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Good morning Chairman Levin, Ranking Member McCain, and Members of the Committee. Thank you for inviting me here to discuss the Department of Veterans Affairs' (VA) efforts to respond to, treat, and minimize the impacts of traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and Veteran suicide. My testimony will describe VA's programs and initiatives in the areas of TBI and mental health, with a specific emphasis on our suicide prevention programs, and highlight the close cooperation VA maintains with the Department of Defense (DoD) and the Services.

Traumatic Brain Injury

Care, Management and Transition of Veterans and Servicemembers

"Polytrauma" is a new word in the medical lexicon that was termed by VA to describe the complex, multiple injuries to multiple body parts and organs occurring as a result of blast-related injuries seen from Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF). Polytrauma is defined as two or more injuries to physical regions or organ systems, one of which may be life threatening, resulting in physical, cognitive, psychological, or psychosocial impairments and functional disability. TBI frequently occurs in polytrauma in combination with other disabling conditions such as amputation, auditory and visual impairments, spinal cord injury (SCI), post-traumatic stress disorder (PTSD), and other medical problems. Due to the severity and complexity of their injuries, Servicemembers and Veterans with polytrauma require an extraordinary level of coordination and integration of clinical and other support services.

VA has developed and implemented numerous programs to ensure it provides world-class rehabilitation services for Veterans and active duty Servicemembers with TBI. VA

has enhanced its integrated nationwide Polytrauma/TBI System of Care. The VA Polytrauma/TBI System of Care consists of four levels of facilities, including 4 Polytrauma Rehabilitation Centers, 22 Polytrauma Network Sites, 82 Polytrauma Support Clinic Teams, and 48 Polytrauma Points of Contact. The System offers comprehensive clinical rehabilitative services including: treatment by interdisciplinary teams of rehabilitation specialists; specialty care management; patient and family education and training; psychosocial support; and advanced rehabilitation and prosthetic technologies. In 2005, VA expanded the scope of services at existing VA TBI Centers, and accordingly renamed them Polytrauma/TBI Rehabilitation Centers, to establish an integrated, tiered system of specialized, interdisciplinary care for polytrauma injuries and TBI.

PRCs provide the most intensive specialized care and comprehensive rehabilitation care for Veterans and Servicemembers with complex and severe polytrauma. PRCs maintain a full staff of dedicated rehabilitation professionals and consultants from other specialties to support these patients. Each PRC is accredited by the Commission on Accreditation of Rehabilitation Facilities, and each serves as a resource to develop educational programs and best practice models for other facilities across the system. The four regional Centers are located in Richmond, VA; Tampa, FL; Minneapolis, MN; and Palo Alto, CA. A fifth Center is currently under construction in San Antonio, TX, and is expected to open in 2011.

Since 2007, VA has placed Polytrauma Nurse Liaisons at Walter Reed Army Medical Center and National Naval Medical Center (at Bethesda, MD) to support coordination of care, patient transfers, and shared patients between DoD and VA PRCs. Whenever an injured Veteran or Servicemember requires specialized rehabilitative services and enters VA health care, the Polytrauma Nurse Liaison maintains close communication with the admissions nurse case manager at the VA PRC, providing current and updated medical records. Before transfer, the Center's interdisciplinary team meets with the DoD treatment team and family by teleconference as another way to ensure a smooth transition.

VA Accomplishments

A total of 1,792 inpatients with severe injuries have been treated at the Polytrauma Rehabilitation Centers from March 2003 through March 2010; 907 of these patients have been active duty Servicemembers, of which 754 were injured in OEF or OIF. VA continues following these patients after their discharge from a VA PRC to assess their long-term outcomes. Data available for 876 former PRC patients indicate:

- 781 (89 percent) are living in a private residence;
- 642 (73 percent) live alone or independently;
- 413 (47 percent) report they are retired due to age, disability or other reasons;
- 206 (24 percent) are employed;
- 90 (10 percent) are in school part-time or full-time; and
- 59 (7 percent) are looking for a job or performing volunteer work.

Throughout the Polytrauma/TBI System of Care, we have established a comprehensive process for coordinating support efforts and providing information for each patient and family member. Specialized rehabilitation initiatives at the PRCs include:

- In 2007, VA developed and implemented Transitional Rehabilitation Programs at each PRC. These 10-bed residential units provide rehabilitation in a home-like environment to facilitate community reintegration for Veterans and their families, focus on developing standardized program measures, and investigate opportunities to collaborate with other entities providing community-based reintegration services. Through December 2009, 188 Veterans and Servicemembers have participated in this program spending, on average, about 3 months in transitional rehabilitation. Almost 90 percent of these individuals return to active duty, or transition to independent living.
- Beginning in 2007, VA implemented a specialized Emerging Consciousness care path at the four PRCs to serve those Veterans with severe TBI who are slow to recover consciousness. Patients with disorders of consciousness (e.g., comatose) require high complexity and intensity of medical services and resources in order to improve their level of responsiveness and decrease medical

complications. To meet the challenges of caring for these individuals, VA collaboratively developed this care path with subject matter experts from Defense and Veterans Brain Injury Center (DVBIC) and the private sector. VA and DVBIC continue to collaborate on research in this area, and incorporate improvements to the care path in response to advances in science. From January 2007 through December 2009, 87 Veterans and Servicemembers have been admitted in VA Emerging Consciousness care. Approximately 70 percent of these patients emerge to consciousness before leaving inpatient rehabilitation.

- In October 2008, all inpatients with TBI at VA PRCs began receiving special ocular health and visual function examinations based upon research conducted at our Palo Alto PRC. To date, 840 inpatients have received these examinations.
- In April 2009, VA began an advanced technology initiative to establish assistive technology laboratories at the four PRCs. These facilities will serve as a resource for VA health care, and provide the most advanced technologies to Veterans and Servicemembers with ongoing needs related to cognitive impairment, sensory impairment, computer access, communication deficits, wheeled mobility, self-care, and home telehealth.
- The PRCs have been renovated to optimize healing in an environment respectful of military service. Military liaisons located at the centers help to support active duty patients and to coordinate interdepartmental issues for patients and their families. Working with the Fisher House Foundation, we are also able to provide housing and other logistical support for family members staying with a Veteran or Servicemember during their recovery at one of our facilities.
- In fiscal year (FY) 2009, 22,324 unique outpatients had 83,794 total clinic visits across the Polytrauma Support Clinic Team sites; an increase of over 30 percent from FY 2008.

In addition to improvements in the Polytrauma/TBI System of Care, VA developed and implemented the TBI Screening and Evaluation Program for all OEF/OIF Veterans who receive care within VA. From April 2007 through March 2010:

- 408,474 OEF/OIF Veterans have been screened for possible TBI;

- 56,161 who screened positive have been evaluated and received follow-up care and services appropriate for their diagnosis and their symptoms;
- 30,368 have been confirmed with a diagnosis of having incurred a mild TBI;
- Over 90 percent of all Veterans who are screened are determined not to have TBI, but all who screen positive and complete a comprehensive evaluation are referred for appropriate treatment.

VA continues to increase collaborations with private sector facilities to successfully meet the individualized needs of Veterans and complement care in cases when VA cannot readily provide the needed services, or cases where the required care is geographically inaccessible. VA medical facilities have identified private sector resources within their catchment area that have expertise in neurobehavioral rehabilitation and recovery programs for TBI. In FY 2009, 3,708 enrolled Veterans with TBI received inpatient and outpatient hospital care and medical services from public and private entities, with a total disbursement of over \$21 million.

VA and DoD Cooperation on Outreach, Transition and Complementary Care

VA and DoD have shared a longstanding integrated collaboration in the area of TBI through the DVBIC. Since 1992, DVBIC staff members have been integrated with VA Lead TBI Centers (now Polytrauma Rehabilitation Centers) to collect and coordinate surveillance of long-term treatment outcomes for patients with TBI. Other significant initiatives that have resulted from the ongoing collaboration between VA and DVBIC include: developing collaborative clinical research protocols; developing and implementing best clinical practices for TBI; developing materials for families and caregivers of Veterans with TBI; developing integrated education and training curriculum on TBI, and joint training of VA and DoD health care providers; and coordinating the development of the best strategies and policies regarding TBI for implementation by VA and DoD.

In addition to the longstanding affiliation with DVBIC, since 2007, VA has collaborated with DoD to develop implementation plans for Defense Centers of Excellence (DCoE)

and the associated injury registries, including Centers for Psychological Health and Traumatic Brain Injury, Extremity Injuries and Amputation, Hearing Loss and Auditory System Injuries, and Vision. VA has assigned personnel at the Center for Psychological Health and TBI, and at the Vision Center. VA continues to be involved in working groups with DoD representatives to assist in developing concepts of operations and plans for the Hearing Loss and Auditory System Injuries Center and the Center for Extremity Injuries and Amputation.

VA, in collaboration with DVBIC, developed a uniform training curriculum for family members in providing care and assistance to Servicemembers and Veterans with TBI: "Traumatic Brain Injury: A Guide for Caregivers of Servicemembers and Veterans." In 2009, VA and DoD collaboratively developed clinical practice guidelines for mild TBI and deployed this to health care providers, as well as recommendations in the areas of cognitive rehabilitation, drivers' training, and managing the co-occurrence of TBI, post-traumatic stress disorder (PTSD), and pain.

In 2009, the VA-led collaboration with DoD and the National Center for Health Statistics produced revisions to the International Classification of Diseases, Clinical Modification (ICD-9-CM) diagnostic codes for TBI, resulting in significant improvements in the identification, classification, tracking, and reporting of TBI and its associated symptoms.

The Federal Recovery Coordination Program

The Federal Recovery Coordination Program (FRCP) serves an important function in ensuring that severely injured Veterans and Servicemembers receive access to the benefits and care they need to recover. Beginning in 2008, FRCP has helped coordinate and access Federal, state and local programs, benefits and services for severely wounded, ill and injured Servicemembers, Veterans, and their families through recovery, rehabilitation, and reintegration into the community. The Program is a joint program of DoD and VA, with VA serving as the administrative home.

The Program has grown since enrolling the first client in February 2008. Not every individual referred to the Program meets enrollment criteria or needs the full services of FRCP. Some individuals are enrolled for a period of time and then determine that they no longer need the Program's services. Currently, 538 clients are enrolled and another 26 individuals are being evaluated for enrollment; 478 have received assistance. Anyone can return for re-enrollment or additional assistance if the problems are not resolved or if new problems develop.

Recovering Servicemembers and Veterans are referred to FRCP from a variety of sources, including from the Servicemember's command, members of the interdisciplinary treatment team, case managers, families or clients already in the Program, Veterans Service Organizations and other non-governmental organizations. Generally, those individuals whose recovery is likely to require a complex array of specialists, transfers to multiple facilities, and long periods of rehabilitation are referred.

FRCP outreach efforts include brochures, a presence on VA's OEF/OIF Web site, participation and presentations at local, state and national events. Our toll-free number (1-877-732-4456), new in April 2009, provides another avenue for referral or assistance. When a referral is made, a Federal Recovery Coordinator (FRC) conducts an evaluation that serves as the basis for problem identification and determination of the appropriate level of service.

FRCs coordinate benefits and services for their clients through the various transitions associated with recovery and return to civilian life. FRCs work with military liaisons, members of the Services' Wounded Warrior Programs, Service recovery care coordinators, TRICARE beneficiary counseling and assistance coordinators, VA vocational and rehabilitation counselors, military and VA facility case managers, VA Liaisons, VA specialty care managers, Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) OEF/OIF case managers, VBA benefits counselors, and others.

Each enrolled client receives a Federal Individual Recovery Plan (FIRP). The FIRP, based on the goals and needs of the Servicemember or Veteran and upon input from their family or caregiver, is designed to efficiently and effectively move clients through transitions by identifying the appropriate services and benefits. The FRCs, with input and assistance from interdisciplinary team members and case managers, implement the FIRP by working with existing governmental and non-governmental personnel and resources.

FRCP staffing has grown to meet the Program's needs. Eight FRCs were initially hired in January 2008. We are adding 5 additional FRCs to the 20 current positions in order to meet the growth, and success, of the Program. Most of these new hires will be placed at VA PRCs adding additional support for severely wounded, ill and injured Servicemembers and Veterans. The table below shows the current locations, as well as the locations for the new FRCs.

Facility Name and Location	Total FRCs
Walter Reed Army Medical Center, DC	3
National Naval Medical Center, Bethesda, MD	3
Brooke Army Medical Center, San Antonio TX	4
Naval Medical Center, San Diego, CA	3
Camp Pendleton, CA	1
Eisenhower Army Medical Center, Augusta, GA	2
James A. Haley VAMC, Tampa, FL	1
Providence VAMC, Providence, RI	1
Michael E DeBakey VAMC, Houston, TX	1
USSOCOM Care Coalition, Tampa, FL	1
Richmond VAMC Polytrauma, VA	2 (new hire)
Palo Alto VAMC Polytrauma, CA	2 (new hire)
Navy Safe Harbor, DC	1 (new hire)
Total (FRC) FTE	25

Administrative staff includes an Executive Director, two Deputies (one for Benefits and one for Health), an Executive Assistant, an Administrative Officer and two Staff Assistants.

The FRCP is VA's lead for the National Resource Directory (NRD), an online partnership of the U.S. Departments of Defense, Labor and Veterans Affairs for wounded, ill or injured Servicemembers, Veterans, their families, caregivers, and supporting providers. The NRD is a comprehensive online tool available worldwide with over 11,000 Federal, state and local resources organized into nine easily searchable topic areas including: benefits and compensation, families and caregivers, employment, education and training, health care, housing, transportation and travel, and homeless assistance. The NRD has an average of 1,200 visitors a day where they access approximately 5,000 page views.

FRCP's success rests in its extraordinary and well-trained problem solving professional staff. We have learned a great deal over the past 2 years and have been able to respond quickly to developing needs or problems. We are looking forward to the results from a current Government Accountability Office program evaluation and those from our satisfaction survey. This input will guide the Program's future development and adaptation.

Mental Health Care and Suicide Prevention

VA has responded aggressively to address previously identified gaps in mental health care by expanding our mental health budgets significantly. In fiscal year (FY) 2010, VA's budget for mental health services reached \$4.8 billion, while the amount included in the President's budget for FY 2011 is \$5.2 billion. Both of these figures represent dramatic increases from the \$2.0 billion obligated in FY 2001. VA also has increased the number of mental health staff in its system by more than 6,000, since 2005 when VHA began implementing its Mental Health Strategic Plan. During the past 3 years, VA trained over 3,000 staff members to provide psychotherapies with the strongest evidence for successful outcomes for post-traumatic stress disorder (PTSD), depression, and other conditions. Furthermore, we require that all facilities make these therapies available to any eligible Veteran who may benefit. In FY 2010 and FY 2011, we will continue to expand inpatient, residential, and outpatient mental health programs and continue our emphasis on integrating mental health services with primary and

specialty care. We thank the Congress for its strong support over the past several years, as without its help, none of this would be possible.

VA is working closely with our colleagues at the Department of Defense (DoD) to improve the quality of care for Veterans and Servicemembers alike. Since October 2009, VA and DoD have held two major conferences related to the mental health needs of Veterans and Servicemembers.

VA offers mental health services to Veterans through medical facilities and Community-Based Outpatient Clinics (CBOC), and in addition, VA's Vet Centers offer another important component of mental health care focused on readjustment counseling. Vet Centers embrace a Veteran-centric program model that goes beyond formal procedures in making a personal and empathic connection that helps combat Veterans overcome stigma and other barriers to care. Approximately 80 percent of all Vet Center staff members are Veterans, and 60 percent are combat Veterans. In addition to 100 Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Veteran Outreach Specialists, more than one-third of all staff now serving in Vet Centers are OEF/OIF Veterans. Early access to readjustment counseling in a safe and confidential setting can help reduce the risk of suicide and promote recovery among Servicemembers returning from a combat theater. Through the end of December 31, 2009, Vet Centers have made contact with 424,398 (39 percent) of all separated OEF/OIF Veterans, and 317,309 were provided outreach services, primarily at demobilization sites, while 107,089 received substantive readjustment counseling in a VA Vet Center.

VA has been making significant enhancements to its mental health services since 2005, through the VA Comprehensive Mental Health Strategic Plan and special purpose funds available through the Mental Health Enhancement Initiative from FY 2005 to FY 2009. In 2007, VA approved the *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics* to define what mental health services should be available to all enrolled Veterans who need them, no matter where they receive care, and to sustain

the enhancements made in recent years.

VA's enhanced mental health activities include outreach to help those in need to access services, a comprehensive program of treatment and rehabilitation for those with mental health conditions, and programs established specifically to care for those at high risk of suicide. To reduce the stigma of seeking care and to improve access, VA has integrated mental health into primary care settings to provide much of the care that is needed for those with the most common mental health conditions. In parallel with the implementation of these programs, VA has been modifying its specialty mental health care services to emphasize psychosocial as well as pharmacological treatments and to focus on principles of rehabilitation and recovery. VA is ensuring that treatment of mental health conditions includes attention to the benefits as well as the risks of the full range of effective interventions. Making these treatments available responds to the principle that when there is evidence for the effectiveness of a number of different treatment strategies, the choice of treatment should be based on the Veteran's values and preferences, as well as the clinical judgment of the provider.

Screening, Treatment and Access

Crucial to initiating such care, VA requires that all new patients to primary care be screened for post-traumatic stress disorder (PTSD), depression, and problem drinking. If the PTSD or depression screen is positive, an evaluation for suicidality also is required. VA repeats this screening at consistent intervals, since problems can arise at any time, not just on initial access to VA care. Any positive screen leads to further evaluation in the primary care setting, followed by initiation of mental health services, if needed, in the primary care setting or through referral to mental health specialty care.

For patients identified through these screens, or in any other way, VA has established access standards that require prompt evaluation of new patients (those who have not been seen in a mental health clinic in the last 24 months) with mental health concerns. New patients are contacted within 24 hours of the referral by a clinician competent to evaluate the urgency of the Veteran's mental health needs. If it is determined that the

Veteran has an urgent care need, appropriate arrangements (e.g., an immediate admission) are required. If the need is not urgent, the patient must be seen for a full mental health diagnostic evaluation and development and initiation of an appropriate treatment plan within 14 days. Across the system, VA is meeting this standard 95 percent of the time.

Screening usually occurs in the primary care setting where most Veterans initially seek care for mental health as well as physical health problems. VA has expanded integrated mental health services in primary care throughout the system. To ensure Veterans are monitored appropriately while they are receiving mental health services, including treatment with psychotherapeutic medications, VA requires that these integrated care programs include evidence-based care management and co-located, collaborative care by a mental health professional.

In addition, research has shown the value of having co-located, collaborative mental health staff that can complement the medication-focused care management programs with psychosocial interventions to address depression and other mental health problems. The mental health providers co-located in primary care also can engage with family members when appropriate to listen to their concerns, ensure they understand the care the Veteran is receiving, and describe how they can contribute to ongoing treatment for the Veteran.

One important set of requirements in the Handbook was to ensure that evidence-based psychotherapies are available for Veterans who could benefit from them and that meaningful choices between effective alternative treatments are available. VA implemented the broad use of evidence-based psychotherapies in response to evidence that for many patients, specific forms of psychotherapy are the most effective and evidence-based of all treatments. Specifically, the Institute of Medicine report on treatment for PTSD emphasized findings that exposure-based psychotherapies, including Prolonged Exposure Therapy and Cognitive Processing Therapy, were the best-established of all treatments for PTSD. Other specific psychotherapies included in

VA's programs include Cognitive Behavioral Therapy and Acceptance and Commitment Therapy for depression; Skills Training, Social Skills Training for Veterans with serious mental illness, such as schizophrenia; and Family Psycho-Education for schizophrenia. VA is adding other treatments such as Problem Solving for Depression, Cognitive Behavioral Therapy and Contingency Management for Substance Use Disorder, and behavioral strategies for managing both pain and insomnia.

For several years, VA has provided training to clinical mental health staff to ensure that there are therapists in each facility able to provide evidence-based psychotherapies for the treatment of depression and PTSD as alternatives to pharmacological treatment or as a course of combined treatment. More recently, VA has begun training Vet Center mental health professionals in Cognitive Processing Therapy (CPT). To date, 120 Vet Center staff members have participated in training courses to develop full competency in this treatment approach. Vet Center staff training will also be enhanced this year through national training in May commemorating the Vet Center program's thirtieth year in existence. VA is initiating a training academy for all Vet Center team leaders.

VA has expanded care for Veterans with Substance Use Disorders (SUD), for example, greatly expanding Intensive Outpatient Centers for Veterans with Substance Use Disorders. These Centers have the strongest evidence base for effective treatment; they provide a team of mental health professionals in a comprehensive program format that offers care at least 3 days each week for at least 3 hours each day. In addition, SUD care also has been integrated in PTSD Clinical Teams by including a SUD provider to work with these Teams at each VA facility.

A central concept for all services is a recovery orientation. For those with serious mental illness, the focus on recovery reflects major scientific advances in treatment and rehabilitation. Although it is still not possible to offer definitive cures for all patients with serious mental illness, it is realistic to offer the expectation of recovery. Veterans, often with their families, should collaborate with their providers in planning treatments based on the goals that will help the Veteran live the kind of life he or she chooses, in spite of

any residual signs or symptoms of mental illness. To achieve this vision, VA has hired a Local Psychosocial Recovery Coordinator at every facility and has hired staff members to provide peer support, trained clinicians in evidence-based strategies for treatment and rehabilitation, enhanced the care in residential treatment settings, developed Psychosocial Rehabilitation and Recovery Centers and strengthened programs that involve families.

Suicide Prevention

Preventing suicides is a top priority for VA. A suicide by a Servicemember or Veteran is a tragedy for the individual, his or her friends and family, and the Nation. Data indicate that while civilian suicide rates have remained fairly static over the past 30 years, there has been a deeply concerning increase in the suicide rate among members of the Armed Forces over the last 5 years. Eighteen deaths per day among the Veteran population are attributable to suicide. More than 60 percent of suicides among VA health care users are among patients with a known mental health diagnosis. We have initiated several programs that put VA in the forefront of suicide prevention for the Nation. Chief among these are:

- Establishment of a National Suicide Prevention Hotline, including a major advertising campaign to provide this phone number to all Veterans and their families;
- Placement of Suicide Prevention Coordinators at all VA medical centers;
- Significant expansion of mental health services; and
- Integration of primary care and mental health services to help alleviate the stigma of seeking mental health assistance.

In 2007, VA developed its signature program, the Suicide Prevention Hotline (1-800-273-TALK (8255)), in partnership with the existing Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Prevention Hotline. At the same time, VA provided specific funding and training for each facility to have a designated Suicide Prevention Coordinator; it also held the first Annual Suicide Awareness and Prevention Day. The same year, VA initiated

system-wide screening for suicide in primary care patients, instituted training for Operation S.A.V.E. (which trains non-clinicians to recognize the SIGNS of suicidal thinking, to ASK Veterans questions about suicidal thoughts, to VALIDATE the Veteran's experience, and to ENCOURAGE the Veteran to seek treatment), and required Suicide Prevention Coordinators to begin tracking and reporting suicidal behavior. In addition, VA added more suicide prevention coordinators and suicide prevention case managers in our larger medical centers and community-based outpatient clinics, doubling the number of dedicated suicide prevention staff in the field. By 2008, VA had re-established a monitor for mental health follow-up after patients were discharged from inpatient mental health units and held a fourth regional conference on evidence-based interventions for suicide. In 2009, VA launched the Veterans Chat Program to create an online presence for the Suicide Prevention Hotline. Veterans Chat and the Hotline are intended to reach out to all Veterans, whether they are enrolled in VA health care or not. VA also added a flag to patient records to notify physicians of patients at risk for suicide. This year, VA has already held a Suicide Prevention Coordinator conference and co-hosted a conference with the Department of Defense (DoD) to discuss ways VA and DoD can reduce the prevalence of suicide among Veterans and Servicemembers.

VA has adopted a broad strategy to reduce the incidence of suicide among Veterans. This strategy is focused on providing ready access to high quality mental health and other health care services to Veterans in need. This effort is complemented by helping individuals and families engage in care and addressing suicide prevention in high risk patients. VA cannot accomplish this mission alone; instead, it works in close collaboration with other local and federal partners and brings together the diverse resources within VA, including individual facilities, a Center of Excellence in Canandaigua, New York, a Mental Illness Research and Education Clinical Center in Veterans Integrated Service Network (VISN) 19, VA's Office of Research and Development, and clinicians.

This evidence clearly demonstrates that once a person has manifested suicidal behavior, he or she is more likely to try it again. As a result, VA has adopted a comprehensive treatment approach for high risk patients. This includes a flag in a patient's chart, necessary modifications to the patient's treatment plan, involvement of family and friends, close follow up for missed appointments, and a written safety plan included in the Veteran's medical record. This plan is shared with the Veteran and includes six steps: 1) a description of warning signs; 2) an explanation of internal coping strategies; 3) a list of social contacts who may distract the Veteran from the crisis; 4) a list of family members or friends; 5) a list of professionals and agencies to contact for help; and 6) a plan for making the physical environment safe for the Veteran.

During 2009, the VA Call Center for the Suicide Prevention Hotline (1-800-273-TALK) received approximately 10,000 calls per month, approximately 20 percent of all calls to the National Suicide Prevention Lifeline. Approximately a third of these calls are from non-Veterans. These calls led to 3,364 rescues of those determined to be at imminent risk for suicide and 12,403 referrals to VA Suicide Prevention Coordinators at local facilities. In 2009, the VA Call Center received calls from 1,429 active duty Servicemembers, a little more than one percent of all calls. To address the needs of the active duty population, VA worked with SAMHSA to modify the introductory message for Lifeline, developed memoranda of understanding with DoD, and established processes for facilitating rescues, including collaborations with the Armed Services in Iraq. Also during 2009, the Hotline services were supplemented with Veterans Chat, which has been receiving more than 20 contacts a day.

The online version of the Hotline, Veterans Chat, enables Veterans, family members and friends to chat anonymously with a trained VA counselor. If the counselor determines there is an emergent need, the counselor can take immediate steps to transfer the visitor to the Hotline, where further counseling and referral services can be provided and crisis intervention steps can be taken. Since July 2009, when Veterans Chat was established, VA has learned many valuable lessons. First, it is clear that conversations are powerful and capable of saving lives. As a result, opening more

avenues for communications by offering both an online and phone service is essential to further success. Second, training and constant monitoring is very important, and VA will continue pursuing both of these efforts aggressively.

The Lifeline and VA Call Center may be the most visible components of VA's suicide prevention programs, but the Suicide Prevention Coordinators are equally important. Both the VA Call Center and providers at their own facilities notify the Suicide Prevention Coordinators about Veterans at risk for suicide. The Coordinators then work to ensure the identified Veterans receive appropriate care, coordinate services designed specifically to respond to the needs of Veterans at high risk, provide education and training about suicide prevention to staff at their facilities, and conduct outreach and training in their communities. Other components of VA's programs include a panel to coordinate messaging to the public, as well as two Centers of Excellence charged with conducting research on suicide prevention: one, in Canandaigua, focused on public health strategies, and one in Denver, focused on clinical approaches. VA also has a Mental Health Center of Excellence in Little Rock, Arkansas, focused on health care services and systems research.

Data also support the conclusion that high quality mental health care can prevent suicide. The suicide rate for all Veterans who used VA health care declined significantly from FY 2001 to FY 2007. Fully understanding these data require some background on VA's efforts to track suicide rates for Veterans. First, it is important to consider who accesses VA health care. For this, it is useful to refer to findings on those Veterans returning from Afghanistan and Iraq who participated in the Post-Deployment Health Re-Assessment (PDHRA) program administered by DoD. Between February 2008 and September 2009, approximately 119,000 returning Veterans completed PDHRA assessments using the most recent version of DoD's form. Of the more than 101,000 who screened negative for PTSD, 43,681 came to VA for health care services (43 percent). Among 17,853 who screened positive for PTSD, 12,674 came to VA for health care services (71 percent). These findings demonstrate that Veterans screening positive for PTSD were substantially more likely to come to VA for care. Findings about

depression were similar. Both sets of findings support earlier evidence that those Veterans who come to VA are those who are more likely to need care and to be at higher risk for suicide. The increased risk factors for suicide among those who came to VA is often referred to as a case mix difference.

Working with the Centers for Disease Control and Prevention's National Violent Death Reporting System, VA recently calculated rates of suicide for all Veterans, including those using VA health care services and those who do not. This analysis included data from 16 states for individuals aged 18-29, 30-64, and 65 and older for the years 2005, 2006, and 2007 (during the period of VA's mental health enhancement process). The year 2005 marked the beginning of enhancement, while the year 2007 is the most recent one for which data are available.

Suicide rates for Veterans using VA health care services aged 30-64, and those 65 and above were higher than rates for non-users, and they remained higher from 2005 to 2007, probably a reflection of the case mix discussed above. However, findings for those aged 18-29 were quite different. In 2005, younger Veterans who came to VA for health care services were 16 percent more likely to die from suicide than those who did not. However, by 2006, those younger Veterans who came to VA were 27 percent less likely to die from suicide, and by 2007, they were 30 percent less likely. This difference appears to reflect a benefit of VA's enhancement of its mental health programs, specifically for those young Veterans who are most likely to have returned from deployment and to be new to the system.

Because the number of Veterans from the 16 states in this group is relatively low, the rates are, for statistical reasons, variable. Nevertheless, they demonstrate important effects. In 2005, 2006, and 2007, respectively, those who came to VA were 56, 73, and 67 percent less likely to die from suicide. Those who utilized VA services were, to some extent, protected from suicide with an effect that appeared to increase during the time of VA's mental health enhancements. More broadly, the rate of suicide among Veterans receiving health care from VA has declined steadily since FY 2001; specifically, the rate

declined more than 12 percent during this time. From a public health perspective, the decline in rates is significant, corresponding to about 250 fewer lives lost as a result of suicide.

Conclusion

In conclusion, thank you again for the opportunity to speak about VA's efforts to treat and reduce TBI, PTSD and suicide among Servicemembers and Veterans.