

**STATEMENT OF
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BEFORE
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HEARING ON VETERANS' SUICIDES
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Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on suicide prevention and the Office of Inspector General (OIG) report, *Implementing the VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention*. My statement today is based on that report as well as individual cases that the OIG has reviewed and reported on involving veteran suicides and accompanying mental health issues. In the process of these inspections, clinicians in our office have had the opportunity to meet with and listen to the concerns of surviving family members, and to witness the devastating impact that veteran mental health issues and suicide have had on their lives.

The May 2007 OIG report reviewed initiatives from the Veterans Health Administration's (VHA) mental health strategic plan pertaining to suicide prevention and assessed the extent to which these initiatives had been implemented. In prior testimony, we have stressed the importance of the need for VA to continue moving forward toward full implementation of suicide prevention initiatives from the mental health strategic plan. In terms of other changes VA could make, we would offer the following observations:

Community Based Outreach – In our report, we noted that while several facilities had implemented innovative community based suicide prevention outreach programs, (e.g., facility presentations to New York City Police Department officers who are Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans, participation by mental health staff in local Spanish radio and television shows) the majority of facilities did not report community based linkages and outreach aimed at suicide prevention. In addition, less than 20 percent of facilities reported utilizing the Chaplain service for liaison and outreach to faith-based organizations in the community (e.g., inviting faith-based organizations in the area to a community meeting at a VA Medical Center (VAMC) to explain VHA services available, having a VA Chaplain accompany the OIF/OEF coordinator to post-deployment events in the community). Although facilities would need to tailor strategies to consider local demographics and resources, a system-wide effort at community based outreach appears prudent.

Timeliness from Referral to Mental Health Evaluation – In our report we noted that while most facilities self-reported that three-fourths or more of those patients with a moderate level of depression referred by primary care providers are seen within 2 weeks of referral, approximately 5 percent reported a significant 4-8 week wait. Because these patients are at risk for progression of symptom severity and possible development of suicidal ideation, Veterans Integrated Service Network leadership should work with facility directors to ensure that once referred, patients with a moderate level of depression and those recently discharged following hospitalization are seen in a timely manner at all VAMCs and Community Based Outpatient Clinics (CBOCs).

Co-Occurring Combat Stress Related Illness and Substance Use – Substance use may contribute to the severity of a concurrent or underlying mental health condition such as major depression. The presence of alcohol may cause or exacerbate impulsivity and acute alcohol use is associated with completed suicide. In a recent study published in the Journal of the American Medical Association (JAMA), *Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War*, Milliken et al., found that soldiers frequently reported alcohol concerns on the Post Deployment Health Assessment and Reassessments “yet very few were referred to alcohol treatment.”

Regardless of why a patient begins to abuse alcohol, with frequent and/or excessive use, physiologic and psychologic drives develop until alcohol misuse ultimately takes on a life of its own that is independent of patient history and circumstance. Functional ability and quality of life become dually impacted by both underlying anxiety and depressive symptoms and co-morbid substance use issues. For patients with concurrent conditions, an effective treatment paradigm may require addressing the primacy of not only anxiety/depressive conditions but also of co-morbid substance use disorders. VA should consider augmenting services that address substance use disorders co-morbid with combat stress related illness for inclusion in a comprehensive program aimed at suicide prevention.

Enhanced Access to Mental Health Care – Treatments for mental health problems may take time to show effect. For example, antidepressant medication, when indicated, may take several weeks to several months to effect symptom reduction or remission. For some patients, treatment may necessitate multiple visits that occur consistently over time and may entail multiple modalities including individual and/or group evidence based psychotherapy, medication management, and/or readjustment counseling. Therefore, efforts that enhance patient access to appropriate treatment may help facilitate both patient engagement and the potential for treatment benefit.

For example, ongoing enhancements in the availability of mental health services at CBOCs may help mitigate vocational and logistical challenges facing some

veterans residing in more rural areas who otherwise may have to travel longer distances to appointments at the parent VAMC.

In certain locations, the VA may want to consider expanding care during off-tour hours to increase the ability for some transitioning OIF/OEF veterans to access mental health treatment while minimizing interference with occupational, and/or educational obligations. This would be consistent with the recovery model for mental health treatment which emphasizes not only symptom reduction but also promotion and return to functional status.

Facilitating Early Family Involvement – Mental health symptoms can have a significant and disruptive impact on family and domestic relationships. Relational discord has been cited as one factor associated with suicide in active duty military and returning veterans. In addition, some studies indicate that family involvement in a patient's treatment may enhance the ability for some patients to maintain treatment adherence. VA should consider efforts to bolster early family participation in patient treatment.

Coordination between VHA and Non-VHA Providers – When patients receive mental health treatment from both VHA and non-VHA providers, seamless communication becomes an increasingly complex challenge. This fragmentation of care is particularly worrisome in periods of patient destabilization or following discharge from a hospital or residential mental health program. VA's Office of Mental Health Services should consider development of innovative methods or procedures to facilitate flow of information for patients receiving simultaneous treatment from VA and non-VA providers while adhering to relevant privacy statutes. In addition, VA's Readjustment Counseling Service and VA's Office of Patient Care Services should pursue further efforts to heighten communication and record sharing for patients receiving both counseling at Vet Centers and treatment at VAMCs and/or affiliated CBOCs.

Mr. Chairman, thank you again for this opportunity to testify. I would be pleased to answer any questions that you or other Members of the Committee may have.