Dear Chairman Moran, Ranking Member Blumenthal, and Members of the Committee:

On behalf of Reason for Hope and the Veteran Mental Health Leadership Coalition (VMHLC), thank you for the opportunity to provide testimony in support of S. 4220, the *Veterans Health Administration Novel Therapeutics Preparedness Act.* This legislation addresses one of the most urgent structural failures in Veteran healthcare today: a system that lacks the infrastructure, authority, and urgency needed to prepare for and deliver novel mental health therapies. This is not a theoretical problem. It is a national emergency.

Introduction

My name is Dr. Lynnette Astrid Averill, and I serve as Chief Science Officer for Reason for Hope and the Veteran Mental Health Leadership Coalition (VMHLC). Our coalition brings together Veterans, family members, clinicians, researchers, advocates, and over 50 organizations committed to improving mental health care and preventing suicide in the Veteran community, including by expanding research and access to evidence-based psychedelic and other breakthrough therapies. Many of VMHLC's founding members are Veterans who felt compelled to travel abroad to access psychedelic therapies after exhausting approved treatments in the United States, and the organizations who supported them through this journey. I have been able to publish several observational reports on the experiences of Veterans leaving the country to engage in these interventions after exhausting all options within traditional healthcare. My perspective on this issue is both deeply personal and grounded in a lifetime of lived experience and decades of clinical, research, and policy experience.

I am the daughter of a Vietnam Veteran who died by suicide after years of struggling with ineffective treatments. That experience shaped the course of my life and my career. I began working in the Department of Veterans Affairs as a junior in college, initially supporting a PTSD clinic. Over time, I grew within the system from a research assistant to a faculty member, principal investigator, and a clinically credentialed psychologist.

I have provided care across a wide range of VA settings, including inpatient psychiatry, outpatient and residential PTSD programs, spinal cord injury units, and polytrauma clinics focused on traumatic brain injury. I have also led and contributed to research focused on trauma, suicidality, and treatment innovation, working with hundreds of Veterans across all branches and service eras. Through this work, I have heard not only the experiences of Veterans, but of their families, who are often deeply and permanently affected.

I also spent seven years working within the National Center for PTSD, where I saw firsthand the challenges of how resources are allocated. Each year, during the end-of-fiscal-year "September spike," we were asked to rapidly spend remaining funds—often on items that could not meaningfully support pilot studies, expand enrollment, increase staffing, or otherwise improve care or research capacity. This experience reinforced a critical reality: the issue is not only the amount of funding, but how intentionally and effectively it is deployed.

I believed I would spend my career in the VA. This work is where my heart and my purpose are. However, I left the VA in 2025 after reaching a point where I could no longer reconcile the care I was providing with what I believed Veterans needed. I found myself delivering manualized

treatments and following required protocols—even when those approaches were not effective for the individuals in front of me. I saw Veterans cycling through treatments without meaningful improvement. I saw systems that prioritized adherence to protocol over responsiveness to patient need. I saw prescribing practices that raised serious concern, including cases of extreme polypharmacy with significant medical consequences. I reached a point where I felt complicit in a system that was not meeting Veterans' needs, and I could not continue. These were not isolated experiences—they reflect broader structural challenges within the system.

At the same time, my connection to this issue remains deeply personal, as it does for all members of the VMHLC and Reason for Hope. I have lost multiple family members to suicide, and many others have been permanently impacted by their service. Within the past month, a close family member—a Marine Veteran, who has dedicated himself to helping other Veterans—attempted suicide, and he, his wife, and children began the steps to recover from this and see what the future holds.

This is not an abstract policy issue for me. It is something I have experienced, witnessed, and worked doggedly to address from every angle—clinical, scientific, and personal.

The Current System Cannot Meet the Moment

The reality of this situation, and our coalition's very existence, belies why S. 4220 is needed. Every day, Veterans are dying by suicide, overdose, and from the long-term consequences of untreated or inadequately treated mental health conditions. Despite decades of effort, the current system is not meeting the needs of those it is designed to serve. That reality must be acknowledged clearly and without defensiveness if we are to move forward.

Fortunately, President Trump recently signed a historic Executive Order to expand research and accelerate patient access to psychedelic therapies in response to this crisis.[1] It directs federal agencies, including the VA, to increase clinical trial participation, data sharing, and real-world evidence generation for psychedelic drugs with an FDA Breakthrough Therapy designation. We appreciate that the VA has already taken steps in this direction over the past year.

However, perhaps more significantly for the VA, the EO could meaningfully accelerate the timeline for regulatory approvals of investigational psychedelic drugs – particularly those that received national priority vouchers through the FDA Commissioner's National Priority Voucher (CNPV) Pilot Program.[2]

Yet approval alone does not equal access for Veterans. The VA still needs specially trained clinicians and interdisciplinary care teams, dedicated infrastructure, and updated scheduling, billing, and clinical workflow systems to deliver these treatments at scale.

Notably, the VA has taken some proactive steps to prepare, including the launch of an Integrated Project Team (IPT) in 2023. Yet by all indications, the IPT has not been given the resources or authority to move forward at a sufficient pace, and the VA will not be ready for a serious rollout upon approval of the first psychedelic therapy. We expect at most a handful of sites to be prepared

[1] https://www.whitehouse.gov/presidential-actions/2026/04/accelerating-medical-treatments-for-serious-mental-illness/
[2] https://www.fda.gov/news-events/press-announcements/fda-accelerates-action-treatments-serious-mental-illness-following-executive-order

and authorized for the initial launch—a reality that will leave many Veterans beyond frustrated and disappointed.

Given the intensity of hope surrounding these treatments, the absence of at least one accessible site in every state could itself become a significant source of distress and disillusionment for Veterans seeking care.

We have seen a similar pattern before. During President Trump's first term, the VA was directed to accelerate access to Esketamine (an FDA-approved derivative of ketamine) treatment. Uptake was painfully slow, and years later, based on the most recent publicly available data from 2023, fewer than 1,900 Veterans received esketamine or generic intravenous ketamine treatment across the entire VA system in a single year.[3] That is a drop in the ocean compared to both the number of Veterans the VA has identified as treatment-refractory and the number dying by suicide each year. We cannot afford to repeat this pattern.

Significantly, VA leadership has not emphasized funding, staffing, or infrastructure as the primary barriers to implementing psychedelic therapies. Rather, at the 2025 Senate Veterans' Affairs Committee field hearing hosted by Senator Tuberville in Alabama, the VA representative noted that the greatest challenge is simply that **"change is hard"** for such a large and complex healthcare system.[4]

We recognize this is a complex undertaking – even with many diligent VA officials working hard and with the best intentions to improve care and outcomes.

This is precisely why the VHA Novel Therapeutics Preparedness Act is necessary. Without system-level reforms to strengthen proactive planning and provide clear implementation authority for truly transformative approaches, the VA risks repeating a familiar pattern: promising treatments are approved, but Veterans wait years before they are meaningfully accessible.

The Department of Veterans Affairs is home to many excellent, highly skilled, and deeply dedicated providers committed to helping Veterans heal. This testimony is not a critique of those clinicians, their capacity, or their commitment. It is a critique of the limited tools available within the system and the structural constraints that prevent effective care delivery, given the realities of military service and its aftermath.

To be clear, many Veterans do benefit from existing treatments, and many VA clinicians deliver exceptional care under difficult conditions. This is not a rejection of those efforts—it is a recognition that the current toolkit is insufficient for a substantial portion of Veterans, particularly those with complex, chronic, or treatment-refractory conditions.

The VA system remains heavily centered on polypharmacy and manualized psychotherapies. While these approaches have value, they are insufficient for a large and growing population of Veterans with complex clinical presentations. Dropout rates for trauma-focused therapies

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[3] Emerson, LaTina. Intravenous ketamine treatment improves depression in Veterans. *US Medicine.* April 10, 2024. https://www.usmedicine.com/clinical-topics/depression/intravenous-ketamine-treatment-improves-depression-in-veterans/

[4] S. Hrg. 119-156, Separating Fact from Fiction: Exploring Alternative Therapies for Veterans' Mental Health, Committee on Veterans' Affairs, United States Senate, August 10, 2025. https://www.govinfo.gov/content/pkg/CHRG-119shrg61533/pdf/CHRG-119shrg61533.pdf

frequently reach 50 percent or higher. Medications are often slow acting, variably effective, and associated with significant side effects.

Veterans with the most severe and complex presentations are also frequently excluded from the clinical trials designed to generate evidence, meaning we are building an evidence base that does not fully reflect the realities of those most in need of care. These are not Veterans who failed because they lacked motivation or resilience. They have exhausted available treatments because those treatments were not enough. The result is predictable: Veterans are labeled "treatment-resistant," not because they cannot heal, but because the system lacks the tools and flexibility to reach them.

The Science Has Moved Forward—The System Has Not

We are no longer operating in a vacuum of innovation.

There is now substantial and growing evidence supporting a range of emerging interventions, including psychedelic therapies such as MDMA, psilocybin, methylone, LSD, and 5-MeO-DMT. Many of these are in FDA-regulated trials, with multiple compounds having received Breakthrough Therapy designation across PTSD, depression, and anxiety-related conditions. Ibogaine has also shown remarkable promise in observational studies for traumatic brain injury, opioid and other substance use disorders, and trauma-related conditions.

These therapies often act rapidly—including on suicidality—show promise in treatment-refractory populations, and target underlying neurobiological and psychological mechanisms not addressed by current standards of care. This matters particularly because many of the invisible wounds of war, including moral injury, are not fear-based conditions and cannot be resolved through cognitive restructuring alone.

Like all treatments, these emerging therapies also carry risks. They are powerful tools that require careful screening, clinical oversight, and structured delivery models. It is critical to ensure safety, but we cannot use safety as a justification for inaction.

We must always seek to optimize the benefit-risk calculus, and ongoing research is essential to do so. Yet, the VA has invested remarkably little of its own funds toward generating this evidence. In its most recent budget submission, the VA requested only $2.4 million for psychedelic therapy research for FY2027. This amount is woefully inadequate, profoundly misaligned with the scale and urgency of the crisis, and, frankly, an insult to Veterans.

New Treatments Require New Systems of Care

A fundamental challenge to implementing these treatments is structural. There is a prevailing assumption that new therapies can simply be layered onto existing systems. This is not unique to the VA, but it is particularly problematic here.

We already know that existing treatments are not effective for all Veterans. They are often slow acting, associated with side effects, and characterized by high dropout rates. Forcing fundamentally different, novel interventions into the same system that has failed many Veterans defeats the very purpose of innovation.

At the 2023 VA State of the Art conference on psychedelic therapies, and in subsequent discussions, VA leadership has rightly highlighted the strength of its clinical workforce—

particularly the number of therapists trained and certified in evidence-based treatments such as Cognitive Processing Therapy and Prolonged Exposure. That investment is deserving of recognition.

However, these interventions do not work for a substantial proportion of Veterans. And critically, these therapies—highly manualized, agenda-driven, and time-limited—do not align well with the mechanisms or clinical delivery models of psychedelic-assisted treatment. While certain therapy modalities warrant further study in combination with psychedelics, we should not delay access to therapies already demonstrating incredible benefit in pursuit of perfect integration with existing VA models.

Research and extensive clinical experience demonstrate that psychedelic-assisted therapeutic experiences are not linear or predictable. They cannot be confined to a worksheet or a predefined session agenda. Clinicians cannot redirect patients away from their internal experience simply because it does not align with that day's session plan.

These therapies require a fundamentally different model of care: substantial preparation, extended patient-directed treatment sessions, structured integration, and ongoing follow-up.

When providers are already overburdened and patients are waiting unacceptable lengths of time, asking clinicians to spend significantly more time with individual patients represents a profound shift. And yet—it may be exactly what is required. More time, more attention, and more intentional engagement, combined with interventions that enhance neuroplasticity and emotional processing, may create the conditions for truly transformative healing—and in doing so, may ultimately reduce long-term system burden while improving outcomes.

This is not simply a question of adding new treatments. It is a question of restructuring how care is delivered.

Access, Staffing, and Resource Allocation Must Match the Crisis

The system is already under severe strain. Veterans wait months for providers. Clinicians are overburdened and burned out. In some cases, patients continue seeking care long after their provider has departed, without reassignment or continuity of care.

Layering additional complexity onto this system without structural change will not succeed.

We appreciate that the IPT has taken steps to prepare and that approximately 250 clinicians have received some level of training. However, we anticipate that only a small number of sites will be ready and authorized to offer treatment upon FDA approval. This is tragic for Veterans nationwide.

We urge the VA to significantly invest over the next year in new hiring and training for clinical staff, development of appropriate infrastructure, and system changes that accommodate a new model of care. This is not solely a resource scarcity issue—it is a resource prioritization issue.

There must be a more rational and intentional approach to aligning funding with need. We cannot continue to see patterns in which funds are rapidly obligated at the end of fiscal cycles on low-impact expenditures while Veterans struggle to access both basic and advanced care—particularly those in rural and underserved areas. And we cannot continue to see minimal VA investment in advancing FDA-designated Breakthrough Therapies for conditions that disproportionately impact Veterans.

The question is no longer whether innovation exists. The question is whether we are prepared to advance and implement it with the urgency the crisis demands.

The Novel Therapeutics Infrastructure Must Be Built to Innovate

We strongly support establishing dedicated infrastructure within the Veterans Health Administration to prepare for the evaluation and implementation of emerging therapies. The creation of dedicated leadership, coordinated networks, and clear implementation pathways is an important step forward.

However, the purpose of this infrastructure must be clear. It should not simply observe innovation—it must enable it, and ensure its benefits are equitably delivered to Veterans throughout the country.

True innovation authority requires the ability to:

- Pilot new care models outside traditional productivity constraints
- Rapidly iterate based on outcomes data
- Include complex, real-world patients
- Partner with external centers of excellence
- Hire and train new clinical staff
- Authorize new treatment, staffing, and billing models based on best available evidence
- Collaborate across VA offices and with other federal departments, agencies, and state regulators to inform funding and regulatory decisions
- Ensure benefits are equitably distributed across geography and demographics

Congress should ensure that any Office of Novel Therapeutics has clear authority to drive system-wide change, defined accountability, protected funding, implementation timelines, flexibility to pursue external partnerships, and meaningful Veteran advisory input. Without these elements, this effort risks becoming another well-intentioned structure that fails to deliver meaningful change.

Leave No Stone Unturned

There must also be viable pathways for Veterans with life-threatening, treatment-refractory conditions to access emerging therapies when they are unable to participate in clinical trials. The absence of such pathways leaves the most vulnerable without options. President Trump's Executive Order directed FDA and DEA to work together to establish such a pathway for eligible psychedelic therapies under the Right to Try Act, and we encourage the VA to accommodate and support that pathway.

It is also worth noting that much of the innovation in this space—and the willingness to accept risk—has been driven by Veterans themselves, often outside formal systems of care. That reality should inform policy, not be dismissed by it.

Veterans were asked to accept risk in service to this country. We must be willing to accept measured, responsible risk in pursuit of their healing. When a Veteran has exhausted approved treatments, insisting upon recycling through the status quo is not care—it is abandonment.

Conclusion: Delay Is a Decision

The system we have today was built with good intentions. Good intentions are not enough when lives are at stake.

The question before this Committee is not whether innovation is needed. It is whether we are willing to move at the pace required to save lives.

Because in this context, delay is not neutral. It is a decision—with consequences.

Veterans who have cycled through years of polypharmacy and talk therapy without benefit cannot afford to wait. Their families cannot wait. And the country they served should not ask them to.

Thank you. We urge you to support this important legislation.

Sincerely,

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