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STATEMENT OF
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BEFORE THE
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HEARING ON MENTAL HEALTH ISSUES
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Mr. Chairman and members of the committee, good afternoon,

VA recognizes that suicide prevention requires a comprehensive plan that involves integrated strategies, coordinated efforts, and a steadfast commitment to implementation and evaluation. Based on CDC data and not controlling for VHA population specific epidemiologic factors, it is estimated that there are up to 1,000 suicides per year among veterans receiving care within VHA and as many as 5,000 per year among all living veterans. Various strategies have been put into place in order for the VA to understand the problems associated with veteran suicide, assess veterans under their care for suicide risk and provide treatment strategies aimed toward suicide prevention. In addition, the Mental Illness, Education, Research and Clinical Centers (MIRECC) are involved in several clinical research endeavors in the areas of various treatment strategies and neurophysiological approaches to the management of suicide and are working closely with the NIH-funded suicide prevention centers to understand and disseminate current research information.

The VISN 19 MIRECC in Denver has implemented a template tracking system which allows identification of suicide attempts within the network in order to provide follow-up care for these veterans as well as to identify system issues that could be resolved in order to improve the care that these veterans receive. To date we know that over 250 veterans in the Rocky Mountain Network have attempted suicide since October 1st of 2005. We have learned a great deal about this particular group of veterans. Thirty two of them died as a result of their attempt. A vast majority have been diagnosed with various mental illnesses (including PTSD and major depression disorder). Many have substance abuse problems and many have chronic pain issues. The VISN 3 MIRECC is installing and implementing an evidence-based risk assessment tool which is linked to the alerts and clinical reminders sections of our electronic medical record. While knowing the numbers and tracking statistics is critically important to our work we are also cognizant of the fact that we are dealing with individual lives and each life is invaluable. Implementing treatments that we know are useful with suicidal patients has become our mission across the country.

We have begun an education campaign aimed first at mental health and primary care providers. To date, over 750 VA clinicians have been provided with up-to-date information on suicide. This includes two regional evidence-based intervention conferences co-sponsored by VISNs 3, 4 and 19. One was held in Atlantic City in June 2006 and one in Denver this past February. At both of these conferences experts from across the country were brought in to share the latest developments in assessing suicide risk and providing care for those at risk for suicide in our population. National satellite programs have been offered and a web-based program is in development. VISN 19 has held individual face-to-face programs at over 30 medical centers at this point and several others are planned. VISNs 3 and 4 have also extensively trained their providers at regular conferences and programs.

We know that increased awareness of the possibility of suicide will lead to better identification of those who are at risk and improve our ability to implement appropriate suicide prevention treatments. We will continue our awareness campaign. In March of this year I was giving an education program in Battle Creek, Michigan. A psychologist who was "taking urgent care calls" that day was pulled from the program because a veteran was on the phone asking for an appointment. She came back to the program and stated that since suicide was forefront in her mind, she had asked the right questions and was able to determine that this patient was at extreme risk and had gotten him immediate help and he was being admitted. We need to keep suicide in the "forefront" of all of our provider's minds.

We are currently in the process of implementing demonstration projects that will allow us to gather effectiveness data while providing veterans with the most current treatments in suicide. These include training therapists in Cognitive Behavioral Therapy techniques and the Collaborative Assessment and Management of Suicidality (CAMS) program developed by Dr. David Jobes. Through the newly established Center of Excellence in Canandaigua we will be initiating intensive Suicide Prevention Programs in VISNs 2 and 7 with national implementation soon after.

We have also begun to use alternative treatment options with those veterans who require enhanced monitoring and management of their cyclic and persistent suicide ideation. This includes the use of our Health Buddy, a tele-health unit that we give to veterans that they use to track their health care concerns and get immediate education and advice. In Denver, we have 7 chronically suicidal patients currently using the depression module on the Health Buddy. Each of these chronically suicidal patients has had several serious suicide attempts. Since they have been working with the Health Buddy none of them have attempted. One patient told us that he followed the Health Buddy protocols late one night with a gun in his lap. By the time he got to the directions to call for help he had realized that help was really only a phone call away and the urge to kill himself had passed. He came into the facility the next day, was admitted, and is currently receiving on-going treatment and has been doing well with no attempts for over a year. Another patient said that he feels the Health Buddy is the missing piece of the puzzle; he needed to know that his depression and PTSD are manageable.

Each veteran's story is compelling and each treatment success a valuable lesson. It is by working with individuals, assessing their risk, and providing them with appropriate treatment that we will reduce the number of suicides among our nation's veterans. New concerns are constantly emerging. Our newer veterans are coming to us with risk factors such as PTSD and traumatic brain injuries that both carry with them a high suicide risk rate. We have developed a manual to help the providers who care for patients with traumatic brain injuries understand their patients risk for suicide.

We are in the process of placing Suicide Prevention Coordinators at each facility that will carry on these approaches in their own local communities. We are developing awareness programs to reach all of our staff and community partners who work with veterans. Mechanisms to share best practices and ideas will be put into place through the Center of Excellence. We have a large task in front us. Awareness, training, and access to appropriate mental health care continue to be the major components of our multi-faceted approach to reaching and helping these individuals while we continue our research programs to determine and refine our treatment strategies.

Thank you again, Mr. Chairman for inviting me today. At this time, I will answer any questions you or other members may have.