

**STATEMENT OF
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BEFORE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ON
THE DEPARTMENT OF VETERANS AFFAIRS
IMPLEMENTATION OF SUICIDE PREVENTION INITIATIVES
FROM THE MENTAL HEALTH STRATEGIC PLAN
OCTOBER 3, 2007**

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on the issue of suicide and veterans in our Nation.

Epidemiology

Suicide is an unequivocally tragic and often incomprehensible event. Centers for Disease Control and Prevention (CDC) data indicate that in 2004 there were more than 30,000 known completed suicides in the United States and suicide ranked as the 11th leading cause of death with an overall rate of 11.1 suicides per 100,000 U.S. population. It is estimated that each suicide intimately affects at least six other people. Based on the more than 750,000 cumulative reported suicides from 1980-2004, at least 4.5 million Americans have survived the loss of a family member or friend who died by suicide.

Although older adults comprised 12.4 percent of the population in 2004, those 65 years and older represented 16 percent of suicides with a rate of 14.3 per 100,000 U.S. population. Older adult men account for more than 3 out of 4 suicides in this age range. While the ratio of suicide attempts to completion for all ages combined is approximately 25 to 1, the ratio of attempts to completions is roughly 4 to 1 for older adults. These age and sex based disparities have been a consistent trend over time.

Throughout the lifespan, an increased risk of suicide is associated with the presence of a diagnosable mental or substance abuse disorder. Severe and recurrent mood disorders, particularly unipolar and bipolar depression, are associated with the highest suicide risk. Between 1 and 5 percent of older adults living in the community are estimated to have major depression. This estimate increases among those older adults requiring home health care and in long-term care settings. Most depression in older adults is treated by primary care practitioners. Of note, some studies have found that 50 to 75 percent of older adults who die by suicide have had contact with a primary care provider within a month prior to death.

Of the approximately 25 million veterans in the United States, 9.5 million are ages 65 and over with a median age of 59 years old. Of the 5 million veterans who receive care within VA, 45 percent of veteran enrollees were ages 65 or over as of 2005. In addition,

over the past few years, approximately 3 out of 4 veterans seeking mental health treatment for the first time through VA are Vietnam era veterans, many in the 55-64 year old age group.

VA's Mental Health Strategic Plan (MHSP)

In 2003, a VA mental health work group was asked to review the President's New Freedom Commission on Mental Health's 2002 report, to determine the relevance to veteran mental health programs of the Commission's goals and recommendations, and to develop an action plan tailored to the special needs of the enrolled veteran population. A 5-year action plan with more than 200 initiatives was ultimately developed and finalized in November 2004. Among the action items were a number specifically aimed at the prevention of suicide. In addition, endorsement and implementation of the goals from the Surgeon General's 2001 *National Strategy for Suicide Prevention*, and recommendations from the Institute of Medicine's 2002 report *Reducing Suicide: A National Imperative*, were incorporated into the VA Mental Health Strategic Plan.

OIG Report: Implementing VA's MHSP Initiatives for Suicide Prevention

During the past year, the Office of Inspector General undertook an assessment of the extent to which the VA has implemented initiatives for suicide prevention from the MHSP. Individual MHSP initiatives for suicide prevention were categorized and consolidated into the following domains:

- Crisis Availability and Outreach.
- Screening and Referral.
- Tracking and Assessment of Veterans at Risk.
- Emerging Best Practice Interventions and Research.
- Development of an Electronic Suicide Prevention Database.
- Education.

Crisis Availability and Outreach

Although we found that most facilities reported availability of 24-hour mental health care either through the emergency room, a walk-in clinic, or a crisis hotline, this initiative had not achieved system-wide implementation. In addition, although facilities in multiple regions had or were referring to external 24-hour crisis hotlines, availability of a 24-hour crisis hotline was not yet universal throughout the system. On July 25, 2007, VA subsequently began operation of a 24-hour national suicide prevention hotline for veterans. The hotline has reportedly received greater than 800 calls per week. Callers include veterans who previously would have called a non-VA suicide hotline, veterans who would not have utilized a non-VA hotline, family members and friends of veterans, and other distressed non-veterans. Fifty-six of the veteran calls have resulted in 911 emergency rescues, and 165 resulted in admission to VA hospitals. Hotline personnel facilitate referral of distressed non-veterans to a non-VA suicide prevention hotline through a partnership with the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration.

Studies from the geriatric psychiatry literature indicate that many older adults prefer treatment for depression in a primary care setting but geriatric depression is often inadequately treated in primary care settings. One of the more extensive system-wide efforts that began implementation in the first quarter of fiscal year 2007 is the Primary Care-Mental Health Integration Program. Two models for primary care-mental health integration include co-located collaborative care in which a mental health provider and primary care physician are located in the same clinic area or close proximity at the same time, and a case management model in which a primary care physician refers patients to a mental health care manager, usually a registered nurse, who conducts ongoing phone follow-up with patients regarding medication response and adherence, reinforces patient coping skills, provides education to patients and ongoing decision support to the primary care physician. The program will be implemented in 70-80 facilities. A few VA medical centers already have co-located clinics that had been locally developed and initiated over the past few years. These efforts may help to reduce the stigma associated with mental health issues. It is hoped that when the primary care-mental health integration program is implemented at multiple sites in multiple regions, access and continuity of mental health treatment will increase for all veterans, and especially for older adults.

Although many facilities have implemented innovative community based outreach/suicide prevention programs, the majority of facilities did not report community based linkages, for example, to senior centers. As local community demographics, needs, and resources differ, local strategies may be more appropriate than universal, centrally driven strategies. Similarly, less than 20 percent of facilities reported utilizing the Chaplain Service for liaison and outreach to faith based organizations in the community. For older adult veterans, this also may represent an under utilized avenue for facilitating mental health outreach.

Screening and Referral

Although the United States Preventive Services Task Force does not recommend screening of all primary care patients for suicidal ideation, screening for depression by primary care providers is recommended in practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up. VA has implemented system wide screening by primary care providers for depression and post-traumatic stress disorder (PTSD).

Approximately 40 percent of facilities reported local strategies by primary care providers to address positive depression screens with additional hierarchical inquiries. Most facilities reported development of local strategies to facilitate referral of veterans with risk factors to mental health care. While approximately 95 percent of facilities self-reported that patients with a moderate level of depression referred to mental health by primary care providers are seen within 4 weeks of referral, a small percentage (approximately 5 percent) reported a significant 4-8 week wait.

Tracking and Assessment of Veterans at Risk

A thorough evidence based risk assessment tool, electronically linked to the Computerized Patient Record System (CPRS), has been piloted for emergency room and mental health patients in the New York/New Jersey Veterans Healthcare Network. By its design, the tool targets identification of at-risk groups and periods of increased risk.

Prior suicide attempts are one of the better predictors of at-risk patients. An electronic registry of suicide attempts linked to CPRS progress notes has been piloted and tested in the VA Rocky Mountain Network and recently began pilot testing in the VA Healthcare Network Upstate New York.

Centrally, the VA Office of Mental Health Services is in the process of implementing suicide prevention coordinators at all VA medical centers. Plans are for the coordinators to maintain a case-load for case management of at-risk veterans. At present dedicated staff are reportedly in place at approximately 85 percent of facilities and “acting” suicide prevention coordinators are in place at the rest of the sites.

Emerging Best Practice Interventions and Strategies

We found that approximately 40 percent of individual facilities had locally initiated strategies to target special emphasis groups at acute and chronic risk for suicide. Suicide specific therapeutic interventions that are evidence based and have appeared promising in non-VA research settings are presently beginning or undergoing pilot testing in the VA Rocky Mountain Network (e.g., a specialized form of Cognitive Behavioral Therapy tailored for use in suicidal patients).

Development of an Electronic Suicide Prevention Database

Ascertaining an accurate rate of suicide among veterans is an essential element of a nationwide VA suicide prevention program. Currently a VA national rate tracking system is under development and testing but has not been fully implemented. The Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) at Ann Arbor, Michigan, has been working on two projects to attempt to accurately determine suicide rates for veterans.

Data of those who sought health care within VA in the year 2000 was matched with the same data for subsequent years through 2003. A database of patients who did not access VA care in subsequent years was identified. This data was then matched to enhanced data from the CDC’s National Death Index to determine which patients no longer accessing VA care had died from suicide.

The National Violent Death Reporting System (NVDRS) is CDC’s effort to develop a nationwide, state-based monitoring system for violent deaths. In a second effort, researchers at SMITREC reported cleaning and analyzing NVDRS data from Virginia and Oregon in recent months to try to determine an overall suicide rate for all veterans in these states. These rates could then be compared to the rates determined for VA utilizers who live in these states. SMITREC researchers hope that once rates are

determined, predictive models can be used to examine specific demographic and treatment factors.

Education

In terms of MHSP initiatives related to education, we found that 50 to 60 percent of facilities provide programs to train first contact non-clinical personnel about crisis situations involving veterans at-risk for suicide. Only one-fifth of these programs included mandatory presentation of suicide response protocols. The VA New York/New Jersey Veterans Healthcare Network has implemented a training module for all staff and a script for clerical staff is under development. QPR™ gatekeeper training is being piloted in the VA Healthcare Network Upstate New York facilities, and VA Readjustment Counseling Services vet center staff have received regional training based on the QPR™ community gatekeeper training model.

Almost all facilities provide education to health providers on suicide risks, ways to address these risks and best practices for suicide prevention. However, at only a small percentage of facilities were these programs mandatory.

Recommendations

Salient to the care of aging veterans, we made the following recommendations:

- VA facilities should make arrangements for 24-hour crisis and mental health care availability either in person, via a facility-run crisis line, or by facility referral to an established, functioning non-VA crisis/suicide hotline staffed by trained mental health personnel.
- All non-clinical staff who interact with veterans should receive mandatory training about responding to crisis situations involving at-risk veterans; this should include suicide protocols for first contact personnel.
- All health care providers should receive mandatory education about suicide risks and ways to address these risks.
- VA should establish a centralized mechanism to select emerging best practices for screening, assessment, referral, and treatment and to facilitate system-wide implementation, in order to ensure a single VA standard of suicide prevention excellence.

Conclusion

Preventing suicide is a complex, multifaceted challenge to which there is not one best practice but several promising but not proven approaches and methods. Since 2004, progress has been made toward implementation of the MHSP initiatives for suicide prevention. The progress is ongoing, with greater integration and at an accelerated pace. However, more work remains to ensure a coordinated effort in achieving system-wide implementation. At present, MHSP initiatives for suicide prevention are partially

implemented. It is therefore incumbent upon VA to continue moving forward toward full deployment of suicide prevention strategies for our Nation's veterans.

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.