

# CHANGING THE PARADIGM – ADDRESSING THE UNDERLYING CAUSE OF VETERANS AND SERVICE MEMBERS WHO DIE BY SUICIDE

**Michael W. Hartford, LFACHE**  
**CAPT, USN (Ret)**  
**VA Senior Healthcare Executive (Ret)**  
**Healthcare Consultant/Program Advisor**

**December 2025**

## **1. Executive Summary**

America is facing an escalating and deeply personal national crisis—one that claims the lives of those who once swore to defend it. Veterans and Service Members represent only six percent of the U.S. adult population, yet they account for nearly one in five suicides nationwide. Between 2008 and 2022, the Veteran suicide rate increased by 32%, far exceeding the 20% rise seen among non-Veterans. Among active-duty personnel, suicide has now surpassed combat fatalities as the leading cause of death, with 883 confirmed cases between 2014 and 2019 alone.

Emerging investigations, including Operation Deep Dive, reveal that actual Veteran suicide rates may be nearly double official reports—an alarming indication that the true scale of this crisis remains underestimated.

Despite years of initiatives, national campaigns, and unprecedented federal investment—more than **\$3.7 billion across all federal suicide-prevention and mental-health crisis-response programs in FY 2025**—our nation has failed to meaningfully reduce suicide rates among Veterans, active-duty Service Members, or civilians. The numbers remain tragically consistent year after year, underscoring a fundamental flaw in our national approach. Veterans continue to die not because of a lack of compassion, effort, or funding, but because our prevention strategies remain focused on the wrong target—treating suicide primarily as a behavioral or psychological issue rather than addressing the underlying brain trauma and physiological injury driving much of this crisis.

Mounting evidence shows that traumatic brain injury (TBI)—from blast exposure, concussive trauma, and repeated sub-concussive impacts—is the underlying physiological injury driving much of what is currently labeled as “mental illness” among Veterans. Depression, substance misuse, cognitive decline, and suicidal ideation are not isolated psychiatric conditions; they are often symptomatic expressions of untreated brain trauma and neuroinflammatory injury.

*Disclaimer: This paper used ChatGPT 5.1 and input from subject-matter experts (SMEs) for pertinent information included in this document. It is not intended to endorse or promote any treatment modality or model of care.*

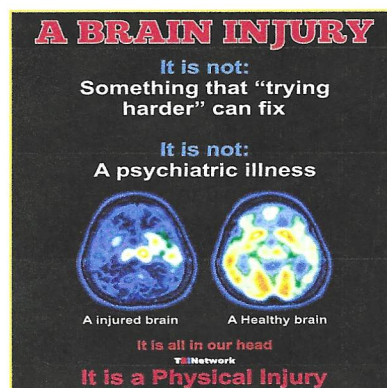
Our healthcare system continues to misclassify and mistreat these physical injuries as psychological disorders. As a result, countless Veterans are prescribed medications that may exacerbate mood instability or even induce suicidal ideation—compounding the very crisis they were meant to prevent.

A transformative paradigm shift is urgently required. We must reframe suicide prevention as a neurobiological and medical imperative, not merely a behavioral one. This white paper calls upon policymakers, Veteran organizations, clinicians, and national leaders to unite in a coordinated effort to identify, diagnose, and treat brain trauma as the root cause of Veteran and Service Member suicide.

The lives of our nation’s defenders depend on our willingness to act with courage, clarity, and compassion—now.

## 2. Introduction

For decades, the national strategy to prevent suicide among Veterans and Service Members has centered on mental health interventions—counseling, crisis hotlines, and psychiatric medication. These initiatives were founded on good intentions and genuine compassion, yet they overlook a critical truth: mental health symptoms often emerge downstream of *physical* brain injury.



When Service Members experience blast exposure, concussive trauma, or chronic operational stress, the brain sustains microscopic injuries that disrupt neurochemical signaling, hormone balance, and inflammatory regulation. These biological changes can manifest as depression, anxiety, insomnia, impulsivity, or emotional volatility—symptoms too often mistaken for purely psychological conditions.

As a result, the system frequently misdiagnoses brain injury as mental illness, offering talk therapy and psychotropic medications when the real issue is physiological and structural. This misalignment between cause and treatment helps explain why billions of dollars in prevention funding have yielded limited improvement in outcomes.

It is time for a transformative shift in perspective—to see suicide not as a moral failing or emotional weakness, but as the tragic endpoint of an unrecognized and untreated injury to

the brain. Just as we would not treat a broken leg with antidepressants, we must stop treating traumatic brain injuries with psychiatric labels alone.

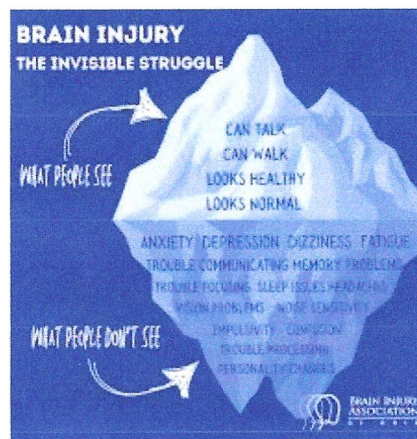
By redefining suicide prevention through a brain-first lens, we open the door to earlier detection, more effective interventions, and genuine recovery. This shift demands new policy direction, cross-sector collaboration, and a willingness to challenge entrenched systems that have failed to protect those who have served.

Our Veterans do not need more awareness campaigns; they need access to accurate diagnosis, integrative brain treatment, and a healthcare model that recognizes the biological roots of despair. Only then can we move from managing symptoms to preventing tragedy.

### 3. Problem Statement

Suicide among Service Members and Veterans has reached epidemic proportions—and the trajectory shows no signs of slowing. Despite more than two decades of focused mental-health campaigns, the core drivers of this crisis remain largely unaddressed. The prevailing model continues to treat suicide as a psychological or social phenomenon rather than recognizing it as the potential outcome of biological brain injury sustained before, during, or after service.

Traumatic brain injury (TBI) and repetitive sub-concussive impacts—common in training, combat, and even non-deployed service roles—initiate a cascade of physiological changes within the brain. These include neuroinflammation, oxidative stress, hormonal dysregulation, and impaired neural-repair mechanisms. Collectively, these changes alter cognition, mood, and behavior, producing symptoms that are often indistinguishable from depression, anxiety, substance dependence, and post-traumatic stress.



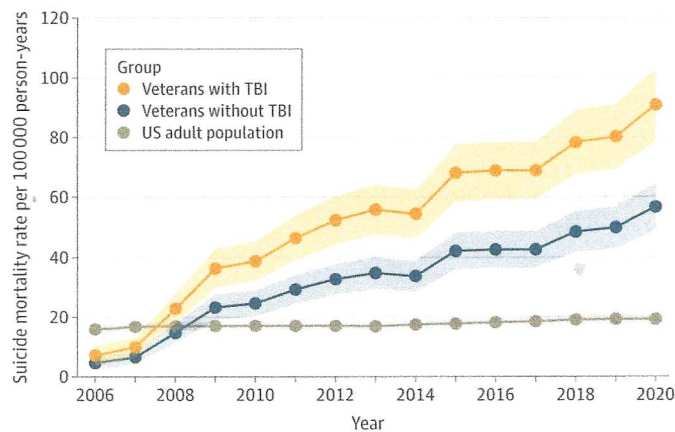
However, rather than screening for or treating these injuries as medical conditions, the healthcare system continues to categorize them as psychiatric disorders. This practice not only delays appropriate care but can entrench chronic dysfunction through symptom-focused treatments that never address the root cause.

In many cases, Veterans seeking help are prescribed medications that list suicidal ideation as a potential side effect. The irony is devastating: a Veteran may seek care for suicidal thoughts and leave with prescriptions that can intensify those same thoughts. Meanwhile, brain-based therapies that show promise remain inaccessible, underfunded, or dismissed as “alternative” rather than essential.

Federal suicide-prevention frameworks prioritize psychological resilience and social reintegration but fail to mandate brain-injury screening or neurobiological assessment as part of standard mental-health evaluation. As a result, tens of thousands of Veterans with undiagnosed brain trauma are left navigating systems that were never designed to treat their true condition.

The consequence is clear: Veterans are dying not because they are unwilling to seek help, but because the help available does not address what is truly broken—their brains.

#### **JAMA Neurol Published Online: August 28, 2023**



## **4. Solution**

A national paradigm shift is required to reduce suicide among Veterans and Service Members. Current strategies overemphasize psychiatric symptoms while overlooking the biological injury to the brain caused by blast exposure, concussive trauma, and chronic operational stress.

A modern prevention strategy must integrate objective diagnostics, neurorestorative treatment pathways, clinician training, insurance modernization, and aligned federal legislation. The following solutions outline the coordinated clinical, policy, and operational actions required to implement a brain-trauma-centered national model.

### **4.1 Standardize TBI as a Chronic Medical Condition**

CMS has formally designated Traumatic Brain Injury (TBI) as a chronic medical condition; however, no single National Coverage Determination (NCD) exists to guide comprehensive evaluation and treatment for chronic or blast-related TBI. As a result,

coverage, care pathways, and diagnostic practices remain inconsistent across federal, state, and private healthcare systems.

### **Actions**

- Establish a comprehensive CMS National Coverage Determination (NCD) for chronic TBI.  
Create a unified federal policy outlining covered diagnostic evaluations, neuroendocrine and metabolic testing, neurorestorative interventions, rehabilitative services, and long-term care requirements. This will ensure consistent reimbursement standards and fully implement CMS's chronic-TBI classification across all care systems.
- Standardize ICD-10 and ICD-11 coding for chronic, repetitive, and blast-related TBI.  
Require uniform adoption of chronic-condition codes to improve surveillance, care continuity, and reimbursement accuracy, and to reduce variability in diagnostic documentation.
- Implement national chronic-care pathways for TBI.  
Develop federally endorsed care pathways that include routine follow-up, multidisciplinary case management, cognitive and behavioral rehabilitation, neuroendocrine evaluation, and longitudinal outcome tracking.
- Expand diagnostic criteria to reflect the full clinical spectrum of chronic and blast-related TBI.  
Incorporate assessment of neuroendocrine dysfunction, autonomic instability, metabolic derangements, inflammatory markers, vestibular/ocular impairment, and other downstream biological effects associated with blast exposure and repetitive sub concussive trauma.

### **Impact**

Creates long-term, reimbursable, mechanism-based care rather than episodic psychiatric treatment.

### **4.2 Improve Clinician Education and Early Detection**

Providers must recognize the biological sequelae of brain trauma that often present as psychiatric symptoms.

### **Actions**

- Require annual TBI/blast-injury training across VA, DoD, and federally supported systems.
- Integrate “brain-health vital checks” into primary care, mental health, pain, and substance-use encounters.
- Implement universal screening for blast exposure, repetitive TBIs, and high-risk military occupations.

## **Impact**

Reduces misdiagnosis and ensures timely access to appropriate care.

### **4.3 Modernize Medical and Allied-Health Training Programs**

Modern brain-injury science must be standard across all healthcare training pipelines.

#### **Actions**

- Require medical, nursing, PA, psychology, and social-work programs to teach chronic-TBI pathophysiology and diagnostics.
- Integrate instruction on neuromodulation, neuroendocrine restoration, metabolic therapy, and neurorestorative care models.
- Establish Centers of Excellence to develop and disseminate standardized curricula.

## **Impact**

Builds a national workforce capable of treating brain trauma as a medical injury, not a mental-health category.

### **4.4 Implement Evidence-Supported Clinical Modalities**

National and international studies consistently demonstrate benefit across multiple neurorestorative modalities. Delays caused by “more research is needed” language have prolonged suffering and preventable suicides.

#### **Actions**

Implement well-studied, safe, and effective treatments across federal and community systems, including:

- Hyperbaric Oxygen Therapy (HBOT)
- Neuromodulation (rTMS, tDCS, neurofeedback, vagal nerve stimulation)
- Photo biomodulation
- Neuroendocrine and metabolic restoration
- Stellate Ganglion Block (SGB)
- Integrated cognitive and functional rehabilitation
- Psychedelic-assisted therapies where legally authorized

Additional requirements:

- VA and DoD must adopt research-informed pathways without deferring implementation until decades of Randomized Controlled Trial consensus.
- Apply proven international care models used in Israel, Canada, Australia, and the UK.

## **Impact**

Improves cognition, emotional regulation, sleep, autonomic stability, and functional capacity—core drivers of suicide risk.

### **4.5 Reduce Overreliance on Psychotropic Medication**

Medication is often prescribed as a first-line response despite symptoms originating from untreated brain injury.

#### **Actions**

- Revise national guidelines to prioritize mechanism-based care over long-term symptom suppression.
- Increase transparency in guideline development.
- Require evaluation of endocrine imbalance, neuroinflammation, metabolic disruption, and autonomic dysregulation before initiating psychiatric medication.

## **Impact**

Promotes functional recovery and reduces long-term dependence on medications that may worsen suicidality.

### **4.6 Modernize Insurance Coverage and Access**

Streamlined access to comprehensive brain-health evaluations and treatment.

#### **Actions**

- Mandate coverage for neuroendocrine testing, neuromodulation, HBOT, SGB, metabolic therapy, cognitive rehabilitation, and authorized psychedelic-assisted therapies.
- Create reimbursement codes for chronic-TBI case management and whole-brain health evaluations.
- Establish expedited approval pathways with documented blast exposure or multiple TBIs.

## **Impact**

Removes financial and administrative barriers that currently prevent access to life-saving care.

### **4.7 Neurorestorative Treatment Framework (Integrated Care Model)**

Neurorestoration targets the biological injury underlying cognitive, emotional, and behavioral dysfunction. This coordinated care model includes:

## **Core Components**

- Neuroendocrine assessment and restoration (addressing hormonal deficiencies and neurosteroid disruption).
- Neuromodulation to stabilize disrupted neural circuits.
- HBOT to reduce inflammation and support neural recovery.
- SGB for autonomic reset and rapid anxiety reduction.
- Metabolic and anti-inflammatory interventions to optimize brain function.
- Cognitive, vestibular, vision, and functional rehabilitation targeting injury-related deficits.
- Integrated behavioral therapies delivered after physiological stabilization to improve treatment response.

## **Impact**

Addresses underlying injury, improve executive function and emotional regulation, impulsivity and suicidality, and support long-term neurological recovery.

### **4.8 Psychedelic-Assisted Therapy**

When integrated within brain-injury care, psychedelic-assisted therapies may accelerate trauma processing, neuroplasticity, and stabilization.

## **Actions**

- Support clinically supervised use of ketamine, MDMA-assisted therapy, psilocybin, Ayahuasca and—where authorized—ibogaine for complex trauma, suicidality, and substance dependence.
- Establish integration protocols within multidisciplinary care.
- Accelerate research and regulatory evaluation for Veteran-specific applications.

## **Impact**

Provides rapid symptom reduction, enhances cognitive flexibility, and supports durable improvements when paired with neurorestorative interventions.

### **4.9 Legislative and Regulatory Actions - Key Legislative Measures**

- National Brain Trauma Implementation Act
- Veterans Brain Health & Suicide Prevention Modernization Act
- National Clinician Training Mandate
- Insurance Modernization for Brain Trauma Act
- Treatment Guideline Transparency Requirements

## **Regulatory Directives**

- **VA/DoD:** Update clinical practice guidelines to include neuromodulation, neuroendocrine restoration, HBOT, SGB, and psychedelic-assisted therapy (where permitted).
- **CMS/HHS:** Issue National Coverage Determination (NCD) specifically for chronic TBI reimbursement across all Medicare services.
- **FDA/NIH:** Accelerate research and regulatory pathways for neurorestorative interventions.

### **Appropriations Priorities**

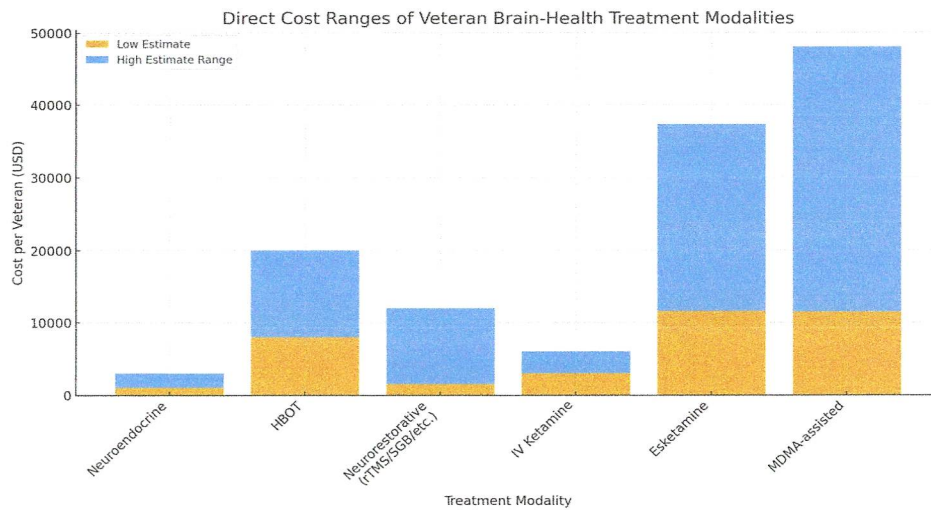
- National treatment pilots
- Data and outcomes systems
- Training infrastructure
- Expansion of neurorestorative clinical capacity

## **5. Results and Benefits**

A brain-trauma-centered national strategy will shift suicide prevention from a reactive crisis-response model to a proactive system of early identification, targeted treatment, and long-term recovery for the injured brain. Implementing these solutions will save lives, reduce human suffering, and finally align national policy with modern clinical science and the lived experiences of Veterans.

For skeptics who believe such reforms may be cost-prohibitive, the evidence says otherwise. While a comprehensive neurorestorative program may require approximately \$1–2 million in initial investment over several years for each 100-Veteran high-need cohort, these interventions consistently:

- Reduce hospitalizations and emergency-department utilization by 20–30%
- Enable a meaningful subset of Veterans to return to work or reduce disability reliance
- Lower long-term costs associated with polypharmacy, chronic mental-health care, and repetitive psychotherapy.
- Prevent suicides—an outcome whose economic impact is substantial, and whose human impact is immeasurable.



References (Cost Sources):  
 - VA/DoD Clinical Cost Estimates  
 - Published HBOT & rTMS pricing surveys  
 - Ketamine & Esketamine program cost analyses  
 - Economic models for MDMA-assisted therapy in peer-reviewed literature

**BLUF:** These costs are rapidly offset within the existing \$10 million-plus baseline economic burden per 100 high-need Veterans, while producing profound human, clinical, and ethical benefits. In short: the return on investment is immediate, sustained, and compelling.

The evidence points clearly to a single truth: **brain trauma is the hidden root of the suicide epidemic among Veterans and Service Members.** Blast exposure, concussive injury, toxic exposure, and chronic operational stress often leave behind invisible scars—neuroinflammatory changes, hormonal disruption, and impaired brain signaling that manifest as depression, anxiety, cognitive decline, and hopelessness.

Yet these biological injuries are rarely identified or treated. Instead, they are misclassified as psychiatric disorders, and Veterans are placed on psychotropic medications that often mask symptoms rather than correct the underlying dysfunction. To continue addressing these symptoms without treating their physical cause is to perpetuate the same tragic cycle that has already claimed too many lives.

A brain-first model changes that trajectory. By implementing objective laboratory testing—measuring neurosteroid hormones (such as pregnenolone, DHEA, progesterone, cortisol, and testosterone) alongside inflammatory and oxidative stress markers—we can uncover the biochemical fingerprints of brain injury that conventional psychiatry overlooks. These data transform the diagnostic process from assumption to precision, revealing which systems are failing and how they can be restored.

From these findings, clinicians can design individualized, biologically focused treatment protocols—integrating hormone rebalancing, anti-inflammatory and neuroprotective interventions, metabolic repair strategies, and evidence-based regenerative therapies. The

result is a personalized roadmap to recovery that restores stability, cognition, and emotional resilience—offering genuine hope where traditional approaches have fallen short.

This is not simply a clinical strategy; it is a moral and national imperative. America must shift from managing symptoms to healing the injured brain—from treating despair to restoring function, purpose, and life.

By embracing this paradigm—rooted in science, guided by compassion, and executed with accountability—we can finally honor our covenant with those who have served. A coordinated national effort to identify, diagnose, and treat brain trauma will not only reduce suicide but also rebuild trust, dignity, and hope within the Veteran community.

The time for incremental change has passed. Now is the moment for bold action, for leadership grounded in truth and courage. If we act decisively, we can restore lives, strengthen families, and fulfill the enduring promise our nation made to every man and woman who has ever worn its uniform.

A shift toward a brain-first model of prevention and treatment would produce benefits that reach far beyond individual recovery. We now have clinical tools and diagnostic capabilities to evaluate, diagnose, and treat brain injuries through strategies that decrease neuroinflammation and leverage light, energy, and oxygen to mitigate trauma-related damage. Integrating these modalities into existing individual and interdisciplinary models of care—alongside exercise, nutrition, and other evidence-based supports—would fundamentally reshape how our nation fulfills its commitment to those who have served. The result would be measurable, long-lasting improvements across health, social, and economic domains for veterans and their families.

By addressing suicide at its biological origin rather than its psychological surface, this new model offers not only hope but measurable, sustainable change. The dividends will be counted in lives saved, families healed and futures reclaimed.

## 6. Conclusions

If not now—when? The data are irrefutable. Despite decades of awareness campaigns, billions of dollars in funding, and the tireless efforts of countless professionals, suicide remains one of the leading causes of death for too many of our nation's defenders. Every number in these statistics represents a name, a family, and a promise unfulfilled.

The evidence points clearly to a single truth: **brain trauma is the hidden root of the suicide epidemic among Veterans and Service Members.** Blast exposure, concussive injury, toxic exposure, and chronic operational stress often leave behind invisible scars—neuroinflammatory changes, hormonal disruption, and impaired neural signaling that manifest as depression, anxiety, cognitive decline, impulsivity, and hopelessness.

Yet these biological injuries are rarely identified or treated. Instead, they are misclassified as psychiatric disorders, and Veterans are often placed on psychotropic medications that

may mask symptoms rather than correct the underlying dysfunction. Continuing to treat symptoms while ignoring their physical cause perpetuates the same tragic cycle that has already claimed far too many lives.

A **brain-first model** offers a fundamentally different trajectory. By implementing objective laboratory testing—measuring neurosteroid hormones (including pregnenolone, DHEA, progesterone, cortisol, and testosterone) alongside inflammatory, metabolic, and oxidative-stress markers—we can uncover the biochemical fingerprints of brain injury that conventional psychiatric models routinely overlook. These objective data transform diagnosis from assumption to precision, revealing which systems are impaired and how they can be restored.

With this information, clinicians can design individualized, biologically focused treatment protocols that integrate hormone rebalancing, anti-inflammatory and neuroprotective interventions, metabolic repair strategies, and evidence-based regenerative therapies. This approach creates a personalized roadmap to recovery—one that supports emotional stability, improves cognition, reduces neuroinflammation, and enhances long-term resilience. It offers genuine hope where traditional approaches have too often fallen short.

This is not simply a clinical strategy; **it is a moral, operational, and national imperative.** America must shift from managing symptoms to healing the injured brain—from treating despair to restoring function, purpose, and life.

By embracing this paradigm—rooted in science, guided by compassion, and executed with accountability—we can finally honor our covenant with those who have served. A coordinated national effort to identify, diagnose, and treat brain trauma will not only reduce suicide but also rebuild trust, dignity, and hope within the Veteran community.

The time for incremental change has passed. Now is the moment for bold action—for leadership grounded in truth, courage, and the unwavering belief that recovery is possible. If we act decisively, we can restore lives, strengthen families, and fulfill the promise our nation makes to every warrior who has borne the weight of service.

## 7. References

1. Department of Veterans Affairs. *2023 National Veteran Suicide Prevention Annual Report*. U.S. Department of Veterans Affairs; 2023. <https://www.mentalhealth.va.gov>
2. Defense Suicide Prevention Office (DSPO). *Annual Suicide Report, Calendar Year 2023*. U.S. Department of Defense; 2024. <https://www.dspo.mil>
3. O'Donnell C, et al. Operation Deep Dive: Analysis of Veteran Suicide and Self-Injury Mortality. *Am J Public Health*. 2022;112(9):1295–1304. <https://doi.org/10.2105/AJPH.2022.306896>
4. Bryan CJ, Clemans TA. Repetitive Traumatic Brain Injury, PTSD, and Suicide Risk Among Military Personnel. *J Head Trauma Rehabil*. 2013;28(4):257–264. <https://doi.org/10.1097/HTR.0b013e318299d5ae>

5. Brenner LA, et al. Traumatic Brain Injury and Suicide: A Systematic Review. *J Neurotrauma*. 2011;28(4):871–879. <https://doi.org/10.1089/neu.2010.1481>
6. Gordon ML, Dziemianowicz MS. Neuroendocrine Dysfunction Following Traumatic Brain Injury: The Hidden Epidemic. *Front Endocrinol*. 2021;12:655780. <https://doi.org/10.3389/fendo.2021.655780>
7. Bailes JE, Patel V. The Neurobiology of Repetitive Head Injury and Chronic Traumatic Encephalopathy. *Neurosurgery*. 2022;90(4):479–492. <https://doi.org/10.1227/neu.0000000000001965>
8. Randel A. Hyperbaric Oxygen Therapy for Post-Concussive Syndromes: A Systematic Review. *Front Neurol*. 2020;11:567345. <https://doi.org/10.3389/fneur.2020.567345>
9. Wilkinson ST, et al. Ketamine for Rapid Reduction of Suicidal Thoughts in Major Depression. *Am J Psychiatry*. 2017;175(4):327–335. <https://doi.org/10.1176/appi.ajp.2017.17060647>
10. National Academies of Sciences. *Evaluation of the Department of Defense’s Suicide Prevention Program*. National Academies Press; 2022. <https://doi.org/10.17226/26486>
11. Gordon M. Neuroinflammation: The Road to Neuropsychiatric Conditions. ResearchGate; 2024. <https://www.researchgate.net/profile/Mark-Gordon-6>
12. Hadanny A, Efrati S. The Efficacy and Safety of Hyperbaric Oxygen Therapy in Traumatic Brain Injury. *Expert Rev Neurother*. 2016;16(4):359–360. <https://doi.org/10.1586/14737175.2016.1157018>
13. Brain Injury Association of America. *CMS Officially Recognizes Brain Injury as a Chronic Condition*. July 31, 2024. <https://biausa.org/public-affairs/public-awareness/news/centers-for-medicare-and-medicaid-services-officially-recognizes-brain-injury-as-a-chronic-condition>
14. Hoch E, Martinez J, Bakhshi R, et al. *A Review of U.S. Military Traumatic Brain Injury Studies: Trends, Gaps, and Opportunities* (RR-A4199-1). RAND Corporation; 2025. [https://www.rand.org/pubs/research\\_reports/RRA4199-1.html](https://www.rand.org/pubs/research_reports/RRA4199-1.html)
15. Citizens Commission on Human Rights. *Diagnostic & Statistical Manual: Psychiatry’s Deadliest Scam* [Film]. <https://www.cchr.org/documentaries/diagnostic-and-statistical-manual>
16. Luttrell M. Lawmaker ‘Reborn’ Through Psychedelic Therapy Wants GOP to Embrace It. U.S. House of Representatives; May 19, 2025. <https://luttrell.house.gov/media/in-the-news/lawmaker-reborn-through-psychedelic-therapy-wants-gop-embrace-it>
17. Sher J (Director). *Quiet Explosions: Healing the Brain* [Film]. Quiet Explosions; 2020. <https://quietexplosions.com>
18. Lee AK, Bagley LJ, Hwang W-T. Advanced Imaging of Traumatic Brain Injury. *Neuroimaging Clin N Am*. 2020;30(1):1–23. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7192808>
19. Marr A, Marr A. *Tales from the Blast Factory: A Brain-Injured Special Forces Green Beret’s Journey Back from the Brink*. Morgan James Publishing; 2019. <https://www.amazon.com/Tales-Blast-Factory-Injured-Special/dp/1683504941>
20. Johnston-Brooks CH, Grassmeyer RP, Filley CM, Kelly JP. The Marcus Institute for Brain Health: An Integrated Practice Unit for the Care of Traumatic Brain Injury in

- Military Veterans. *Brain Inj.* 2021;35(14):1702–1710.  
<https://doi.org/10.1080/02699052.2021.2013535>
21. Cohen B, Shenk J. *War to Waves* [Documentary Film]. 2025. <https://wartowaves.com>
  22. Olson-Madden J, Green A, Anderson A, et al. Traumatic Brain Injury and Psychiatric Conditions as Predictors of Medical Service Use. *Psychiatr Serv.* 2012;63(7):716–723. <https://doi.org/10.1176/appi.ps.201100417>
  23. Taylor CA, Bell JM, Breiding MJ, Xu L. Traumatic Brain Injury–Related Emergency Department Visits, Hospitalizations, and Deaths—United States, 2007 & 2013. *MMWR Surveill Summ.* 2017;66(9):1–16.  
<https://www.cdc.gov/mmwr/volumes/66/ss/ss6609a1.htm>
  24. Tanielian T, Jaycox LH, Schell TL, et al. *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* RAND Corporation; 2008. <https://www.rand.org/pubs/monographs/MG720.html>
  25. Hendricks AM, Haider AH, Mann NC, et al. Economic Impact of Medical and Surgical Conditions Among Veterans. *Med Care.* 2016;54(4):302–309.  
<https://doi.org/10.1097/MLR.0000000000000496>
  26. Etier BE, Barlow P, Kitt M, et al. Cost-Effectiveness of Repetitive Transcranial Magnetic Stimulation for Treatment-Resistant Depression. *Neuropsychiatr Dis Treat.* 2020;16:73–85. <https://doi.org/10.2147/NDT.S222969>
  27. Ramage AE, Panizzon MS, Graham-Engeland JE, et al. Neuroendocrine Dysfunction Following Traumatic Brain Injury: Mechanisms, Clinical Consequences, and Treatment Options. *Endocr Rev.* 2020;41(3):300–356.  
<https://doi.org/10.1210/endrev/bnaa001>
  28. Brenner LA, Ignacio RV, Blow FC. Suicide and Traumatic Brain Injury Among Individuals Seeking Veterans Health Administration Services. *J Head Trauma Rehabil.* 2011;26(4):257–264. <https://doi.org/10.1097/HTR.0b013e31821fdbf1>
  29. GfK Government Affairs. *The Economic Burden of TBI in the United States.* National Head Injury Foundation; 2020. <https://www.brainline.org/article/economic-costs-traumatic-brain-injury>
  30. Centers for Disease Control and Prevention. *Surveillance Report of Traumatic Brain Injury–Related Hospitalizations and Deaths in the United States, 2016–2017.*  
<https://www.cdc.gov/traumaticbraininjury/data/index.html>
  31. Defense Health Board. *Traumatic Brain Injury: Evaluation and Recommendations.* Department of Defense; 2022. <https://www.health.mil/Reference-Center/Reports/2022/05/10/Traumatic-Brain-Injury-Evaluation-and-Recommendations>