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>> SANDRO GALEA: Good afternoon. Good evening. Good morning, wherever you are. Welcome. My name is Sandro Galea. I have the privilege of serving as the dean of the Boston University School of Public Health. Welcome to this public health conversation.

These conversations are meant as spaces where we can come together for the discussions that create a healthier world. Health is fundamentally shaped by the ideas we bring to this work of creating this world. These conversations allow us to explore ideas, guided by expert speakers who deepen our understanding of issues of consequence for health. Thank you for joining us for today's event. In particular thank you to the Dean's office and marketing team and communications team, without whose efforts these conversations would not take place.

Ongoing wars have once again brought home the reality of war and its consequences for the health of populations. No population is more familiar with the consequences of wars than those who fight them. Veterans can face a range of physical and mental health challenges as a result of their service. Today we will discuss how we can more effectively center the health of

veterans in the public health agenda. I look forward to learning from all our speakers of how we can do a better job of doing right by those who do so much for so many.

Before I introduce our moderator, a brief word about the cohost of today's event, our Boston University School of Public Health Center for Trauma and Mental Health. Launched earlier this year under the direction of Professor Jaime Gradus, the center is a cross-disciplinary hub for scholarship on the population-level scale of stress and trauma. For those who are interested in learning more, our team will share additional information in the chat. A thank you to Professor Jaime Gradus who was the intellectual architect of today's event.

I'm very pleased to turn over today's event to our moderator, Dr. Sarah Lipson. Dr. Lipson is an associate professor in our Department of Health Law Policy and Management. She is the principal investigator of the Healthy Minds Network, which includes the Healthy Minds Study, the largest, most comprehensive study of mental health in higher education. Dr. Lipson, thank you for being with us. I turn it over to you.

>> SARAH LIPSON: Thank you so much, Dean Galea. I'm thrilled to be here today and moderate this very important conversation. I'm also part of the Center for Trauma and Mental Health here at BU. I'm excited that we are cohosting this event. We have an incredible group of folks to talk about centering the health of veterans in public health.

I would like to introduce the speakers for our program today. I will begin, we will hear first from Richard Brookshire. Mr. Brookshire is the cofounder and CEO of the Black Veterans Project, an organization furthering research, national reporting and storytelling to advance racial equity for Black veterans in and out of uniform. He is a former infantry combat medic and U.S. Army veteran of the war in Afghanistan. Richard's commentary and efforts have been highlighted by the New York Times, the Washington Post, USA Today, theGrio and others. So we will begin with hearing from Mr. Brookshire.

After that we will hear from Carl Castro, who is the Professor as well as the director of the Center for Innovation and Research on Veterans & Military Families and the director of Military Veterans Programs at the University of Southern California School of Social Work. He also serves as director of the USC-RAND Epstein Family Foundation Center for Veterans Policy Research. Before joining the USC Professor Castro served in the U.S. Army for over 30 years, beginning his career as an enlisted infantry man and retiring at the rank of colonel.

Then we will hear from Shaili Jain. Dr. Jain serves as a psychiatrist at the VA Palo Alto Health Care System and is an

Adjunct Clinical Professor of Psychiatry and Behavioral Sciences at Stanford University. She is an internationally recognized leader in communicating to the public about trauma and PTSD. Her posts for her Psychology Today blog on PTSD, In the Aftermath of Trauma, have been viewed over 250,000 times. Her acclaimed debut nonfiction trade book was nominated for a national book award and her essays and commentaries on trauma and PTSD have been presented by the BBC, CNN, the New York Times, The Atlantic, Newsweek, The LA times, TEDx, public radio among others.

From there we will hear from Dr. Lena K. Makaroun. Dr. Makaroun is a staff physician and core investigator at the VA Pittsburgh Healthcare System Center for Health Equity Research and Promotion. Affiliate faculty of the VA Pittsburgh Geriatric Research, Education and Clinical Center as well as Assistant Professor of Geriatrics at the University of Pittsburgh School of Medicine. Dr. Makaroun's research examines health related social risk factors for older adults with a specific focus on elder abuse. Her current work aims to improve detection and response for elder abuse among older veterans in the Veterans Health Administration.

And lastly, we will hear from Barbara Rothbaum, Professor of Psychiatry and Associate Vice Chair of Clinical Research at the Emory University School of Medicine in their Department of Psychiatry and Behavioral Sciences. Dr. Rothbaum also serves as the Executive Director of the Emory Healthcare Veterans Program, a nationally recognized center of excellence for healing the invisible wounds of military service, treating conditions such as post-traumatic stress disorder, traumatic brain injury, military sexual trauma, anxiety and depression.

So we have an incredible interdisciplinary group of experts here with us today. And I know we're really excited to learn from them. So Mr. Brookshire, I will turn it over to you to get us started. I think you are muted.

>> RICHARD BROOKSHIRE: Thank you. I am deeply humbled to be kicking off today's conversation. So I'm -- I approach this as an advocate. My story I think is really important to understanding how I even got involved in this work. I'm sharing in the chat a one pager about the Black Veterans Project.

So I served for seven years as an infantry combat medic. I got to see a lot up close during that time. I come from a family of veterans. My father served for 30 years. And my mother was a Haitian immigrant. I joined up after dropping out of college. I went to Morehouse College in Atlanta, Georgia. Obama ran for president. I got super inspired by his win and found myself in uniform at a time of military conflict deployed

to Afghanistan. I was also serving under Don't Ask, Don't Tell at the time which had its own compounded intersectionalities, intersectionalities compounded my experiences in the military in that way.

And I ended up transitioning off active duty into the New York State National Guard and found myself at the end of my military time after serving for seven years. The year that followed that I had a really difficult transition. One that I had not anticipated. Because on paper, it seemed like I had made a pretty seamless transition. I graduated from Columbia's policy school, landed a great job but still found myself with an existential crisis of identity. I could not get decent mental health care from the VA. And because of that, over the course of a year I deteriorated substantially. And it led to a suicide attempt. And it was when I was in the psyche ward having survived that the seed for the Black Veterans Project was planted.

A book had been sitting on my shelf since graduate school. Nothing else to do when you are locked in four walls. So I read a lot. It was written by an academic out of Columbia and it looks at social welfare policies that precipitated in the 1940s that helped to bolster the white middle class.

And it was explicitly the kind of chapter that was focused on the GI Bill. And I had heard of obstruction to the GI Bill before but it hadn't solely landed. When I transitioned out of the military, transitioned out of the psyche ward, wanting to reconnect with the community, over generations. Viet Nam, Gulf War generations, and to do a racial equity project but also to do a project that was focused on justice. We are advancing the case for reparations for black veterans. Over the course of the last three and a half years, we partnered to do a pretty substantial FOYA effort around racial disparities and disabilities access looking at the last 20 years. We are able to show through our efforts that there was almost a 30% greater likelihood of denial rates that black vets faced. And we know how substantial and how helpful disability compensation can be.

And when you think about the apparatus of basically the welfare safety net that you gain access to, that's so much of a motivator for so many working class people to join the military, education benefits of which I have used almost half a million dollars to go to school. You think about the VA home loans, vocational training, disabilities compensation. It can be life changing. And so many black vets have not had equal access. So much of our work has been around kind of tieing that historical legacy, looking at the initial obstruction around the GI Bill when the vast majority of black vets did not get access to home

loans. To also looking at via disability compensation.

We were able to get a government accountability office study passed by the Biden Administration which was passed this past summer. And also able to begin working directly with policymakers. Looking at legislative repair to try to extend VA housing loan benefits and potentially education benefits as well to direct descendants of World War II vets. I look forward to a lively discussion today. As we think about the social determinants of health, centering veterans. I think it is a really, really important discourse in the public health narrative. Because there is an ecosystem that most would want to have replicated outside of just that in our country. One that would provide access to adequate health care and resources to the majority of Americans. So yeah, that's why I'm here and I appreciate you guys making space for us to be in conversation.

>> SARAH LIPSON: And we very much appreciate having your energy and lived experience and just everything that you have brought kind of historically and from your own personal experiences, to be really it sounds like an entrepreneur in this space. I'm sure there is going to be a lot of questions for you about your work and next steps and priorities. So I'm really excited to learn more. Thank you for that initial background. We will now turn to Dr. Carl Castro.

>> CARL CASTRO: Thank you so much, Sarah. It is a pleasure to be here. And I apologize for not using slides. I'm going to do this a little bit different. I'm going to try to make three points. And the first points I would like to make is I have been studying transition of military service members back to their civilian communities for over a decade now. One of the things that I think we all should appreciate is that most veterans transition okay back to their civilian communities. This doesn't mean that there are not some that have problems along the way as we just heard from Richard.

The problems can be significant. And folks and myself included and many on this panel are laser focused on trying to prevent those kinds of problems from happening. So I want sort of all the listeners at least to appreciate that most veterans do transition fine. They go on as Richard and make major contributions to society in their communities.

It is a blessing to have veterans in your community. And I don't want anyone listening thinking that all veterans have PTSD or homicidal, suicidal and we need to stay away from them because that's similarly not the truth. There are some that do struggle as I mentioned.

So just appreciate that. Second, the VA is a great organization. I know that folks like Richard certainly early on

have major problems, the VA was like the active duty. We are struggling to take care of all the combat veterans that are returning home. The nation was not prepared. We just admit that. The nation was not prepared for this massive influx of veterans and service members with mental health issues, with physical health issues. The list goes on. But the VA has really, really improved in the last 25 years and they continue to improve.

So for those of you like Richard who had a really bad first experience with the VA, please give him another chance. Be patient with them. They are trying. And they are a great organization. All the research that I have conducted and that others have conducted, veterans use the VA love it. Real frustration sometimes is getting access and sometimes getting the VA to listen to the issues that veterans are having. And so I would just say try to be patient. The VA is getting much, much better. So if you visited the VA five years ago, that's not the VA today. And then there is an old saying in the VA I'm not part of the VA. So this is not a paid promotional. It is just looking at the data. They say if you have been to one VA, you have been to all the VAs. But if you have been to one VA five years ago, you have been to one VA.

My second point is give the VA another chance. Give the VA another chance. And then I would like to end by just acknowledging there are major issues around disparity and who gets services. Not just within the VA. But more broadly in society.

And we really need to pay attention to those. The research that we have conducted specifically highlights single mothers as having a really hard time when they transition out of the military.

Also people of color. African Americans, Latinos also have significant issues. LGBT service members can also struggle. And, of course, discharge status and a lot of demographic variables are also very important.

I think the key thing to take away is there are certain groups that really struggle that kind of put them on a path to homelessness, that put them on a path to not getting a job. And it kind of goes back to the military. Sometimes the military doesn't do a good job of preparing service members to lead. And many service members think it is going to be easier than it is. And transition out of the military, I have argued is like moving to a new country.

So imagine if Castro is moving to India as an example, what would I need to do? I need a job. Figure out where I have to live. If I have kids, where are they going to go to school. If

I'm married, what is my spouse going to do. All of these issues have to be figured out. But many service members think it is going to be easier than it is.

So my third point is for those of you who are still serving, plan, plan, plan, plan, plan. You cannot overplan your transition out of the military. It does require a lot of challenges. And all veterans tell it was a lot harder than I thought it was going to be. I thought I had it figured out but it was harder than I had planned it to be and actual -- but eventually, veterans are very savvy. They are an asset to your community. Richard figured it out. Is now making amazing contributions to our society and to other veterans. So I don't want to lose sight of that. So I'm going to stop there and again thank you for having me on the panel.

>> SARAH LIPSON: Thank you so much. And I think that both of you have really underscored the importance of understanding and addressing inequalities that exist among veterans. I'm hoping we can talk even more about that as we continue today's discussion. From here I will turn it over to Dr. Jain.

>> SHAILI JAIN: Thanks for the introduction. And thank you so much for inviting me to speak here today.

I'm a psychiatrist and a PTSD specialist. And I practice here at the VA hospital here in Palo Alto hospital. I thought it might be helpful to share a narrative. Because that's what I feel I do on a daily basis. My work is listen to stories. That's what I'm going to be doing. I'm going to be sharing an excerpt from my 2019 The Unspeakable Mind. What I will be sharing is the prologue to the book. The prologue describes an experience that I had in 2004 when I met a young veteran who just returned from Afghanistan. And I was a resident at that time. I was on the cusp of graduating from residency. And I'm sharing this piece for a few reasons. I think it would be very valuable for everyone here in the audience to really know what PTSD is. And how it manifests and really derails the life of a human being.

And secondly, I think sharing this excerpt will really help emphasize the chronicity of the problem that we are dealing with. As I mentioned, the excerpt I'm going to share took place in 2004. It is now 2023. And it does hurt my heart to say that a week doesn't go by when in my clinic I don't hear a similar story.

Obviously the name has changed, the details change, the specifics change but the essence of the story is kind of the same. And I think that is in part due to the very long nature of these conflicts. And also in part to the chronic

consequences of exposure to combat trauma.

And finally, I just want to point out that PTSD is a pressing public health concern not only amongst the veteran population in the United States in general, I'm hoping that will be illustrated in this excerpt that I'm about to read. So I'll start by reading but I do want to point out that, you know, I'm very particular about not being graphic in the details that I write about because I don't want to trigger anybody who has a trauma history. But at the same time I do want to make folks aware who are listening to this that some of the content might be a little bit distressing.

The interview room at Milwaukee Veteran's Medical Center is small. We rearranged the seating. Our team consists of a series of a medical student, psychiatry intern dressed here in her standard VA scrub, me the chief resident on the cusp of graduating from residency and our attending physician, a seasoned senior psychiatrist. Josh has your undivided attention. Glancing at the clock to see if it is time to move on to the next patient. We are in a way entranced, knowing that we are witnessing something significant. Josh's appearance sets him apart. Self-assured with a muscular build. All of 21 he tells us how along with so many of his friends he was moved to action by the events of 9/11.

He joined the Marines not long after graduating from high school, because that was what was expected in his family. Both his grandfathers, a couple of uncles and a handful of friends have joined the service. He was sent to the "hospital" in the city because his local VA did not have an inpatient psychiatric hospital. He tells us how happy he was to come home after military discharge and how good it felt to see family and friends. Those feelings were brief and gave way to strange thoughts and emotions.

As he -- as he articulates his story, I began a mental checklist. Not long after coming home I started having nightmares. They are worse than nightmares because they are a replay of stuff that really happened in Afghanistan. I felt everything that I felt when I was in Afghanistan; fear, panic, my heart thumping in my throat and I wake up screaming and my sheets are drenched. I dread going to sleep. Nightmares, check. Weird stuff is happening when I'm awake, too. I can't trust my eyes and ears anymore. I look at everything again and again to feel safe. I can't just relax.

Hypervigilance, check.

I went to the store with my kid brother once and we were loading up the truck with groceries when a car back fired and I just hit the ground. My body overreacted. When I realized it

was a car I calmed myself down. There was a bunch of people staring at me. It was the look on my kid brother's face that just killed me. He was scared and shocked. Like he didn't recognize me. I felt so ashamed.

Exaggerated, startled response, check. After that I just started to hang out more at home. I didn't want to do anything of the things that I used to love before I went to Afghanistan. My mom would complain that I was always out with my buddies at the movies, bowling and fishing and now I didn't want to do any of that. I sat at home drinking beer and staring at the TV watching dumb reality shows.

Then I started getting a lot of thoughts about Afghanistan during the day. The slightest thing took me right back. If I happened to flip to news covering the war, then bam, I was lost in this other world. Someone even asked did you kill anyone. Did you see anyone get killed.

The questions made me want to puke. I felt so sick. I would get up and leave. I started to feel pissed all the time, like I was looking for an excuse to knock someone out. Whiskey calms me down. So I started drinking more.

Avoidance of external reminders that arouse distressing memories or thoughts or feelings about the traumatic event, check.

I was doing that for months and then my mom was having a birthday party for my grandpa. The whole family was coming over. I love my grandpa but the thought of all those people, the noise it was too much. I started drinking the morning of the party. I was drunk by the afternoon. I remember the decorations, the cake and then the smoke from the meat on the grill. It just hit me and I was back in Afghanistan again.

Like really there. Fighting for my life. I swear I could not help it. If I could have I would have. I have no idea what is happening to me.

The team knows what happened at the birthday party. We read the eyewitness accounts, police report and emergency room evaluation before we met Josh. He had had a flashback, a quintessential symptom of post-traumatic disorder where he felt a combat experience was happening again in realtime. Once the flashback was under way he lacked the ability to stop it and he relived all the original emotions of rage and terror. During the flashback he assaulted family members. He kicked and punched and grabbed someone by the neck so hard that it took three grown men to pull him off. The police were called and the ambulance arrived.

If this had been 1970s after the Viet Nam war, Josh probably would have been misdiagnosed schizophrenia. This was

2004. The VA patients I met before Josh were typically middle- aged Viet Nam war veterans whose PTSD looked different. For others it was entrenched and layered with decades of severe alcohol addiction. The PTSD was buried under all the other problems. Josh's PTSD was fresh and untreated. Josh stares at his hands with disbelief after revealing this altered version of himself.

His earlier poise caves into the reality and his face falls to anguish. To my left my medical student has teared up and my medical physician seems struck by his story. I abandoned my mental checklist. So yeah, that's the end of the excerpt and I look forward to engaging in Q and A with the audience.

>> SARAH LIPSON: What a powerful piece to share and I think really eye opening for a lot of folks. And there is some great comments coming in already and hopefully folks are going to have some follow-up questions about that. I'm really grateful that our presenters are sharing such powerful personal experiences as well for us to draw on today.

Next I will turn it over to Dr. Makaroun. Lena.

>> LENA MAKAROUN: Thank you so much, Dr. Lipson and thank you to Boston University School of Public Health for hosting this really important conversation. Wow, I've already have gained so much just by listening to the three speakers before me. I'm going to pivot to a different type of presentation. It is hard to follow that one, Shaili, but I am actually going to be sharing some slides. I think I'm a little bit too much of a rambler to go without some guidance. I'm going to share my screen, one second.

And Sarah, do you mind just giving me a thumbs up if you can see the slides okay? Perfect. Thanks so much.

So as Dr. Lipson introduced my name is Lena. I'm a geriatrician. So I take care of older veterans at the VA Pittsburgh Health Care System. That's the third hospital I have worked at. I have been working in the VA for close to ten years now.

And it is also where I trained to become a doctor and to become a geriatrician. In addition to my role as a clinician, I'm a health services researcher focused on health-related social perspectives for older adults. And that interest has taken me into the area of elder mistreatment where my predominate area of research focus. What I'm hoping to pass on to in no more than about ten minutes how we can center older veterans on this conversation. But more considerations when we are thinking about the older generation of veterans.

So let me see, sorry. Okay. Can't do that. That's okay. All right. So first in case this -- I think we probably have

quite a mixed audience here. I have been reading the Q and A and a lot of people have personal experience or may be veterans themselves. But just to bring us all on to the same page, the overall veteran population is an older adult population, at least as of now. So this heat map is using data from 2019, but looks quite similar now. You will see that in many states across the U.S., the older veteran population age 65 and up makes up around 50% and in some states even more than 50% of the veteran population.

These trends are changing over time. So this -- what you will see here is on the X axis. We have different ages. On the Y axis we have numbers of veterans. Each colored line represents a different decade. So starting in 2015 with the blue line, you will see that the big spike where we have the highest number of veterans is around age 67. And that spike kind of moves to the right as we move forward a decade. So coming up in a couple of years in 2025, but actually will kind of flatten over the next several decades. And that's as we have kind of the aging out of some of the earlier war eras, like the Viet Nam veterans. Right now and in the years to come we will have a really large older veteran population. So it is an important population to think about.

So who exactly are older veterans? They're currently estimated to be around 8 and a half million veterans in the U.S. And if you look at 60 and older, so just go back a few more years, that's over half of the veteran population. Unlike younger generations of veterans where we have women as the most rapidly growing population of veterans, older veterans are still disproportionately men by a significant degree. So we only have about 5% of older veterans being women. 68% are Viet Nam war veterans.

Here you will see the racial and ethnic breakdowns. One and a half percent is Asian. And 3 percent is another race or ethnicity. So here we see the war era that these veterans are coming from. So the blue bar is always the most common. And it changes as you look at different age groups. So when we look at all the way at the top of 90 plus. These are a lot of patients that I see, it is actually still the most common to have Korean war. As you move down in the age brackets by five year increments you will see that once we get into the 70s and late 60-year-old age groups the Viet Nam war era is the oldest. This is important to understand because veterans from this era experience a lot of things that were unique for military service. No. 1, they may have joined the military as a part of the draft. And also on return home from the war, you know, they faced a lot of challenging things societally with, you know,

public opinion about the war in Viet Nam.

So when we look at the overall population of older veterans compared to nonveteran older adults in the United States, older veterans actually do enjoy a number of kind of benefits in terms of health and social status. So, for example, older veterans are less likely to live alone. They are more likely to be married. In the graph on the right you will see they are less likely to experience social isolation.

And they are also less likely to experience poverty. Not surprisingly, based on military service and kind of subsequent health conditions that may result from that, they are more likely to have a disability. So this is when we look at the overall veteran population.

But what about those who receive care and enrolled in the VA administration? And this is where I work. What about veterans who receive care there? These are the vets that I take care on a daily basis. So only 41% of all older veterans are enrolled in VA health care. They tend to be lower income, have had less education. They have experienced more trauma. Are less likely to be married. Are more socially isolated and more likely to identify as black or coming from other historically marginalized races and ethnicities. You will see in the graph on the right that older -- that veterans, excuse me, when compared to both veterans who don't get their care in the VA as well as nonveterans, veterans who get their care in VA have higher rates of cancer, diabetes as well as mental health conditions and post-traumatic stress disorder. In the VA we treat a sicker and more complex both health wise and social population of older veterans.

And this is really important to think about because not only do all of these things impact the health of the older adults that we treat in the VA, but sometimes they can also coalesce to create risk for other kinds of complex psychosocial, geriatric syndromes. One of those is elder mistreatment which I will get to in a moment.

So what I'm highlighting here are different ways in which VHA enrolled older veterans may compare to nonveterans. Higher rates of depression and PTSD, to have more chronic health conditions. They -- and more than half of older veterans to get their care in VHA report difficulties in physical functioning. So this is really important for independence as we age. There is a very high prevalence of dementia and this may come from causes. We have a higher prevalence of traumatic brain injury. 50% may experience social isolation. So, you know, people, older veterans in the VA have a lot of these different conditions. And like I mentioned before these coalesce to put

them at risk for other types of phenomenon such as elder mistreatment. What is elder mistreatment? This is financial exploitation or neglect of an older adult at the hands of a trusted other.

And based on what we know about risk factors which you will see kind of outlined in the outer bubbles here veterans who receive their care in the VA who are enrolled in VA health care have a really high prevalence of all these risk factors, including cognitive impairment, substance use disorder, social isolation, mental health problems, functional impairment and then financial dependency and hardship. And this goes both ways. As Richard was mentioning in his talk, a really great thing from the VA are financial benefits such as disability compensation payments and pension payments which can help if you are facing financial hardship, but these things in our research we're seeing they may increase the risk of financial exploitation. There is a huge preponderance of financial scams.

So another thing that I think we have to consider when we are considering any older adults, what is it that they are facing in the health care system but other institutions as they then try to kind of confront and manage these different health conditions and social conditions as they age. And that's ageism. It is stereotyping and prejudice based on chronological age. Stereotypes of how we think. Prejudice, how we feel, and discrimination is the culmination of how the stereotypes and prejudice translate into how we act.

This is a quote by Louise Aronson from the book Elderhood. Many people alive today will be elders for 30 years or more. Yet at the very moment that most of us will spend more years in elderhood than in childhood we have made old age into a disease, a condition to be dreaded, neglected and denied. These are weighty connotations with the idea of getting older and with the identity of being an older person. And then these are things that then get packed on to other identities that we have that may also experience disadvantage.

And so here comes intersectionality, which also layers on top of military and other health care experiences that may have been traumatizing and impacting for people. So in particular and this is not, you know, exhaustive on this slide, but ageism can interact with experiences of racism, experiences of Ableism which is particularly important among the disabled veteran population. Experiences of sexism, again which have been exacerbated through military experiences, homophobia.

Richard again mentioned Don't Ask, Don't Tell which replaced a previous policy which you couldn't serve in the military if you were gay. What are the ways that I want to

encourage people to think about approaching affirming care for older veterans?

So one idea that I want to communicate is something called the life course approach. And I think it is really relevant for veterans but all older adults and the life course approach embodies theories how exposure at different stages of human development shape health within and across generations. So this is the idea that like you can't just look at an older adult at one moment in time when they have reached older adulthood and look at their current situation and think that's going to give you the full story. There is two main perspectives here, the developmental perspective which is the idea that there are sensitive life stages under which an exposure during a sensitive life stage may be more likely to actually set you on a certain health trajectory. And then there is also a structural perspective. So this is, you know, aligned with something called the weathering hypothesis. But this is the idea that repeated stressors over a lifetime create a load, so to speak, to lead to poor health outcomes.

And so, you know, like I said when we look at and have an older person in front of us I want you to see this. Is the idea that everyone comes to whatever point they are in their life with a whole lifetime of experiences beforehand that are all important for understanding where they are at that point in time.

And I think from a research perspective it is really important that researchers who are doing aging related research and doing research with older adults and older veterans think about the entire life course and not just about exposures that people experience in older age.

And so finally, what are the types of things within a Health Care System framework that we are trying to do to, you know, make sure we are addressing the needs of older adults and older veterans in particular? One is called the age friendly health system. This is an effort funding through the Johnny Hartford Foundation and Institute for Healthcare Improvement that you may have heard of or may be hearing more of as I think all Health Care Systems are kind of confronting caring for more and more older adults. But it is based on -- (no audio).

>> SARAH LIPSON: It looks like Lena has frozen for just a moment. We will send good vibes. You froze for just a moment.

>> LENA MAKAROUN: Oh, I'm sorry. I was going briefly through the four Ms.

>> SARAH LIPSON: Great.

>> LENA MAKAROUN: Not just cognitive health but -- oh,

no.

>> SARAH LIPSON: We have got you back again.

>> LENA MAKAROUN: Oh, shoot. This is my second-to-last slide. So hopefully we will make it through. But so let me skip over -- I will focus on the one that's most important. What matters? So really centering the care we deliver, the services we deliver, the design of those services around what is important to veterans and making it really veteran centric. And I will highlight that the VA to Dr. Castro's point is actually a big leader in the age friendly health system movement. And we are kind of making lots of strides towards making all of our facility age friendly.

So to kind of end on some ending points, how can we support what matters most for older veterans? I think it is really important to think beyond just the individual veteran but to their social network, to their caregiver and their families. A healthy, you know, caregiver is a healthy diad. We can't be thinking about the veteran. We need to be supporting caregivers and families as well. Providing services for health-related social risk factors. I think someone did bring up social determinants of health at some point, but we know that this is a major driver for health beyond and even more important than health care. So we need to address these things for older veterans. Veteran centered aging in place.

So innovative programs that go into the community and help veterans stay in their homes as long as possible. Comprehensive care for cognitive and behavioral health. Services to maximize function. So here we are thinking about things not traditionally covered under Medicare. Rehab and fitness. These are all things that the VA really leans on and provides comprehensive services for those who qualify.

Care aligned with goals and preferences at all health stages. So not waiting until end of life to really talk about what's important to people. And then making sure that all the care we deliver is anti-ageist, equitable and trauma-informed.

Thank you so much.

>> SARAH LIPSON: Thank you so much. I think there is so many themes that are coming across here in each of our presenters here today. Thinking about the diversity of veteran populations and thinking about the needs of older veterans is very important. So I'm so glad that you are here on this panel.

Next we will turn it over to Dr. Rothbaum.

>> BARBARA ROTHBAUM: Thank you. And I'm so grateful to be here today and be part of this conversation.

I'm going to talk about treatment of PTSD. First I'm going to talk about standard treatments. And we have two FDA approved

medications for PTSD, Zoloft and Paxil.

And that's great that we have two FDA approved medications. Some of the challenges is I don't think anybody thinks that they're really the treatment that we need for PTSD. The response rates are really not good enough. So most of what is recommended are cognitive behavioral treatments for PTSD.

And there are several trauma focused therapies that are recommended. You will see at the bottom, prolonged exposure has the strongest evidence to support its efficacy for PTSD. For the rest of today I will talk mainly about prolonged exposure.

We do have a number of good treatments for PTSD. So that's great. Some of the challenges is PTSD is a disorder of avoidance. And that includes the treatment. Pretty high dropout rates. And not every treatment works for everyone and even if it helps a little bit, sometimes it doesn't help remit. It doesn't help -- we don't tend to use the cure word. So we have ways that we can go to improve our treatments.

In general what we do for treatment with PTSD is helping people to confront the memories of what happened to them but in a therapeutic manner so that it changes. We've got two main components of prolonged exposure therapy. We ask the person to close their eyes and go back in their mind's eye to the time of the trauma. And recount it out loud, repeatedly. We tape record that and ask them to listen to it for homework. So they're constantly, emotionally processing what happened. We also do what's called invivo exposure where we help people confront situations that they have been avoiding but are realistically safe.

PE, prolonged exposure, is recommended as a first line treatment. So that's the standard treatment. Now I'm going to talk about some new approaches.

The first is the medium of delivery of exposure therapy. And that's a little bit on virtual reality.

>> We will begin to take off momentarily.

>> BARBARA ROTHBAUM: That's the virtual airplane which is actually my favorite because I can exactly control to make sure that everyone is getting the perfect exposure. If they are not ready for turbulence, I will guarantee there is no turbulence. We can take off. We can treat heights, fear of elevators. We have stuff for people with substance use or substance misuse problems.

Now going back to PTSD, the first time that we treated PTSD with virtual reality was with Viet Nam veterans. We did find it useful. Now we are using with veterans who served in Iraq and Afghanistan. They are still doing the imaginable exposure. Now their eyes are open and the therapist is matching in the virtual

reality what the patient is describing.

This is what it looks like. People wear a head-mounted display. We can put someone in the situation that matches almost whatever they experienced in Iraq or Afghanistan. We can put them in a MRAP or Humvee. Put them in whatever position they were in a vehicle, at a checkpoint, on a forward operating base.

(Speaking in a non-English language).

>> BARBARA ROTHBAUM: It is a little clip to show you what some of the capabilities are. And this isn't what the patient would see. Because this is basically a little movie I'm showing you. They would be seeing it in the head mount display. They would be totally immersed. And then only be seeing what they're describing.

So next, innovation, enhancing exposure therapy with pharmacological agents. Most of the studies have been done combining prolonged exposure with an SSRI. Zoloft, Paxil, and in general PE is just as effective with or without the SSRI medication.

And the -- both guidelines, VADOD for PTSD do not recommend the combination of evidence-based psychotherapy, like PE and SSRIs. What people are excited about, what people are thinking might be the next medication to be FDA approved for PTSD is MDMA, combined with therapy. And we're about to start a study combining MDMA with PE, with prolonged exposure. We're very excited about that. Now, timing of exposure therapy. Most of our veterans come to us about ten years after they return from deployment. They have been suffering for a long time.

We know that what happens right after a traumatic event can help or it can hurt. Obviously we want to help. So we have done some early intervention studies in the emergency room where we did basically exposure therapy right after someone was exposed to probably the worst thing in their life. And we have found that three months later, if they receive the earlier intervention, that's in blue, they had half the rate of PTSD of folks who didn't. And it looks like it might have mitigated a genetic risk for PTSD.

The last innovation I want to talk about is massed PE. So most of us when we do therapy we see patients once a week. In the Emory Healthcare Veterans Program we have built an IOP, an intensive outpatient program, a two week IOP that we can fly in post 9/11 veterans from all over the country and put them up in a hotel and feed them. Everything is at no cost to the veteran. We do family therapy. We individualize treatment. So, for example, if they have substance use disorders or substance misuse we have an SED track. If they have issues with mild

traumatic brain injury. We have treated over a thousand warriors this way. This is the number that I'm most proud of. We have almost 93% completion rate. This is the secret sauce to treating PTSD because it helps combat the avoidance, break down so many barriers to care. And it is effective treatment.

This is PTSD symptoms on the PCL. And this first line that's the beginning and end of that two week IOP and then we follow people for a year. So they are getting large gains, improvements in their PTSD that they're maintaining for a year. And similarly for depression.

What we also found is what we thought when you treat the PTSD, the suicidal thoughts decrease as well.

We're also gathering psycho -- physiological measures before and after treatment. When you give them good treatment, their bodies are learning to become less reactive. The startle response is decreasing. Heart rate to activation are decreasing. That makes me so happy that our veterans' bodies are learning to become less reactive to these cues. This is a book that we wrote and this is our contact information if you want to send this to our veterans or active duty service members. Hopefully we can send them back to you better. And with that, I'll stop sharing.

>> SARAH LIPSON: Thank you so much, Dr. Rothbaum. And I feel so grateful that you are doing this work and doing it in a thoughtful way that's protecting individuals that you are serving and customized and tailored to their needs. We have some great questions that have come in already from guests today that I definitely want to make sure that we turn to.

Looks like all of our panelists have already turned their cameras back on so we can see everyone.

So I'm going to maybe I think ask one or two questions to kind of kick us off. And then I want to turn to some of the questions that have come in from the audience. At the end I want to turn to each of you and see kind of what take-away you want, you know, the attendees to come away with. We will organize the next 25 minutes or so in that way.

To start us off, I am curious and I think this is inspired by many of your comments and the work that you are doing, to think about what are the things that bring you hope right now in terms of the ways that we can be centering the needs of veteran populations? What are the things that give you hope and make you feel optimistic about this work moving forward? I would love to hear from each of you on that.

>> RICHARD BROOKSHIRE: I'm happy to jump in. I think things that give me hope, how much traction our work has gotten over the last five years from the grassroots level. And the

fact that there's, you know, now a movement of -- for real transparency by the VA around these racial inequities, access to the data in ways that were never really publically available. Are going to be critical to measuring how we can make an impact and continue to make an impact. With respect to the disparities, specifically around disability compensation. I think that's such a huge driver and kind of beginning to hold the VA accountable around the racial disparities relative to PTSD care. That's super critical. And I'm very optimistic for that.

>> SARAH LIPSON: Thank you. Do others want to chime in with thoughts?

>> SHAILI JAIN: So I think I'm sharing in that optimism, if you look at PTSD science in the last 20 years, what we know about it as a condition, what we know about what treatments work, what doesn't work, there has been an exponential growth in what we know about PTSD in the last 20 years. Partly because of the wars in Iraq and Afghanistan, the things like the great tsunami, massive amount of research that has been done. So when I was starting out in my career, PTSD was sometimes considered like disabling and incurable. And I don't view it that way now at all. It is something manageable. People can deal with this condition. It doesn't have to define the rest of their life. So I think in that sense it is really good.

A few things that I'm seeing on the clinical fronts that make me really excited. We have launched a lot of -- we have done a lot of work to include peers in the treatment of mental health conditions for veterans. Because I do think one of the massive barriers culturally to veterans seeking to help is that, you know, especially mental health help is that, you know, why should they open up to somebody like me, who is not a veteran. I might not look or sound. These are some of the barriers that we have culturally. A lot of my research has involved integrating peers into the treatment of PTSD. And I think that reduces some of the barriers because I think having veteran peers who have that lived experience and who can be a beacon of hope in recovery and share their experience helps with adherence and with engagement in treatment.

Another thing is primary care mental health integration, so the clinic that I work at the VA in Palo Alto, which is a fallacy is broken down when we are working in primary care together. And that reduces a lot of the stigma about seeking mental health. There is less barriers. And finally one thing that came out of the pandemic we were all forced to really embrace virtual care. Anecdotally, prepandemic we had a

no- show rate of 20%. 20% is pretty high.

One thing I have noticed since the pandemic because we are doing a lot more video care, my no-show rate is really low. I feel like I'm reaching people who do have barriers to come to the clinic. You know, like real physical barriers. Either they are working or in school. And offering this modality is just really helpful. So those are some of the things that maybe are really helpful and to address the comments about inequity and reaching people who historically have been underserved. I do think that virtual elements have been rewarding. So those are some of the things that make me feel really hopeful and optimistic.

>> SARAH LIPSON: Great. Thank you.

>> BARBARA ROTHBAUM: You heard what makes me hopeful. I'm thrilled with our program, with our IOP that we're breaking down barriers and it is effective in keeping people in treatment. And I agree, there is so many innovations going on now and looking at the treatment of PTSD over the years, over like hundreds or thousands of years. In some ways it is military psychiatry, military psychology. So although wars are terrible, innovation comes out of it. We want to help veterans. We have got some good treatment and I can think they are only going to get better.

>> LENA MAKAROUN: I will chime in to say, this has been understudied and an unattended problem. It is extremely common that 1 in 10 experience elder mistreatment every year. One thing I'm excited is that the VA and, you know, research and program development in the VA is really leading the charge for innovative kind of approaches to addressing this. But I think could translate out to kind of impact the population outside of the VA as well. So I think it is broadly speaking our culture and society in the U.S. and our institutions and structures are not set up to kind of have just wholistic responsibility for people's well-being. For example, within a Health Care System, the financial structures are not set up where you wholistically care about someone. The VA, we can do innovative things to consider social risk factors and functional health and mental health and all these things. Sensory impairments and kind of wholistically consider the whole person and the whole veteran. And I think that that approach I'm hoping is going to translate into people seeing that that's what's really needed and certain for complex situations like elder mistreatment but across the health spectrum for older adults. That gives me hope.

>> CARL CASTRO: And I would add, Lena's work is just phenomenal. I will tell you ten years ago no one cared about old veterans in America. And I think primarily because they

were white old men. And white old men are the least studied, the least understood group. And so when I see inclusion being expanded to include other groups, that gives me comfort. And this life course approach that Lena has really led the world on I would say has just been phenomenal. And hats off to Lena for taking this wholistic approach and really embracing it. It is truly difficult to do. And I'm just thrilled to see the inclusiveness. Richard's work with addressing African American and black disparities that exist.

The VA has been a big leader in all kinds of disenfranchised groups, including LGBT, woman. I would love to see a bigger and larger discussion on discharge status and those veterans who served who were discharged, exclude them for many of the benefits. And I would love to see the inclusion of immigrants who join the military and went to combat and came back and got into some minor infractions with the law enforcement, then were deported. So we have combat veterans who served on our military, who have been deported. And I just think that's not fair. That's probably for me one of the greatest injustices that I have seen. And, you know, but I'm hopeful that folks are beginning to think about these topics to broaden the inclusiveness, to include these other groups.

>> SARAH LIPSON: Great. I think that given the urgency of this topic it is no surprise that there is a lot of questions coming in. I hope we can get through as many of these as we can. Carl, you flagged that first question. Maybe you could weigh in about any improvements within the VA or veteran community around stigma and mental health and getting support for PTSD and depression?

>> CARL CASTRO: I flagged. But only because I was going to say it is a tough problem. There is a real stigma around mental health not just within the military, but within the military communities but within U.S. society and within world society.

So it is an earth culture of stigma around mental health and physical health as well. We don't talk about that very much. But there is also this stigma around physical health. It is why we have HIPAA. Because nobody wants anyone to know about their physical and mental health status. That's because we're concerned about how that information will be used and how it will affect us. And also the culture, and Richard brought this up with the identity, the importance that the military identity is one of which individuals solve their own problems. And so I'm a big proponent of research and folks putting self-help techniques in the hands of veterans. Taking advantage of people's lack of knowledge. But to the extent that we could

improve self-help, however you want to talk about it, I think that's a real important way of reducing stigma. Because when people utilize some of these techniques like mindfulness and I saw some notes that that was put on there, then people are more likely to see mental health as being helpful and reduce the stigma. They have to have that personal experience for that.

So I'm sorry that I didn't answer the question about stigma reduction efforts. The U.S. military spent hundreds of millions of dollars on trying to address this issue. We're making slow progress. But it is a tough one.

>> BARBARA ROTHBAUM: I'll jump in. Because we have been trying to address the self-help. We published a book that's basically self-help exposure therapy, making meaning a difficult experience. We have an app now that we're testing because like Carl said, we need evidence-based to help people confront and process difficult memories.

>> SARAH LIPSON: Thank you. And turning to another question, I mean I think that a lot of the discussion today is about some of the unmet needs and trying to meet needs within the current VA system. But there is a great question here about just acknowledging many veterans don't seek care in the VA and what can we do to help support and train clinicians and providers in the community? So outside of the VA to be able to identify veterans in their own communities and to provide supportive care for veterans?

>> LENA MAKAROUN: I do think that's important. We have to remember, this distinction between VA enrolled and VA not enrolled. Most veterans are not VA enrolled. But I think that's why it is important for all of us to build bridges across systems. For example, in my own work, where, you know, elder abuse, detection and response, is a very interdisciplinary approach where adult protective services may be at the county level and we are here in the VA which is federal level. So we have done a lot of work to do presentations to APS about veteran, you know, related health issues. Health-related issues for veterans. Educating about TBI, occupational exposures which is big for Viet Nam era veterans as well as others. There needs to be a lot of us who work in VA. I think to also have other spheres where we work. I'm also at the University of Pittsburgh and I always take every opportunity when giving talks or teaching students or to insert that in there. It is not -- it is not a systematic approach but taking every opportunity to kind of educate is really important. So I'll let Barbara add in.

>> BARBARA ROTHBAUM: I can refer people to the center for deployment psychology. They offer a lot of trainings. We

have a training that we are training people in prolonged exposure. So there are a number of programs across the country that can offer military and PTSD and evidence-based treatment training.

>> SARAH LIPSON: Fantastic. There are a few questions around the use of virtual reality and a few around the use of virtual reality, virtual therapy for which conditions. So obviously we talked about PTSD. If there are other conditions that you are applying this to as well as whether this is covered by insurance.

>> BARBARA ROTHBAUM: I will talk to those. I will take the VR questions. So yes. It is -- there are a number of VAs across the country that do have the virtual reality. And if they have it, then it is covered under the VA. And there was a question about, you know, is there anxiety. Yes. But I mean in general for exposure therapy, it's -- we want the dance between tapping into that anxiety but not being overwhelmed by it. So hopefully that's where you have a good therapist who can, you know -- I tell patients I'm going to push you out of your comfort zone but not out of your safety zone. And so we want to help confront these things but in a therapeutic manner so it gets easier and better. So that's part of the art and science of it.

We've got the virtual reality exposure therapy for a number of disorders. So we use it for PTSD. Fear of flying is my favorite just because it is so feasible. We've got a virtual bar for substance use disorders. We have got virtual audiences for fear of public speaking. We have got virtual relaxation. So there are a number of them out there. And they're only now -- things are getting into cheaper and cheaper head-mounted displays. There is going to be more available soon.

>> SARAH LIPSON: Great. That's really exciting. Another question that has come in is about resiliency training and I think -- I'm particularly interested in a lot of what's been said around what can we do as a structural or system level and putting less of the onus on the individual. But, of course, you know, and resilience is not just at an individual level. We can have a resilience system as well. I wonder if anyone can talk sort of from the prevention perspective around how resiliency training is incorporated into resources for veterans. Is that something that anyone has any specific experience? And if not we can address that question in offline follow-up.

Looking at the time and knowing that I think my next prompt for folks may take a minute or so for each person to have a chance to respond to this, but so I think we'll turn to that now and just hear what do you hope, you know, are the biggest

take-aways that people leave today's discussion with? Like we've said there is so much urgency addressing the needs of the veteran population, both physical and mental health. Based on your work and moving forward, what do you hope that people are going to come away with from today's discussion? And we can go in whatever order --

>> BARBARA ROTHBAUM: I can start because I definitely -- I want people to know that treatment works. A lot of our veterans will say why should I engage in treatment. My life is ruined because of what happened to me. And you can't change what happened to me.

Yes. It is likely awful what happened and we can't change that. But to help them understand the problems they're going through now, and we help understand what they are. If it is PTSD or depression or substance use that we can treat. So I really want to put out there a message of hope and kind of like Carl was saying even if you tried to get -- Richard, too, if you tried to get treatment, try again. Try a different provider, a different place, a different kind of treatment. But treatment does work. So please have hope.

>> RICHARD BROOKSHIRE: I'll go next. What I would like people to leave with is that equity is possible. That the VA unfortunately given its history was kind of built on a level of prejudice. It is endemic in our society but the need for greater transparency allows for greater accountability. And we're already kind of seeing how disparities in the past when it comes to being able to service, one in which there is still strides to be made. So yeah, I think that's what I want folks to really censor is necessary. And for me like culturally competent care is like critical. Because not every veteran is not monolithic. A lot of different experiences. And so I think that those -- that's a critical pathway to being able to foster a greater level of equity. And so that black vets for all the different reasons that they haven't been able to get equitable access, targeted approaches to ensuring that greater equity is achieved.

>> SARAH LIPSON: Do you have a sense from your work, Richard, if you could wave a magic wand, are there things that you would think, you know, we could change this and it would really improve the lives of black veterans?

>> RICHARD BROOKSHIRE: Yes. I mean I think one is a targeted outreach. I think some of the work that we were doing over the course of the last three years is helping to build an ecosystem, a coalition of black veterans organizations that are strung out across the country, fighting for decades to raise the banner because they have been largely neglected by the white

facing veteran service organizations in the country who haven't looked at race as a critical factor to address.

So that population has been neglected. So trying to organize them and I think it has been very interesting. It gives me hope. But it does give me hope that the solutions are in the community, right? And so making sure that the VA is engaging with the community and not just thinking that oh, because they engage with the American Legion, the VFW, the moneyed veteran's organizations have a blind spot in today, that that's sufficient. It is not sufficient and the data is proving that's why these disparities are persisting. Whether at the local level or national level to have targeted approach on how they reach black veterans.

>> SARAH LIPSON: Great. I'm glad you are able to articulate that and have a seat at the table today in this conversation is so important. So thank you. Do others want to chime in?

>> LENA MAKAROUN: Veterans are not a monolith. Older adults are the most diverse population. If you look at two five-year-olds, two 20-year-olds they are pretty similar. Two 75-year-olds in terms of what they can do, their cognition, function it could probably vary differently. And I would say the same with veterans. We will make statements about the veteran population, but while there are some commonalities and experiences and kind of culture, this is a very heterogenous group and just remember that.

>> SARAH LIPSON: Thank you.

>> SHAILI JAIN: I might add some thoughts specific to post-traumatic stress disorder. It is a pressing public health concern not only amongst the veteran population but in the United States generally. And I do think one of the ways of reducing stigma we have to elevate the public health literacy around. If you don't have a trauma-related issue, you know somebody who does. Going to a trauma-informed culture or society is key to transcending some of these retractible problems.

>> CARL CASTRO: I would like to add, I know that we're running out of time. A lot of veterans don't access the VA or don't access care in general. And I think we need to be respectful of people's decisions and veterans' decisions not to seek care and not to seek resources but to be there for them when they're ready to seek care. So, you know, in America you have the right to refuse health. And I don't like seeing it. I want to jump in there and help. But if someone says I don't want any help, I want to be left alone, I think we need to be respectful of that decision. Being there for them when they are

ready to receive help. And then receive help in a caring, supportive way. I'll stop there. But I think I made my point.

>> SARAH LIPSON: I think that really underscores the importance of having a public health priority in addition to a Health Care System that's there and ready for folks when they engage in, but to have a public health approach that reaches everyone. Thank you all so much. This has been extremely insightful. So many comments are coming in. I will turn it back over to you, Dean Galea.

>> SANDRO GALEA: Thank you for the excellent moderation. And it was a privilege to listen to all of you and to learn from you all. I know many of you and I have learned from you over the years and I learned even more today.

I want to thank the audience and participants, very interesting questions and excellent comments in the chat. And feel these conversations are a conversation as we hear from people. I want to thank you all for what you do.

As we heard, we are dealing with a population that's often underserved. And it is people in this room today both on the panel as well as participating who are making a difference in people's lives. So thank you to everyone. We set for ourselves the title of this panel to try to center the health of veterans within public health and hopefully it is conversations like this that help this. Have a good afternoon. Take good care.

>> Thank you.

(Session concluded at 1:30 p.m. CT)

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