STATEMENT of

NAMI Montana

for the Record

U.S. Senate Committee on Veterans' Affairs

"Harnessing the Power of Community: Leveraging Veteran Networks to Tackle Suicide"

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June 19, 2019

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I. Introduction

Chairman Isakson, Ranking Member Tester and distinguished members of the Committee, on behalf of NAMI Montana, and NAMI, the National Alliance on Mental Illness, I would like to extend our gratitude for the opportunity to share with you our views and recommendations regarding ""Harnessing the Power of Community: Leveraging Veteran Networks to Tackle Suicide." NAMI Montana and the entire NAMI community applauds the Committee's dedication in addressing the critical issues around veterans' suicide. NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, support and research, and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

NAMI Montana is also a member of the Coalition to Heal Invisible Wounds (Coalition). The Coalition was founded in February 2017 to connect leading public and private scientific investigators of new PTSD and traumatic brain injury (TBI) treatments with policymakers working to improve care for veterans. Coalition members support innovators at all stages of the therapy development lifecycle, from initial research to late-stage clinical trials. The Coalition aims to spur strategic federal institution support to create better treatment and care for veterans suffering from PTSD and TBI.

I am the Director of the Center for Mental Health Research and Recovery (CMHRR) at Montana State University. While the CMHRR does have statewide suicide prevention research, none of that research funding presents a conflict with this testimony. I have also been appointed to the Creating Options for Veterans' Expedited Recovery (COVER) Commission. This testimony does not reflect the views of Montana State University, the Montana University System, or the COVER Commission.

II. Recommendations

A. The Veterans Administration should develop a telehealth resource to deliver Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment (SAFE VET) to emergency rooms throughout the country.

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In 2008, the Blue Ribbon Panel on Veteran Suicide recommended the development and implementation of an Emergency Department (ED)-based intervention for suicidal Veterans who are discharged from the ED VA leadership responded to this recommendation and developed a clinical demonstration project: Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment (SAFE VET) project.[1] This program was specifically designed to address the issue of the "dearth of empirically supported brief intervention strategies to address this problem in health care settings generally and particularly in emergency departments (EDs), where many suicidal patients present for care."[2]

In September of 2018, JAMA Psychiatry published the results of a large-scale cohort comparison study to determine whether the SAFE VET intervention was associated with reduced suicidal behavior and improved outpatient treatment engagement in the 6 months following discharge, an established high-risk period.[3] The study found that SAFE VET was associated with 45% fewer suicidal behaviors, approximately halving the odds of suicidal behavior over 6 months (odds ratio, 0.56; 95% CI, 0.33-0.95, P = .03). Additionally, veterans that received the SAFE VET intervention had more than double the odds of attending at least 1 outpatient mental health visit (odds ratio, 2.06; 95% CI, 1.57-2.71; P < .001).

A study published in the Archives of Suicide Research analyzed medical staff perceptions of the SAFE VET intervention.[4] Almost all staff perceived that SAFE VET was helpful in connecting veterans' follow-up services. A slight majority of staff believed SAFE VET increased the safety of participating veterans. The study found that medical staff members also benefited from the implementation of SAFE VET, because their comfort discharging Veterans at some suicide risk increased.[5]

The SAFE VET program is ready for a broader scale intervention. The logistics of providing the intervention in person to veterans in emergency rooms across the country are likely infeasible. However, the Suicide Safety Plan portion of SAFE VET could be delivered via

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[1] Knox, K., L., Stanley, B., Currier, G., Brenner, L., Holloway, M., & Brown, G.K. (2012). An emergency department based brief intervention for Veterans at risk for suicide (SAFE VET). American Journal of Public Health. 102 suppl(1): S33-7, 2012

[2] Stanley, Barbara, et al. "Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department." *JAMA psychiatry* 75.9 (2018): 894-900.

[3] *Id*.

[4] Chesin, Megan S., et al. "Staff views of an emergency department intervention using safety planning and structured follow-up with suicidal veterans." *Archives of suicide research*21.1 (2017): 127-137.

[5] *Id*.

telehealth networks to participating emergency rooms, with the follow-up conversations being administered telephonically.[6]

The VA has a strong expertise in delivering telehealth care. The agency is in an excellent position to be able to deliver this critical intervention across the country.

B. The Veterans Administration and the National Institute of Mental Health need more funding to develop research-proven suicide prevention initiatives.

In June of 2017, Psychiatric Services published "Suicide Risk Assessment and Prevention: A Systematic Review Focusing on Veterans."[7] This research was funded by the Quality Enhancement Research Initiative, Office of Research and Development, Veterans Health Administration (VHA), U.S. Department of Veterans Affairs.

The systematic review's authors sought to update evidence of the accuracy of methods to identify individuals at increased risk of suicide and the effectiveness and adverse effects of health care interventions relevant to U.S. veteran and military populations in reducing suicide and suicide attempts.[8] While the study did have some exclusions such as interventions involving medication, it can be seen as a broad view of the current state of the science for this critical issue.

The conclusions of the systematic review were bleak:

> *Risk assessment methods have been shown to be sensitive predictors of subsequent suicide and suicide attempts, but the frequency of false positives limits their clinical utility. Future research should continue to refine these methods and examine clinical applications. Studies of suicide prevention interventions provide inconclusive evidence to support their use, and additional RCTs of promising individual therapies and*

[6] In person discussion between Matt Kuntz of NAMI Montana and Dr. Barbara Stanley PhD, one of the SAFE VET program developers. Columbia University. April 18, 2019.

[7] Nelson, Heidi D., et al. "Suicide risk assessment and prevention: a systematic review focusing on veterans." *Psychiatric services* 68.10 (2017): 1003-1015.

[8] *Id*.

site-randomized population-level interventions are needed.[9]

The author's statement that further research is needed is mirrored by 2014 article in Psychiatry, "Suicide Among Soldiers: A Review of Psychosocial Risk and Protective Factors."[10] That research behind that article was funded by Department of the Army, the U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health (NIH/NIMH). That article's authors concluded that, "Moving forward, the prevention of suicide requires additional research aimed at: (a) better describing when, where, and among whom suicidal behavior occurs, (b) using exploratory studies to discover new risk and protective factors, (c) developing new methods of predicting suicidal behavior that synthesize information about modifiable risk and protective factors from multiple domains, and (d) understanding the mechanisms and pathways through which suicidal behavior develops."[11]

C. Expand the VA's existing Precision Mental Health program as described in the bipartisan *Commander John Scott Hannon Veterans Mental Health Care Improvement Act*.

According to the authors of "Suicide Among Soldiers: A Review of Psychosocial Risk and Protective Factors," "The fact that the vast majority of suicides occur among people with a current mental disorder makes this risk factor a prime target for screening and prevention efforts."[12]

However, the state of the science in the screening, diagnosis and treatment of mental health conditions is in flux. A strong analysis of this issue is given by Dr. Thomas Insel MD, et al. in the paper introducing the National Institute of Mental Health's Research Domain Criteria effort. At the time of this article was published, Dr. Insel was the Director of the National Institute of Mental Health.

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[9] Nelson, Heidi D., et al. "Suicide risk assessment and prevention: a systematic review focusing on veterans." *Psychiatric services* 68.10 (2017): 1003-1015.

[10] Nock, Matthew K., et al. "Suicide among soldiers: a review of psychosocial risk and protective factors." *Psychiatry: Interpersonal & Biological Processes* 76.2 (2013): 97-125.

[11] *Id*.

[12] *Id*.

Current versions of the DSM and ICD have facilitated reliable clinical diagnosis and research. However, problems have increasingly been documented over the past several years, both in clinical and research arenas. Diagnostic categories based on clinical consensus fail to align with findings emerging from clinical neuroscience and genetics. The boundaries of these categories have not been predictive of treatment response. And, perhaps most important, these categories, based upon presenting signs and symptoms, may not capture fundamental underlying mechanisms of dysfunction. One consequence has been to slow the development of new treatments targeted to underlying pathophysiological mechanisms.

History shows that predictable problems arise with early, descriptive diagnostic systems designed without an accurate understanding of pathophysiology. Throughout medicine, disorders once considered unitary based on clinical presentation have been shown to be heterogeneous by laboratory tests—e.g., destruction of islet cells versus insulin resistance in distinct forms of diabetes mellitus. From infectious diseases to subtypes of cancer, we routinely use biomarkers to direct distinct treatments. Conversely, history also shows that syndromes appearing clinically distinct may result from the same etiology, as in the diverse clinical presentations following syphilis or a range of streptococcus-related disorders.[13]

The critical nature of this issue to the VA's services is one of both issue severity (veteran suicide) and scope. According to the VA's Office of Research and

[13] Insel, Thomas, et al. "Research domain criteria (RDoC): toward a new classification framework for research on mental disorders." (2010): 748-751.

Development, “More than 1.8 million Veterans received specialized mental health care from VA in fiscal year 2015.”[14]

Therefore, the VA serves almost 2 million veterans a year in a treatment system based upon mental health diagnosis categorization that the former Director of the National Institute of Mental Health has deemed not to be “predictive of treatment response.”[15] (emphasis added)

The VA’s Precision Mental Health Program led by Dr. Amit Etkin MD, PhD of the Palo Alto VA is tackling some of the most critical questions about how to improve the diagnosis and treatment of psychiatric conditions. The program recently published the results of its groundbreaking study, “Using FMRI Connectivity to Define a Treatment-Resistant Form of Post-Traumatic Stress Disorder.”[16] That research “We found that a subgroup of patients with PTSD from two independent cohorts displayed both aberrant functional connectivity within the ventral attention network (VAN) as revealed by functional magnetic resonance imaging (fMRI) neuroimaging and impaired verbal memory on a word list learning task. This combined phenotype was not associated with differences in symptoms or comorbidities, but nonetheless could be used to predict a poor response to psychotherapy, the best-validated treatment for PTSD.”[17]

The VA’s Precision Mental Health program is making real headway in identifying the scientific tools to improve care for veterans’ brain health treatment. There is also room to add additional partners for the program. For example, the “Establishing Moderators and Biosignatures of Antidepressant Response for Clinical Care for Depression (EMBARC)” has made significant strides in their analysis of depression.[18] That effort and related efforts by Dr. Madhukar Trivedi’s team at the University of Texas

[14] Office of Research & Development website. Department of Veterans Affairs. Accessed on June 19, 2019. https://www.research.va.gov/topics/mental_health.cfm

[15] Insel, Thomas, et al. "Research domain criteria (RDoC): toward a new classification framework for research on mental disorders." (2010): 748-751.

[16] Etkin, Amit, et al. "Using fMRI connectivity to define a treatment-resistant form of post-traumatic stress disorder." *Science translational medicine* 11.486 (2019): eaal3236.

[17] *Id*.

[18] National Institute of Health, National Library of Medicine, Clinical Trials.gov website. Accessed on June 19, 2018. https://clinicaltrials.gov/ct2/show/NCT01407094

Southwestern have identified potential biosignatures involving inflammation[19], blood,[20] [21] and advanced imaging.[22]

E. The VA needs to continue to work on its suicide prevention messaging to ensure that it carries the overall point that suicide is not a rational brain response to adverse experiences

1. <u>There is significant danger of having suicide prevention models be lost in the weeds of this complex and evolving science</u>.

The circularities and similarities between mental illness symptoms and suicide risk factors make it incredibly difficult to determine after a suicide if someone would actually have the right number and type of symptoms that they would have been diagnosed with a mental illness. This makes it difficult to determine how to interpret unresolved question that arises from the statistic that "50% of veterans who completed suicide had received a mental health diagnosis before their death."[23]

What about other 50%? How many of them would have had the right symptom cluster to have been diagnosed with a mental illness? Would the numbers agree with what used to be a general acknowledgment that "over 90% of those who committed suicide had a psychiatric diagnosis at the time of death?"[24] Is it lower? Is it potentially even much lower? Is it possible to even come close to the right number and how relevant is the symptom cluster possible mental illness diagnoses question anyway.

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[19] Jha, Manish, and Madhukar Trivedi. "Personalized antidepressant selection and pathway to novel treatments: clinical utility of targeting inflammation." *International journal of molecular sciences* 19.1 (2018): 233.

[20] Czysz, Andrew H., et al. "Can targeted metabolomics predict depression recovery? Results from the CO-MED trial." *Translational psychiatry* 9.1 (2019): 11.

[21] Furman, Jennifer L., et al. "Adiponectin moderates antidepressant treatment outcome in the combining medications to enhance depression outcomes randomized clinical trial." *Personalized medicine in psychiatry* 9 (2018): 1-7.

[22] Cooper, Crystal M., et al. "Cerebral blood perfusion predicts response to sertraline versus placebo for major depressive disorder in the EMBARC trial." *EClinicalMedicine* (2019).

[23] Dr. Keita Franklin PhD presentation to COVER Committee on January 30, 2019.

[24] Bertolote, José Manoel, and Alexandra Fleischmann. "Suicide and psychiatric diagnosis: a worldwide perspective." *World Psychiatry* 1.3 (2002): 181.

Dr. Jerry Reed Ph.D. of the Suicide Prevention Resource Center spoke to the issue. "We certainly need to learn more about the relationship between mental illness and suicidal behaviors. I welcome any research and dialogue that will help clarify this association. But from a prevention standpoint, we should not let the "90 percent" figure limit our pursuit of solutions or prevention opportunities."[25]

NAMI Montana fully agrees with Dr. Reed and we believe that the VA and other partners are following his advice of not letting this debate limit the "pursuit of solutions or prevention opportunities." However, there is a need for an overall model to communicate to veterans, family members, and others how to prevent suicide and why certain strategies work.

In NAMI Montana's opinion, any effective suicide prevention model must be based on the irrationality of suicide while incorporating both susceptibility for suicidality and the impact of stressful situations.

2. <u>NAMI Montana recommends using that the VA use the Stress-Diathesis Model as a foundation in its suicide prevention messaging.</u>

As an organization immersed in suicide prevention policy, in a state that regularly has the country's highest suicide rate, NAMI Montana has considered a number of different tools for helping explain the complex realities of suicide, suicide prevention, and treatment for suicidal behavior. We ground our message in in the Stress Diathesis Model. As described in an article in *Lancet Psychiatry*, "The stress-diathesis model posits that suicide is the result of an interaction between state-dependent (environmental) stressors and a trait-like diathesis or susceptibility to suicidal behavior, independent of psychiatric disorders."[26]

The article "Suicide as a Public Health Burden" goes into more depth:

> *In this model, diathesis describes the development of risk, defined by conditions that create an enduring vulnerability to be suicidal. Stress refers to triggering environmental (and contextual) factors that promote acute risk and the breakdown of protective factors among those already vulnerable. The development of suicidal behavior is the result of an interaction between stressors and a susceptibility to suicidal behavior (diathesis). A typical stressor includes the acute worsening of a psychiatric condition, but often an acute psychosocial crisis seems to be the most proximate*

[25] http://www.sprc.org/news/90-percent

[26] Van Heeringen, Kees, and J. John Mann. "The neurobiology of suicide." *The Lancet Psychiatry* 1.1 (2014): 63-72.

stressor or "the straw that broke the camel's back" leading to suicidal behavior. Pessimism and aggression/impulsivity are components of the diathesis for suicidal behavior. Sex, religion, familial/genetic factors, childhood experiences, and various other factors influence the diathesis stress model. The model posits that suicide is the result of an interaction between state-dependent (environmental) stressors a trait-like diathesis or susceptibility to suicide behavior, independent of psychiatric disorder. Stressors, such as life events and psychiatric disorders, are important risk factors for suicide, but the diathesis concept explains why only a few of these individuals exposed to these stressors will take their own life. Early-life adversity and epigenetic mechanisms seem to be related to causal mechanism for diathesis.[27]

This model has held up for years for the variety of suicide factor data that has arisen in both military and veteran populations. It is easily grasped by a wide variety of populations, from families affected by suicide, clinicians, and policymakers. Other suicide factors can be added to the diathesis or stress categories. The model also has a strong basis in neurobiology which renders it less susceptible to changes in the process of diagnosis and treatment of psychiatric conditions.[28]

This model also explains other conditions that generally stem from malfunctions in neuron communications of the brain, such as depression, bipolar disorder, schizophrenia, substance abuse, etc. are substantial risk factors for suicide. These conditions can be activated without trauma experience and are critical to understanding why some veterans are in danger of committing suicide even if they have not been in combat.

D. Ensure that all veterans who in the VHA system have access to effective care for treatment-resistant depression.

The VA/DOD Major Depressive Disorder (MDD) Clinical Practice Guidelines (VA/DOD Guidelines) state that, "Military personnel are prone to depression, at least partially as a result of exposure to traumatic experiences, including witnessing combat and separation from family

[27] Wilcox, Holly C., et al. "Suicide as a Public Health Burden." *Public Mental Health* (2019): 207.

[28] Van Heeringen, Kees, and J. John Mann. "The neurobiology of suicide." *The Lancet Psychiatry* 1.1 (2014): 63-72.

during deployment or military trainings."[29] [30] The VA/DOD guidelines highlighted data from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) as an example.

Army STARRS described the 30-day prevalence of MDD as 4.8% compared to less than 1%—five times higher— among a civilian comparison group.[31] In fiscal year 2015, among Veterans served by the Veterans Health Administration (VHA), the documented prevalence of any depression (including depression not otherwise specified) was 19.8% while the documented prevalence of MDD only was 6.5%.[32]

The VA's ability to effectively serve veterans with depression is hampered by the current state of the science to diagnose and treat depression. As described by the Depression Task Force, "An estimated 50% of depressed patients are inadequately treated by available interventions. Even with an eventual recovery, many patients require a trial and error approach, as there are no reliable guidelines to match patients to optimal treatments and many patients develop treatment resistance over time. This situation derives from the heterogeneity of depression and the lack of biomarkers for stratification by distinct depression subtypes."[33] Other

[29] VA/DOD Major Depressive Disorder Clinical Practice Guidelines, Version 3.0-2016. Available at https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf. *Citing* Depression and the military. March 29, 2012; http://www.healthline.com/health/depression/military-service#1.

[30] *Id*. *Citing* Hoge CW, Auchterlonie JL, Milliken CS. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA. Mar 1 2006;295(9):1023-1032.

[31] *Id*. *Citing* Kessler RC, Heeringa SG, Stein MB, et al. Thirty-day prevalence of DSM-IV mental disorders among nondeployed soldiers in the US Army: Results from the Army study to assess risk and resilience in service members (Army STARRS). JAMA Psychiatry. 2014;71(5):504-513.

[32] *Id*. *Citing* Veterans Health Administration Mental Health Services. Preliminary findings regarding prevalence and incidence of major depressive Disorder (MDD), non-MDD depression diagnoses, and any depression diagnosis in FY2015 among Veterans. Veterans Health Administration Mental Health Services; 2015

[33] Akil, Huda, et al. "Treatment resistant depression: a multi-scale, systems biology approach." *Neuroscience & Biobehavioral Reviews* 84 (2018): 272-288.

estimates of the prevalence of treatment-resistant depression range from 30%[34] to 50%[35]. A recent study in the United Kingdom found treatment-resistant depression rates of 55%.[36]

The Depression Task Force saw hope in the future, "Recent advances in methodologies to study genetic and epigenetic mechanisms, as well as the functioning of precise brain microcircuits, prompt new optimism for our ability to parse the broad, heterogeneous syndrome of human depression into biologically-defined subtypes and to generate more effective and rapidly-acting treatments based on a knowledge of disease etiology and pathophysiology and circuit dynamics."[37]

However, the possibility of future scientific advancements does not relieve the current burden that the VA bears to provide adequate care options for veterans with treatment-resistant depression. The VA/DOD Major Depressive Disorder (MDD) Clinical Practice Guidelines have the following recommendations for veterans with treatment resistant depression.[38]

- "For patients with treatment resistant MDD who had at least two adequate pharmacotherapy trials, we recommend offering monoamine oxidase inhibitors (MAOIs) or tricyclic antidepressants (TCAs) along with patient education about safety and side effect profiles of these medications."[39]
- "We recommend offering electroconvulsive therapy (ECT) with or without psychotherapy in patients with severe MDD and any of the following conditions:"[40]
    - Catatonia

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[34] Rush AJ , Trivedi MH , Wisniewski SR , Nierenberg AA , Stewart JW , Warden D , et al.Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. Am J Psychiatry 2006;163:1905–17. 10.1176/appi.ajp.163.11.1905.

[35] Souery DA , Oswald P , Massat I , Bailer U , Bollen J , Demyttenaere K , et al. Clinical factors associated with treatment resistance in major depressive disorder: results from a European Multicenter study. J Clin Psychiatry 2007;68:1062–70. 10.4088/JCP.v68n0713.

[36] Wiles N, Thomas L, Abel A, et al. Clinical effectiveness and cost-effectiveness of cognitive behavioural therapy as an adjunct to pharmacotherapy for treatment-resistant depression in primary care: the CoBalT randomised controlled trial. Southampton (UK): NIHR Journals Library; 2014 May. (Health Technology Assessment, No. 18.31.) Chapter 8, The prevalence of treatment-resistant depression in primary care. Available from: https://www.ncbi.nlm.nih.gov/books/NBK261988/

[37] Akil, Huda, et al. "Treatment resistant depression: a multi-scale, systems biology approach." *Neuroscience & Biobehavioral Reviews* 84 (2018): 272-288.

[38] VA/DOD Major Depressive Disorder Clinical Practice Guidelines, Version 3.0-2016. Available at https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf

[39] *Id*. at 19.

[40] *Id*. at 20.

    - Psychotic depression
    - Severe suicidality
    - A history of a good response to ECT
    - Need for rapid, definitive treatment response on either medical or psychiatric grounds
    - Risks of other treatments outweigh the risks of ECT (i.e., co-occurring medical conditions make ECT the safest treatment alternative)
    - A history of a poor response to multiple antidepressants
    - Intolerable side effects to all classes of antidepressant medications (e.g., seizures, hyponatremia, severe anxiety)
    - Patient preference
    - Pregnancy
- "We suggest offering treatment with repetitive transcranial magnetic stimulation (rTMS) for treatment during a major depressive episode in patients with treatment-resistant MDD."[41]

NAMI Montana believes that the VA must make all of these treatment modalities available to veterans that need them. Treatment-resistant depression is such a major component of the veterans' patient population that there is no excuse for not making the service available either within the VA or through contracts with outside treatment providers. While the VA does appear to be offering these services as some of its flagship facilities, our perception is that the VA does not offer them consistently across its facilities - particularly in rural states like Montana.

III. Conclusion

Thank you again for the opportunity to testify in front of this honorable Committee. Your attention to this issue means a lot to me, our entire NAMI organization, veterans and their families. We look forward to working with you to save the lives of America's injured heroes.

Sincerely,

Matt Kuntz, J.D.
Executive Director
NAMI Montana

[41] VA/DOD Major Depressive Disorder Clinical Practice Guidelines, Version 3.0-2016. Available at https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf at 20.