Veteran Suicide and Mental Health

February 26, 2019

Testimony by:

Joe Hunt
Director – Veterans Mental Health Coalition
Administered by
Vibrant Emotional Health, Inc. (formerly the Mental Health Association of New York City, Inc)

Thank you, Council Members Ayala and Deutsch, and members of the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services and the Committee on Veterans, for the opportunity to provide testimony regarding suicide and mental health services for NYC-area veterans. My name is Joe Hunt, I am an Army veteran and I serve as Director of the Veterans Mental Health Coalition of New York City (VMHC), which is administered by Vibrant Emotional Health (Vibrant), formerly the Mental Health Association of New York City.

For more than 50 years, Vibrant has provided direct services, public education and advocacy to address the needs of New Yorkers living with behavioral health needs. In addition to overseeing the VMHC, Vibrant provides training and technical assistance, as well as back up call center support, for the Veterans Crisis Line, which connects veterans, their families and caregivers with qualified Department of Veterans Affairs counselors who can respond effectively to crises and other emotional health concerns.

The VMHC works to improve the access to, and the quality of, behavioral health services specifically for veterans, active duty service members, and their families. It accomplishes this by conducting knowledge and skills building trainings and educational programs to broaden the capacity of providers to identify and address the behavioral health needs of NYC's military-connect community. The VMHC has a diverse membership made up of more than 850 members from over 370 organizations representing housing, legal services, academic institutions, hospitals and mental health providers; as well as City, State and Federal agencies. Eighty percent (80%) of our members are civilian, non-mental health providers who seek information and training about the culture and unique needs of veterans and their families in order to become more effective in delivering their services.

In addition to my role in the VMHC, I am Vibrant's Project Director for a new 3-year SAMHSA grant for Mental Health Awareness Training. This grant enables Vibrant, in cooperation with the Institute of Veterans and Military Families (IVMF), to provide Mental Health First Aid - Veterans Module Instructor training and certification to selected staff of IVMF's AmericaServes Coordination Centers who will, in turn, provide Mental Health First Aid training to over 1,000 veteran-serving non-mental health providers in their networks across the country. Two members of VetConnect NYC staff were among those trained in the first cohort. The goals of this initiative are to:

1. Increase the number of mental health providers in each of the AmericaServes Coordination Centers' referral networks
2. Train non-mental health providers to identify potential mental health and substance abuse issues among those they serve, and to provide the skills and resources necessary to enable these providers to make referrals for mental health support through their AmericaServes' Coordination Center.
3. Determine the baseline number of Mental Health referrals that occur in all AmericaServes network during Year-1,
4. Measure the increase in mental health referrals through the AmericaServes Coordination Centers as a result of Mental Health First Aid Training conducted within their communities.

Veterans, service members, and military families face unique challenges when they or a loved one needs behavioral health services. Insufficient capacity to address the needs of service members returning home, coupled with a lack of understanding about behavioral health disorders, treatment options, and the stigma associated with both, contribute to

underutilization of behavioral health treatment by veterans, service members and their families. Although the prevalence of mental health conditions and reported traumatic brain injury for troops returning from Iraq and Afghanistan is 31%, fewer than half seek treatment (Rand, 2008). This is further compounded by a lack of awareness of military culture by many community-based providers of service, a particularly salient point since approximately 38% of veterans are not enrolled in VA services. Earlier identification and intervention is necessary to have an impact on the 20 veterans who die by suicide every day, as reported by the Department of Veterans Affairs.

Increasingly, veterans, service members and their families are turning to veterans' service organizations for help in navigating the complexities of a fragmented and uncoordinated service system that include organizations providing employment services, housing/shelter, benefits navigation, financial management, legal services, help with basic needs such as food, clothing and utilities, as well as health and behavioral health services. To increase utilization of needed behavioral health services, it is necessary to enhance mental health awareness of not only veterans, service members and military families, but of the non-clinical providers serving this population, in order to ensure that they are able to identify at-risk individuals and connect them to appropriate sources of care.

Vibrant and the VMHC supported the creation of the New York City Department of Veterans Services (DVS) to meet the needs of New York City's more than 210,000 veterans[1], and applaud the Department's comprehensive effort to address the mental health and emotional well-being of veterans. But, it takes a community working together to accomplish these goals.

[1] NYC Mayor's Press Office November 11, 2017

The importance of information and training to a largely civilian, non-mental health provider community that serves as the "front line" to meet the needs of veterans returning home is essential. Also critical is the ability to measure the community 's impact on helping veterans access needed services and supports, particularly as it relates to mental health and suicide prevention.

We ask the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services and the Committee on Veterans to consider placing more emphasis on the training in Military Cultural Competence and Mental Health First Aid to providers of services to our military connected community. We also ask that both Committees encourage the expansion of veteran-serving organizations in the VetConnect NYC network among the providers in their respective districts and citywide. We encourage the committees to review the data collected by VetConnect related to participation of veterans' services agencies, particularly the data on mental health referrals through the VetConnect network.

Vibrant and the VMHC are grateful for the New York City Council's leadership and commitment to addressing the needs of New York City veterans and their families, including their behavioral health needs. We greatly appreciate the DVS Commissioner, Dr. Loree Sutton, for her leadership and dedication to meeting the integrated needs of veterans and their families. Vibrant looks forward to continued work with the Council and the current administration to continue to make New York City a place where the emotional well-being of veterans, active duty military, and their families can flourish.

Research and Recognition Project

A 501(c)(3) Charitable Organization

2018 UPDATED RTM PROJECT RESULTS

The PTSD Research field has spent over $900M in the last ten years with no appreciable advances in treatment. The American Medical Association brought the problem into clear focus in its most prestigious Journal, *JAMA,* September 2015. The article made two important points about the field's accepted evidence based treatments for PTSD starting with a very pointed criticism, "... approximately two-thirds of troops continued to meet criteria for a PTSD diagnosis after "successful" treatment and one quarter dropped out". Later it stated, "There is a need for improvement in existing PTSD treatments and for development and testing of novel evidence-based treatments, both trauma- focused and non–trauma-focused". We believe that the results of the following five completed studies and feedback from the training initial training programs, reflect the implied and direct recommendations by the A.M.A. in the JAMA article. The R & R Project is seeking funding for RTM Training for counselors working with PTSD clients and evaluation of the clinical effectiveness of the RTM manualized training process.

1. Pilot Study published in the *Journal of Military, Veteran, and Family Health*, (JMVFH; NY $300,000 Pilot Grant). 25 of 26 (96%) no longer test as having PTSD and their PTS intrusive symptoms were fully alleviated in under five sessions. (Gray & Bourke, 2015)

2. First Replication Study. Results were published in the *JMVFH* in 2017 (Tylee et al., 2017). Over 90% of the 30 male veterans were symptom and diagnosis free at the two- week, six-week, and twelve-month follow-ups.

3. Second Replication Study. Results are in preparation for submission to a peer-reviewed Journal. Over 96% of the 30 women veterans have scored below diagnostic threshold on the PCL-M and PSS-I at two weeks post and all subsequent measures to one year, follow-ups.

4. Third Replication Study. (NY $800 K Grant). 75 veteran study published in Psychotherapy Research (Gray, Budden-Potts, & Bourke, 2017). Over 90% of the male veterans completing treatment have scored below diagnostic threshold on the PCL-M and PSS-I. About half of those treated were followed to six months and retained freedom from PTSD intrusive symptoms and diagnosis.
5. Neurological Studies using EEG, pre- and post-treatment, have begun at the Mind Research Network in New Mexico. The first pilot "Quantitative EEG Markers of PTSD and Impact of the (RTM) Treatment Protocol has been submitted for publication to the J. of Biological Psychiatry. The research is being conducted in Dr Jeff Lewine's laboratory at New Mexico's, Mind Research Network for Neuro-diagnostic Discovery. Dr Lewine is one of the foremost neurological research scientists in the US working on PTSD.

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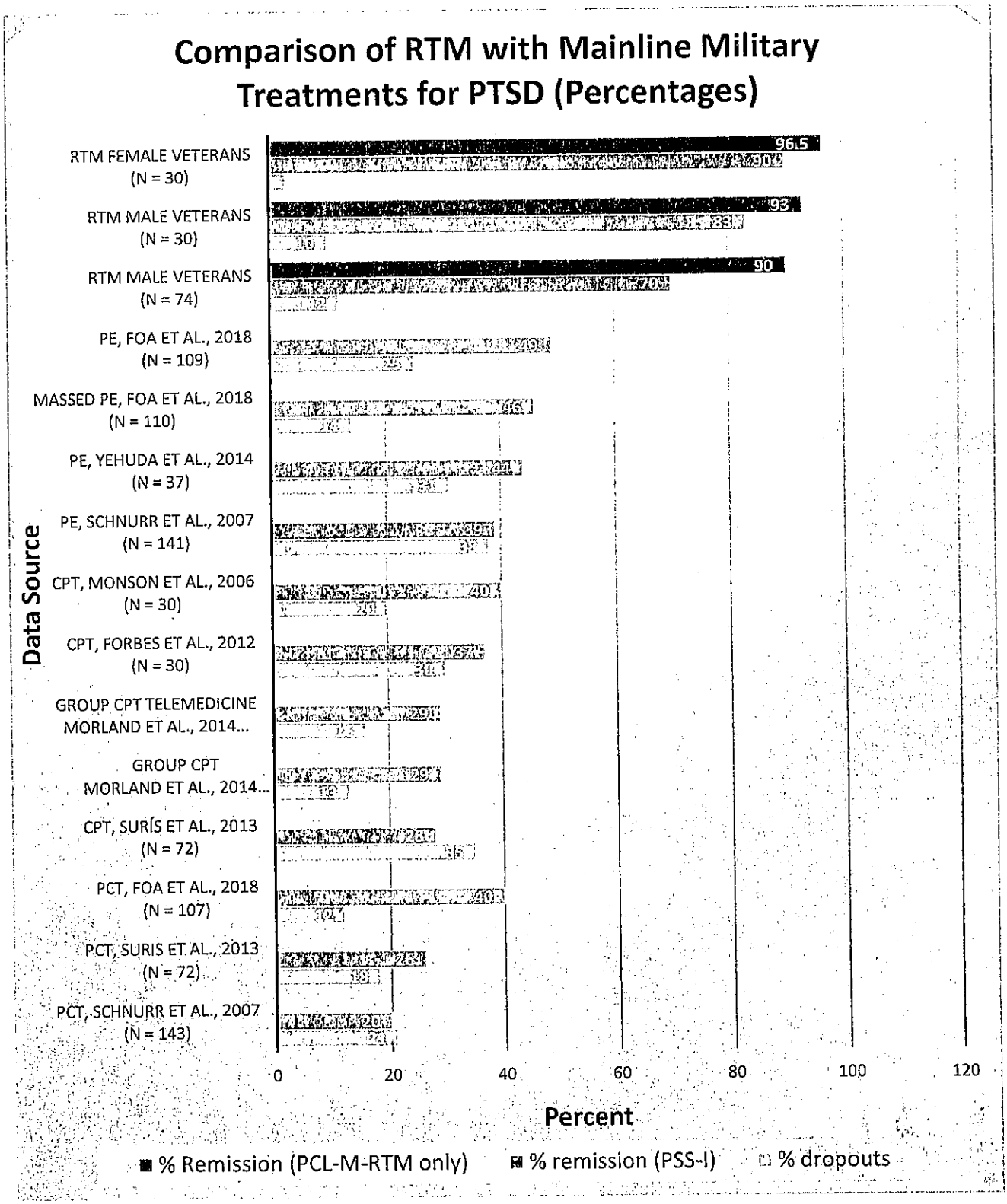
Graphic comparisons: The first graph below shows the results of the first three post-pilot RTM. studies as compared with evidence-based treatments currently approved and used by the VA and Army using PSSI.



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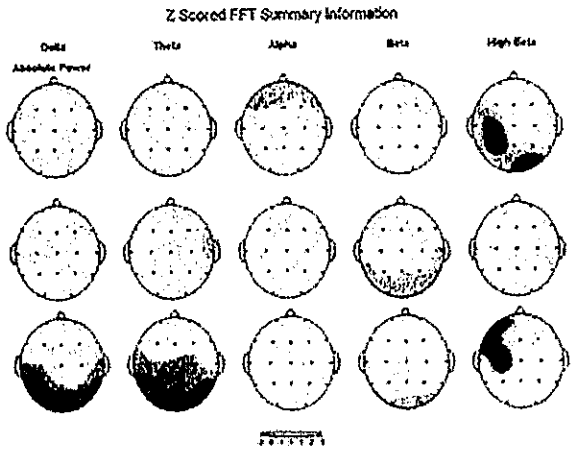
Website www.researchandrecognition.org

(Table Notes: PCL results for the 2014 RTM study required a pre-existing diagnosis of PTSD with at least one nightmare or flashback in the preceding 30 days and a score > 45 on the PCL-M. For the three RTM replication studies, PCL-M remission was determined by presenting with a PCL-M score > 50, with at least one nightmare or flashback in the preceding 30 days. The PSSI was added to the pre and post measurements of RTM's treatment administration in the three replication studies in order to allow a direct comparison to the larger number of studies of other PTSD therapies already approved as evidence-based treatments).

The Second Graph shown below is a sample of the initial pilot results of the neurological study submitted by Dr. Lewine to the Biological Psychiatry Journal. The dark reds and blues in the left row Pre RTM-Treatment scans are indicative of PTSD abnormality. They have completely disappeared in the Post Treatment scans measured five days after treatment. Light turquoise color is within normal limits. Dark reds and blues indicate deviations from normality. The research is being conducted in Dr Jeff Lewine's laboratory associated with the U. of New Mexico

Pre RTM Treatment Baseline qEEG



5 Days Post-RTM Treatment qEEG

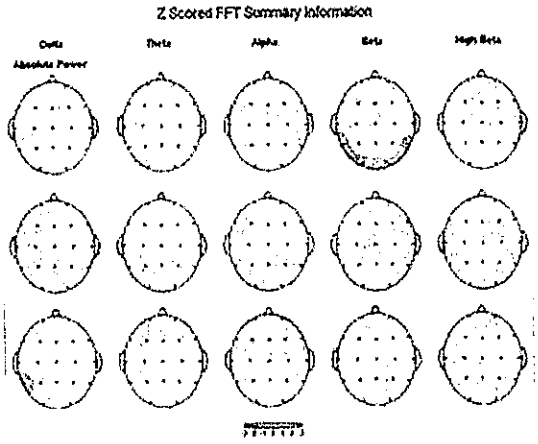


Table of RTM Research Results:

Related to the *JAMA* Article cited above, note the following Table that show RTM has removed PTSD Diagnosis (along with nightmares and flashbacks) as measured by pre and post treatment PCL-M scores over 90% of the time in its first four scientific studies. The results hold for the twelve months followed thus far.

Percentage loss of diagnosis by PCL-M from all RTM studies				
	NY 2014	SD 2015	SD 2016	NY 2016
N	26	27	30	66
Last measure	6 weeks	12 months	12 Months	6 months
PCL-M > 50 Tx failure n (%)	1 (4%)	1 (4%)	1 (3.4 %)	5 (7.5%)
Total loss of Dx (all Criteria) n (%)	**25/26 (96%)**	**25/27 (93%)**	**28/29 (96.5%)**	**60/66 (90 %)**

Table Note: Dx = Diagnosis; Tx = Treatment. The three replication studies (2015, 2016, & 2016a) have been updated since publication. Participants in the 2014 study were required to have a pre-existing diagnosis of PTSD and one flashback or nightmare in the preceding 30 days. The cut off for military diagnosis was set at 45 Points. For all other studies, PCL-M status was determined by presenting with a PCL-M score of ≥ 50. Remission for military PTSD was defined as PCL-M < 50, complete loss of intrusive symptoms, and improved life adjustment and satisfaction.

Conferences, Trainings and Network Developments:

- The RTM Protocol was presented to clinical staff at Walter Reed Medical Center Grand Rounds in November 2016. As a result of the presentation and follow-up, professional staff at Fort Belvoir Community Hospital asked to be taught the protocol, February 13-14, 2017, followed in April 2017 by professional, clinical and research staff at Walter Reed Army Medical Center. Both those trainings were very well received and have resulted in clinical and research networks beginnings with leading Army researchers and clinical/training staff.

- In a similar fashion to network developments after the Grand Rounds Presentation at Walter Reed, RTM research findings were presented to Staff at the Department of Veterans Affairs' (VA) Innovation Demo Day, "Brain Trust: Pathways to InnoVAtion" in Boston. This led to meetings in Washington DC with VA executives to explore means to bring the treatment to VA counselors and that produced a pilot training in the administration of the RTM Protocol for 24 Veteran Health Administration clinical staff from the Northeast Community Health Division. They were successfully clinically trained in a five-day program held at their Towson Maryland training facility, in November 2017.

- On April 15, 2018 we were invited to present the RTM Protocol at the Annual World Conference of the Society for Brain Mapping and Therapeutics in Los Angeles,

California. The presentation, "The Reconsolidation of Traumatic Memories Protocol (RTM) for PTSD: a brief treatment in the neural context of reconsolidation blockade" focused upon our current and ongoing research.

- On April 18, 2018 we met with Leila Jackson, Director of the VHA Center for Compassionate Innovation, Dr. Alyssa Adams and Michael Fisher, Director of the VA's 380 Readjustment Counseling Services. Director Fisher assured us that our training for the outpatient service providers in November 2017 had been well received and that we could expect further training contracts from the VA in the not-too distant future.

- In May 2018, we were invited and submitted a Grant, with Dr. Michael Roy (M.D., MPH, FACP, COL (Ret), Professor of Medicine and Director of the Division of Military Internal Medicine at Uniformed Services University (USU). Together we submitted a letter of intent (LOI) for the grant. In the Spring Our LOI was accepted and the full Grant application has been submitted titled, "Reconsolidation of Traumatic memories to Resolve Posttraumatic Stress Disorder". This Grant, will include the opportunity to work alongside of Dr. Roy and other CRNM/USU scientists, using their facilities at Walter Reed Military Hospital. It will place the RTM Protocol in the highest scientific circles for PTSD research in the world.

- Further, in April 2018, we met with Staff at Uniformed Services University including Col. David Benedeck, MD, Chair of the Department of Psychiatry; Lt. Col. Gary Wynn, MD, Assistant Chair; Dr. Robert Ursano, MD, Professor of Psychiatry and Neuroscience, Director Center for the Study of Traumatic Stress; and Dr. Michael Roy. They assured us of the USUs full support for our efforts to develop a collaborative study at Walter Reed with Dr. Roy and further RTM investigations.

- Dr Harold Kudler, former Acting Assistant Deputy Under Secretary for Health for Patient Care Svc., Veterans Health, retired in June 2018. Dr. Kudler is a prominent figure not only in the VA's Executive but across the PTSD treatment and research field. Dr. Kudler has signed on to help the R & R Project get the RTM Protocol approved by the VA as evidentiary medicine, as soon as possible.

Future Contracted Research and Trainings:

- A randomized controlled comparison study of RTM vs Prolonged Exposure using neurological pre and post measurements is under development for 2019. The study is a collaboration Dr. Jeff Lewine at the Mind Research Network in Albuquerque New Mexico and is being privately funded by Research and Recognition Project supporters.

- R and R was contracted to train 10 to 20 officers and Managers from the New York State Department of Corrections in the administration of the RTM protocol. The training was conducted in Albany NY in the second week of August 2018 and evaluated 9.5 on both the clinical need for the RTM Protocol for DOCCS employees and the quality of the training to administer the RTM Protocol.

- Leila Jackson, Director of the VHA Center for Compassionate Innovation, Dr. Alyssa Adams and Michael Fisher, Director of the VA's 380 Readjustment Counseling Services have approved and begun formal contracting for a second RTM Training for 30 VA counselors from their West Coast Division to be run in June 2019.

- The Project has assembled a group of 18 NLP trainees with a minimum of ten years, experience to be certified as RTM Trainers in 2018. These RTM certified training experts will allow us to expand our training capabilities and allow some Institutes to provide RTM Training and RTM treatment, under contract with the R & R Project.

- The RandR project was delighted to contribute to the recent consultation on effective treatments for PTSD, currently being developed by UK agency for Health Care, NICE. NICE (National Institute for Health and Care Excellence) is a UK statutory body that has legal responsibility for developing guidance and standards for health care delivery across the UK. Treatments approved under NICE are then accepted as clinically proven and can be used for service delivery. The Project provided evidence of our own clinical trials which have shown five times, under strict scientific standards, that over 90% of the veterans (N 160) completing the program finished treatment with measured loss of their PTS Diagnosis and complete elimination of their PTS nightmares, flashbacks and directly related emotional symptoms. We are delighted to be included in this consultation and see this as a preliminary step to developing international trials in the RTM protocol.

  In Sept. 2018, Mike Roy from the Uniformed Services University (USU) and the R and R Project had a grant funded at the Center for Neuroscience and Regenerative Medicine (CNRM). The study will be run at Walter Reed Hospital and compare RTM against PE in a population of vets who suffer from both TBI and PTSD. The study is a large step forward in the scientific recognition of the RTM Protocol.

  In Oct. and Dec. 2018, the third revision of the manualized RTM Training Process was used to train 60 licensed mental health professionals at the Mind Research network in Albuquerque N.M and The First Counseling Center in Orlando Florida. The evaluations for both trainings were rated 9.5, both on the training materials and the clinical value of the RTM Protocol. The trained clinicians will treat and measure PTSD clients scores for PTSD remission before training certification.

A huge research development occurred in December of 2018. ISTSS, the International Society for Traumatic Stress Studies, has recognized the RTM protocol as an intervention with, "Emerging Evidence". As such it will be included in their 2019 book, *Effective Treatments for PTSD*.

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TESTIMONY BEFORE THE CITY COUNCIL VETERANS COMMITTEE

February 26, 2019 1 P.M.

Good afternoon Chairman Deutsch and good afternoon to the honorable members of this committee. My name is Kent Eiler and I'm the Project Director of the City Bar Justice Center's Veterans Assistance Project. The Veterans Assistance Project is one of a dozen projects at the City Bar Justice Center providing vital legal services to low-income New Yorkers. I also continue to serve as a Major in the United States Air Force Reserve Judge Advocate General's Corps.

The crisis of veteran suicide that you discuss here today is pernicious. Veterans commit suicide every year by the thousands but each, when they commit this final act, does so alone. Every year over the last decade more than six thousand veterans committed suicide. Statistically speaking, before the close of today's hearing at least one additional veteran will have taken his or her own life.

Mental health is perceived as a common issue in thousands of these deaths. As a lawyer representing and advocating for low-income veterans and their families, I can speak as an observer of how the need for, and stress of, unmet legal needs impacts veterans and their families. Attached to my statement is a copy of the VA's June 2016 Community Homelessness Assessment which VA refers to as its Project CHALENG. Notably, Project CHALENG's Survey asked homeless veterans to identify their top unmet needs. For both male and female homeless veterans, five of the top ten identified unmet needs were unmet legal needs.

It is also worth noting that one area of legal need the VA's CHALENG Survey does not ask respondents to rank is whether respondents feel they require legal assistance in a dispute with

the VA itself over benefits administered by the agency's Veterans Benefits Administration. At present over 400,000 appeals of VA benefit denials are currently pending before the federal agency. In New York City today fewer than 15% of the city's veterans are receiving either VA pension or the VA's disability compensation whereas the national average is above 22%. These benefits are designed to keep totally disabled, war-time veterans out of poverty and, separately, to offset the loss in income disabled veterans experience from a service-connected disability. While it's important to not stigmatize the broader veteran community as in crisis, the group of veterans at-risk, while a minority of the veteran community, is a sizable enough minority that action can and should be taken to address this slow-moving crisis.

I applaud you all for examining this issue to see what the City of New York can and should be doing to assist. I can only offer there are not easy fixes to this crisis. Congress has not hesitated to legislate in this field but good intentions only go so far. Programs, past, present, and future, should be evaluated based on their efficacy in addressing the symptoms and root causes of this crisis. From the City Bar Justice Center's perspective serving the legal needs of hundreds of low income veterans in New York City, greater access to free, high quality legal services for veterans is important to helping them to stabilize their lives, stay out of homelessness and above the poverty line.

Thank you.

Attachments

June 2016 VA Homelessness Assessment, Local Education & Networking Groups (CHALENG) (11 pages)
City Bar Justice Center Veterans Assistance Project Information Flyer (1 page)

VA | U.S. Department of Veterans Affairs | Fact Sheet
Office of Public Affairs
Media Relations
Washington, DC 20420
(202) 461-7600
www.va.gov

June 2016

Community Homelessness Assessment, Local Education and Networking Groups (CHALENG)

Community Homelessness Assessment, Local Education and Networking Groups for Veterans, commonly referred to as Project CHALENG was launched in 1994 to bring together providers, advocates, Veterans and other concerned citizens to identify the needs of homeless Veterans and work to meet those needs through planning and cooperative action.

Project CHALENG has two components: a CHALENG survey, in which participants rate the needs of homeless Veterans in their local communities, and CHALENG meetings, which encourage partnership development between VA and community service providers. The results of the CHALENG survey are used each year to identify unmet needs and encourage new partnership development to meet those needs.

The legislation guiding this initiative is contained in Public Laws 102-405, 103-446 and 105-114.

Over the years CHALENG has helped build thousands of relationships between VA and community agencies so they can better serve homeless Veterans locally. Data from CHALENG on Veterans' unmet needs has assisted VA in developing major new services for Veterans such as the Homeless Veteran Dental Program (HVDP), the expansion of the Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program, the Veterans Justice Programs and Supportive Services for Veteran Families (SSVF). In addition community organizations use CHALENG data in grant applications to support services for homeless Veterans; grant applications are for VA, other Federal, local government, and community foundation dollars, which maximizes community participation in serving homeless Veterans.

2015 CHALENG Survey Participation

- In 2015, 6,161 individuals completed a CHALENG Participant survey. This included 3,765 homeless Veterans and 2,396 non-homeless Veterans (VA staff, state and public officials, community leaders, volunteers).

- Eleven percent of the homeless Veteran survey participants were women. 57.7 percent were between the ages of 45-60 with another 19.9 percent 61 or older. 48.2 percent indicated other than White (including "Don't Know" responses); 8.4 percent identified their ethnicity as Hispanic/Latino.

- There were 2,396 non-homeless Veteran participants. Of these, 43.6 percent were VA staff, 1.9 percent were other Federal employees, 37.9 percent were state/local official or community providers, and 16.5 percent were interested members of the community.

Top Homeless Veteran Needs Identified in 2015 CHALENG Survey

- Nine of the top ten *unmet* needs were the same for male and female Veterans: housing for registered sex offenders, child care, legal assistance in four separate areas (prevent eviction/foreclosure, child support issues, restore a driver's license, outstanding warrants and fines), family reconciliation assistance, credit counseling, and discharge upgrade. One need that was in the top ten unmet for male Veterans (but not female Veterans) was financial guardianship. Conversely, dental care was one need on the female Veterans' top ten unmet list, but not on the male Veterans' needs list.

- Nine of the top ten *met* needs were also the same for male and female Veterans: medical services, testing and treatment in three separate areas (TB, Hepatitis C, HIV/AIDS), case management, services for emotional or psychiatric problems, medication management, substance abuse treatment, and food. Personal hygiene and clothing were needs unique to the top 10 lists of male and female Veterans respectively.

- For male Veterans, the nine of the top ten *unmet* needs were the same in 2014 and 2015 (financial assistance to prevent eviction or foreclosure in 2014 was replaced by credit counseling in 2015). Nine of the top ten *unmet* needs for female Veterans were the also the same (financial guardianship in 2014 was replaced by discharge upgrade in 2015.)

- Similarly, the top ten *met* needs were the same for male Veterans in 2014 and 2015. Nine of the top ten *met* needs for female Veterans were the same in 2014 and 2015 (health and wellness in 2014 was replaced by clothing in 2015.)

- Consistent with 2014 data and with the previous ten years of CHALENG data, met needs primarily reflect services that Veterans Health Administration (VHA) can provide directly, and unmet needs are primarily services that require community partnership to meet. This consistency underscores the importance of collaboration between federal, state, local, and community partners to meet the needs of homeless Veterans to successfully end homelessness.

CHALENG 2015 Survey Results Summary

CHALENG Participant Survey

A. CHALENG Participant Survey: Participation

Total number of participants: 6,161

- **Homeless Veteran participants:** 3,765
    - homeless Veteran male participants: 3,337
    - homeless Veteran female participants: 428
- **Non- homeless Veteran participants:** 2,396
    - VA Staff: 1,049
    - Other Federal staff: 46
    - State/local government agency, or community based homeless provider: 910
    - Interested member of the community: 391

B. CHALENG Homeless Veteran Participant Demographics

	Male Veterans	Female Veterans
Gender	88.6%	11.4%

Age	Male Veterans	Female Veterans	All Veterans
Less than 25	.8%	1.6%	.9%
25-34	8.7%	15.5%	9.4%
35-44	10.8%	22.5%	12.1%
45-60	57.9%	56.1%	57.7%
61+	21.9%	4.2%	19.9%

Ethnicity	Male Veterans	Female Veterans	All Veterans
Non-Hispanic/ Non-Latino	77.4%	80.5%	77.7%
Hispanic/Latino	8.1%	10.3%	8.4%
Don’t Know	14.5%	9.2%	13.9%

Race	Male Veterans	Female Veterans	All Veterans
American Indian or Alaskan	6.8%	6.7%	6.8%
Asian	0.7%	.7%	0.7%
Black or African American	38.2%	36.0%	37.9%
Native Hawaiian or Other Pacific Islander	0.6%	1.2%	0.7%
White	51.7%	52.7%	51.8%
Don’t know	2.1%	2.7%	2.2%

Where Veteran was living at time of Survey	Male Veterans	Female Veterans	All Veterans
Literally Homeless (on streets, in shelter, in car, etc)	28.6%	27.8%	28.5%
Emergency Housing	5.5%	5.1%	5.5%
Transitional Housing (Grant and Per Diem housing, community contract housing)	29.6%	18.2%	28.3%
Permanent subsidized housing (HUD-VASH, section 8, etc)	20.2%	23.4%	20.6%
Unsubsidized housing (private apartment/house/condominium)	16.2%	25.5%	17.2%

C. Ranking of Male Veteran Need (1 to 4 scale, with 1 equals unmet and 4 equals met)

Top Ten Highest Unmet Needs, Male Veterans

Rank	Need	Mean Score
1	Registered Sex Offender Housing	2.09
2	Child Care	2.20
3	Legal Assistance to Prevent Eviction and Foreclosure	2.30
4	Legal Assistance to Help Restore a Driver's License	2.33
5	Legal Assistance for Child Support Issues	2.33
6	Family Reconciliation Assistance	2.37
7	Legal Assistance for Outstanding Warrants and Fines	2.37
8	Financial Guardianship	2.39
9	Credit Counseling	2.43
10	Discharge Upgrade	2.43

Top Ten Highest Met Needs, Male Veterans

Rank	Need	Mean Score
1	Medical Services	3.42
2	TB Testing and Treatment	3.33
3	Substance Abuse Treatment	3.24
4	Case Management	3.23
5	Services for Emotional or Psychiatric Problems	3.21
6	Medication Management	3.20
7	Personal Hygiene (Shower, Haircut, etc)	3.17
8	Food	3.17
9	HIV/AIDS Testing and Treatment	3.16
10	Hepatitis C Testing and Treatment	3.14

D. Ranking of Female Veteran Need (1 to 4 scale, with 1 equals unmet and 4 equals met)

Top Ten Highest Unmet Needs, Female Veterans

Rank	Need	Mean Score
1	Registered Sex Offender Housing	2.08
2	Child Care	2.32
3	Credit Counseling	2.49
4	Family Reconciliation Assistance	2.49
5	Legal Assistance for Child Support Issues	2.49
6	Legal Assistance to Help Restore a Driver's License	2.49
7	Dental Care	2.51
8	Legal Assistance to Prevent Eviction and Foreclosure	2.53
9	Legal Assistance for Outstanding Warrants and Fines	2.53
10	Discharge Upgrade	2.54

Top Ten Highest Met Needs, Female Veterans

Rank	Need	Mean Score
1	Medical Services	3.39
2	TB Testing and Treatment	3.34
3	HIV/AIDS Testing and Treatment	3.25
4	Case Management	3.23
5	Hepatitis C Testing and Treatment	3.23
6	Services for Emotional or Psychiatric Problems	3.23
7	Food	3.21
8	Substance Abuse Treatment	3.16
9	Clothing	3.11
10	Medication Management	3.10

E. Ranking of Male Homeless Veteran Needs: Complete List ordered by Highest Unmet to Highest Met (1 to 4 scale, with 1 equals unmet and 4 equals met)

Rank	Need	Score
1	Registered Sex Offender Housing	2.09
2	Child Care	2.20
3	Legal Assistance to Prevent Eviction and Foreclosure	2.30
4	Legal Assistance to Help Restore a Driver's License	2.33
5	Legal Assistance for Child Support Issues	2.33
6	Family Reconciliation Assistance	2.37
7	Legal Assistance for Outstanding Warrants and Fines	2.37
8	Financial Guardianship	2.39
9	Credit Counseling	2.43
10	Discharge Upgrade	2.43
11	Financial Assistance to Prevent Eviction or Foreclosure	2.46
12	Family and Marital Counseling	2.49
13	Emergency Housing for Families	2.50
14	Welfare Payments	2.51
15	Dental Care	2.52
16	Drop In Center and Day Programs	2.57
17	Goods (Furniture and Housewares) for New Apartment	2.63
18	Money Managing	2.64
19	Utility Assistance	2.66
20	Move-In Assistance	2.66
21	Re-Entry Services for Incarcerated Veterans	2.67
22	Social Networking	2.67
23	Parent Education	2.68
24	Vocational Rehabilitation	2.69
25	Affordable Housing	2.70

Rank	Need	Score
26	Prevention	2.70
27	Job Training	2.72
28	Supplemental Security Income (SSI) and Social Security Disability (SSD)	2.74
29	Finding a Job or Getting Employment	2.74
30	Life Skills Training	2.75
31	Long-term Permanent Housing	2.75
32	Transportation	2.75
33	Help Getting Identification and Other Legal Documents	2.76
34	Landlord Relations and Tenancy	2.76
35	Basic Services (Phone, Voicemail, Address)	2.77
36	Military Sexual Trauma	2.81
37	VA Disability/Pension	2.83
38	Education	2.84
39	Spiritual	2.87
40	Assisted Living for the Elderly	2.88
41	Elder Healthcare and Resources	2.91
42	Transitional Living Facility and Halfway House	2.96
43	Treatment for Dual Diagnosis	3.01
44	Eye Care and Glasses	3.01
45	Emergency/Immediate Shelter	3.02
46	Clothing	3.07
47	Detoxification from Substance	3.12
48	Health and Wellness	3.13
49	Hepatitis C Testing and Treatment	3.14
50	HIV/AIDS Testing and Treatment	3.16
51	Food	3.17
52	Personal Hygiene (Shower, Haircut, etc)	3.17
53	Medication Management	3.20
54	Services for Emotional or Psychiatric Problems	3.21
55	Case Management	3.23

Rank	Need	Score
56	Substance Abuse Treatment	3.24
57	TB Testing and Treatment	3.33
58	Medical Services	3.42

F. Ranking of Female Homeless Veteran Needs: Complete List ordered by Highest Unmet to Highest Met (1 to 4 scale, with 1 equals unmet and 4 equals met)

Rank	Need	Score
1	Registered Sex Offender Housing	2.08
2	Child Care	2.32
3	Credit Counseling	2.49
4	Family Reconciliation Assistance	2.49
5	Legal Assistance for Child Support Issues	2.49
6	Legal Assistance to Help Restore a Driver's License	2.49
7	Dental Care	2.51
8	Legal Assistance to Prevent Eviction and Foreclosure	2.53
9	Legal Assistance for Outstanding Warrants and Fines	2.53
10	Discharge Upgrade	2.54
11	Financial Guardianship	2.54
12	Drop In Center and Day Programs	2.60
13	Money Managing	2.64
14	Emergency Housing for Families	2.68
15	Social Networking	2.69
16	Family and Marital Counseling	2.69
17	Financial Assistance to Prevent Eviction or Foreclosure	2.70
18	Parent Education	2.72
19	Prevention	2.74
20	Breastfeeding Information and Supplies	2.75
21	Transportation	2.77
22	Basic Services (Phone, Voicemail, Address)	2.77

Rank	Need	Score
23	Move-In Assistance	2.80
24	Affordable Housing	2.81
25	Re-Entry Services for Incarcerated Veterans	2.81
26	Goods (Furniture and Housewares) for New Apartment	2.82
27	Life Skills Training	2.83
28	Transitional Living Facility and Halfway House	2.83
29	Welfare Payments	2.83
30	Spiritual	2.84
31	Assisted Living for the Elderly	2.84
32	Help Getting Identification and Other Legal Documents	2.87
33	Landlord Relations and Tenancy	2.87
34	Vocational Rehabilitation	2.88
35	Job Training	2.90
36	Supplemental Security Income (SSI) and Social Security Disability (SSD)	2.90
37	Finding a Job or Getting Employment	2.90
38	Long-term Permanent Housing	2.90
39	Domestic Violence Support Services	2.91
40	Women's Specific Mental Health Providers	2.92
41	Education	2.92
42	Military Sexual Trauma	2.93
43	Emergency/Immediate Shelter	2.93
44	Elder Healthcare and Resources	2.94
45	Utility Assistance	2.94
46	Gender-Specific Healthcare Provider Availability	2.95
47	Eye Care and Glasses	2.97
48	Treatment for Dual Diagnosis	3.00
49	VA Disability/Pension	3.01
50	Detoxification from Substance	3.04
51	Personal Hygiene (Shower, Haircut, etc)	3.04

Rank	Need	Score
52	OB/GYN Services	3.05
53	Health and Wellness	3.07
54	Medication Management	3.10
55	Clothing	3.11
56	Substance Abuse Treatment	3.16
57	Food	3.21
58	Services for Emotional or Psychiatric Problems	3.23
59	Hepatitis C Testing and Treatment	3.23
60	Case Management	3.23
61	HIV/AIDS Testing and Treatment	3.25
62	TB Testing and Treatment	3.34
63	Medical Services	3.39

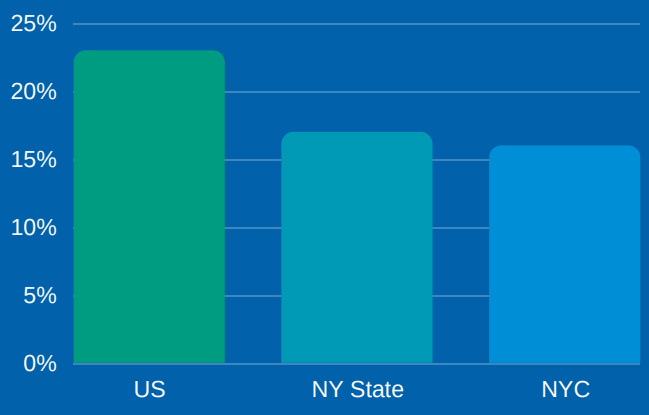
Veterans Assistance Project

Who We Are

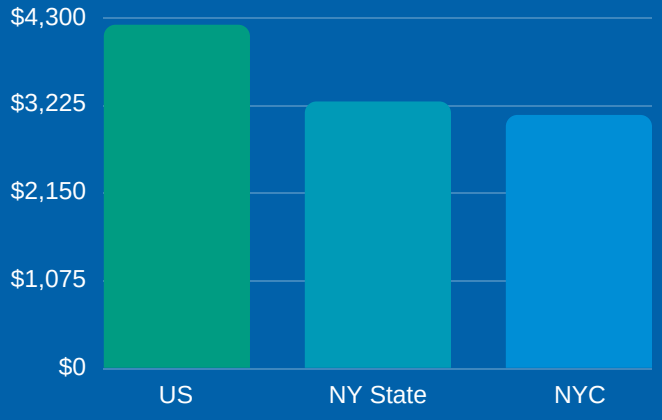
- Since 2007, VAP has been leveraging the efforts of over 400 pro bono attorneys to help low-income, disabled veterans in NYC receive the VA benefits they deserve.
- Last year, VAP helped veterans obtain $770,532.65 in retroactive benefits and $40,322.86 in monthly recurring benefits.
- According to an analysis done by outside experts, the VA benefits awarded to VAP clients over the last year will result in a total lifetime value of over six million dollars.

NYC's Vets are Receiving Less*

Percent of Veterans Receiving SCD Compensation



Expenditures on Compensation and Pension per Vet



Veterans in the city are less likely to receive service connected disability (SCD) compensation. Further, the veterans that do manage to receive compensation or pension are getting less than their peers across the US.

Help Us Help the City

City & State

Federal

VAP's work takes veterans off city and state public benefits and transfers them to more favorable federal benefits.

8-10

VAP currently has a waitlist of 8-10 months. With additional resources we would be able to assist more veterans faster.

*Sources: Veterans Populations 2016 County-Level Veteran Population by State, Age Group, Gender, 2015-2045; FY2017 VA Disability Compensation and Pension Recipients by County of Residence; FY2017 Summary of Expenditures by State. All produced by the U.S. Department of Veterans Affairs' National Center for Veterans Analysis and Statistics and retrievable at www.va.gov/vetdata/.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Coro Culhane

Address: 40 Rector

I represent: Veteran Advocacy Project

Address: 40 Rector St. NY NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Amanda Spray, PhD

Address: _____

I represent: Steven A. Cohen Military Family Center at NYU Langone Health

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Danielle Wozniak

Address: _____

I represent: Wurzweiler School of Social Work Yeshiva University

Address: _____

Please complete this card and return to the Sergeant-at-Arms

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dorothy Farley

Address: _____

I represent: Community Healthcare Net

Address: 60 Madison Ave.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Kent Eiler

Address: 42 West 44th Street - City Bar

I represent: City Bar Justice Center — Veterans Assistance Project

Address: 42 West 44th NYC

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/26/19

(PLEASE PRINT)

Name: Samuel Malik

Address: 45 W 22nd St NY NY

I represent: NYC Veterans Alliance

Address: _____

Please complete this card and return to the Sergeant-at-Arms

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 2/26/19

(PLEASE PRINT)

Name: LORRE SUTTON, MD

Address: 1 CENTRE ST # 2208, NN NY 10007

I represent: NYC DVS

Address: 1 CENTRE ST # 2208, NY NY 10007

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Myla Harrison

Address: Assistant Commissioner

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Kelly Posner

Address: 1169 Hudson St.

I represent: Columbia University

Address: _____

Please complete this card and return to the Sergeant-at-Arms

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Robert D. NARDO

Address: 1 Corwin Pl., Newburgh NY 12550

I represent: Research & Recognition Project

Address: Corning N.Y.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Joe Hunt

Address: VMHC 50-Broadway

I represent: Vibrant / Veterans Mental Health

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/26/19

(PLEASE PRINT)

Name: Elaine Hunter

Address: 255 W 94th St NYC

I represent: Samaritans Suicide Prevention Center

Address: BOX 1259 Mad. Sq. Station NYC

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/26/19

(PLEASE PRINT)

Name: SGT(R) Jonathan Lubacky

Address: 306 Seneca River Dr Summerville SC 29485

I represent: MAPS

Address: 1115 Mission St, Santa Cruz CA 95060

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/26/19

(PLEASE PRINT)

Name: Vadim Panasyuk

Address: 35 Broad St. New York, NY

I represent: Iraq & Afghanistan Veterans of America

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: CMSgt (R) Ed Schloeman

Address: 59 East 2 St BKLYN 11218

I represent: Operation Warrior Shield

Address: Same

Please complete this card and return to the Sergeant-at-Arms