Position Brief on
Post-Traumatic Growth Partnerships, Section 203 of S. 785 Commander John Scott Hannon Veterans Mental Health Care Improvement Act
https://www.veterans.senate.gov/imo/media/doc/Commander%20John%20Scott%20Hannon%20Veterans%20Mental%20Health%20Care%20Improvement%20Act.pdf

January 12, 2020

Background
S. 785 Commander John Scott Hannon Veterans Mental Health Care Improvement Act Section 203 requires the VA to enter into partnerships with nonprofit mental health organizations to facilitate posttraumatic growth ("PTG") among veterans. Those organizations must have previously demonstrated a history of success to facilitate PTG. Success is measured by increased, sustained positive psychological changes that emerge following a traumatic life event in five areas: (1) an appreciation of and for life, (2) improved relationships with others, (3) realization of new possibilities in life, (4) realization of personal strength, and (5) spiritual change.

We support the aspiration that treatment interventions should aim to not only reduce PTSD symptoms but to effect positive life changes. We also support continual development of novel, effective interventions for our veterans who have endured trauma. However, we have two major concerns about the effort in this bill.

1.**Duplication of Services**

The VHA already provides robust clinical services for veterans who have experienced trauma. Positive life changes are among the intended outcomes. Thus, **it is not apparent what the partnerships would provide that supplement rather than duplicate VHA services**.

Posttraumatic Stress Disorder Clinical Teams offer not only VA/DoD guideline concordant interventions but also case management of a patient's life circumstances. More broadly, the VA's newly established Whole Health program explicitly addresses the full range of physical, emotional, mental, social, spiritual, and environmental influences in veterans' well-being. Those are the same life domains outlined in the bill.

2. **Lack of Empirical Evidence**

Funding external PTG services is premature. **There is a lack of research to support the benefits of PTG services that are distinct from and**

complementarily additive to psychotherapy. PTG services may have persuasive face value, but they have no strong research base yet.

Asking non-profits to offer and evaluate services won't give adequate information to enable judging their relative contributions compared to existing treatments. A better solution than funding these services would be **funding rigorous scientific research on the effectiveness of PTG interventions, alone and compared with PTSD interventions**. Program evaluations rarely produce the kinds of information that would allow for strong conclusions that justify their interventions, because of a lack of usual controls. This is a huge oversight because it leaves judgment about what policies should be enacted to individual opinion in the absence of evidence.

If PTG interventions include evaluations of both PTSD symptom reduction and impact on PTG cognitions, then it will be possible to see whether a specific PTG intervention is producing either outcome. In order for PTG to demonstrate unique advantage, it would need to do one or both of the following: 1) improve either PTG outcomes or PTSD symptom reduction significantly more than a given psychotherapy, or 2) achieve equivalent outcomes but be more acceptable or engaging (i.e., greater uptake and/or less dropout). Generally, the assumption would be that PTG is unique in improving PTG outcomes more than would be accomplished in a psychotherapy (even though psychotherapies often increase PTG), but this needs to be demonstrated.

Finally, although this shouldn't need to be said, we want to reaffirm that funding to treat veterans with PTSD using VA/DoD Clinical Practice Guidelines must remain fully allocated. If funds for PTG services are taken from the existing VHA Office of Mental Health and Suicide Prevention budget, then the principled intent of the legislation would be degraded.

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