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HOUSE APPROPRIATIONS COMMITTEE  
SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS' AFFAIRS,  
AND RELATED AGENCIES**

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Mr. Chairman, Mr. Ranking Member, and Distinguished Members of the House Appropriations Committee, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies: thank you for the opportunity to appear today to discuss the Department of Veterans Affairs' (VA) response to the mental health needs of America's Veterans. I am accompanied today by my colleagues, Dr. Alfonso Batres, Chief Officer of VA's Readjustment Counseling Service; and Mr. Paul Kearns, Chief Financial Officer for the Veterans Health Administration (VHA).

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 5,000 over the last 3 years. During the past 2 years, VA trained over 2,500 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 subcommittee 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 service members alike. Since October 2009, VA and DoD have held two major conferences related to the mental health needs of Veterans and service members.

My testimony today will make three points. First, it will describe VA's approach to treating mental health conditions and our efforts to ensure that treatment options should be widely available and uniquely tailored to the individual needs of each Veteran. Second, it will detail VA's policy and guidance to the field, as specifically identified in the *Uniform Mental Health Services in VA Medical Centers and Clinics Handbook*. This

Handbook is being implemented across VA's health care system to expand access to mental health services for Veterans. Finally, my testimony will conclude by providing evidence VA has gathered that our programs are successful. In sum, our programs are saving lives and improving the quality of life for Veterans with mental illness.

### **VA's Approach to Mental Health Care**

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.

VA's 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 service members 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.

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.

VA has expanded services throughout the system. 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. 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.

Care management for depression includes repeated contacts with patients to educate them about depression, medications, and other treatment, as well as to provide evaluations of both therapeutic outcomes and adverse effects. The benefits of the frequent contact program relate to increased patient engagement in care. Also, information from patient monitoring is translated into decision-support for providers about when they should modify treatment. Two programs that are used frequently in VA primary care settings are Translating Initiatives in Depression into Effective Solutions (TIDES) and the Behavioral Health Laboratory (BHL), both of which are evidence-based interventions supported by extensive research. Studies on care management for depression in primary care settings have demonstrated that these interventions can decrease both depression and suicidal ideation in older adults.

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.

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. VA has begun training Vet Center mental health professionals in Cognitive Processing Therapy (CPT). 100 Vet Center staff members are participating in training courses leading to certification as CPT providers in VA. 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 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 and Skills Training 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.

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.

### Mental Health Settings

Mental health care for all of these programs, and others covered in the Uniform Mental Health Services Handbook, are supported by care offered in three kinds of settings. Outpatient care is the most typical environment, and is available in primary care settings or in mental health clinics found in every facility. Additional outpatient care is provided

in community-based outpatient clinics (CBOC) by mental health staff on site or through telemental health offered by mental health professionals at the facility that guides the CBOC's services. Inpatient care is provided when patients are a danger to themselves or others and need intensive care, usually in a secured inpatient program. Such programs are designed to meet the needs of Veterans with acute problems and have short lengths of stay designed to stabilize the Veteran and move him or her to a less restrictive level of care. Inpatient care is provided at 120 VA medical centers, and at least one program is available in every VISN. VA's Residential Rehabilitation Treatment Programs (RRTP), which include VA Domiciliaries, provide a place to live in a VA-staffed program that provides intensive rehabilitation services for lengthier stays than in acute inpatient care. Veterans in such programs have a comprehensive mental health treatment plan, and the mental health and SUD services that flow from it provided throughout the week. This includes evening and weekend services to promote recovery. RRTPs are not locked units, so they provide opportunities for Veterans also to maintain community linkages while participating in longer term care to address complex mental health issues. VA requires that such programs be available in every VISN. RRTPs also serve as a cornerstone in VA's plan to ultimately end homelessness among Veterans.

### Vet Centers

VA's Vet Centers are another environment in which Veterans can receive care. Vet Centers serve combat Veterans and their families by providing quality readjustment counseling for Veterans and their families. Vet Center staff welcome home combat Veterans with honor by providing readjustment counseling in a caring, non-clinical setting. Vet Center care consists of a continuum of social and psychological services including community outreach to special populations and referrals to services with community agencies. VA maintains a trained and qualified cadre of professional mental health professionals and other licensed counselors to provide professional readjustment counseling for combat-related PTSD and co-morbid conditions such as depression and substance use disorders. Over 60 percent of Vet Center direct readjustment counseling staff members are qualified mental health professionals (licensed psychologists, social workers and psychiatric nurses). When necessary for the treatment of more complex mental health conditions, Vet Centers refer Veterans to VA medical facilities for mental health services, and promote active partnerships with their VA mental health counterparts to better serve Veterans.

A core value of the Vet Centers is to promote access to care by helping Veterans and families overcome barriers that impede the receipt of needed services. To extend the geographical reach of Vet Center services, VA has implemented initiatives to ensure that new OEF/OIF combat Veterans can access its care. Following the onset of hostilities in Afghanistan and Iraq, VA hired 100 OEF/OIF Veteran Outreach Specialists to contact, proactively, their fellow returning Veterans at military demobilization sites, including National Guard and Reserve locations.

Family members are central to any combat Veteran's readjustment. VA has developed Staff Training and Experience Profiles (STEP) criteria for qualifying family counselors

working in Vet Centers. VA is currently implementing a plan to enhance its capacity to serve families by hiring the additional staff necessary to place a STEP-qualified family counselor in every Vet Center. Military family members of fallen active duty service members are also served through the Vet Center Bereavement Counseling program. Between August 2003 and February 2010, Vet Centers served the families of 1,939 fallen service members, 1,152 (60 percent) were in-theater casualties in Iraq or Afghanistan.

VA's Mobile Vet Center program is another major initiative for expanding outreach and counseling services to OEF/OIF combat Veterans and families. VA has deployed 50 Mobile Vet Centers to strategically selected Vet Centers across the country. VA placed these Mobile Vet Centers to cover a national network of designated Veterans Service Areas that collectively covers every county in the continental United States. The 50 Mobile Vet Centers are being utilized to provide early access to returning combat Veterans via outreach to active military demobilization sites, including National Guard and Reserve sites, and extending services to Veterans at Post-Deployment Health Reassessments (PDHRA). Through early March 2010, the 50 Mobile Vet Centers have attended 1,472 outreach events. The vehicles are also extending Vet Center outreach to more rural communities and are available to respond to emergency situations. For example, 4 Mobile Vet Centers were deployed in response to the shooting at Fort Hood in November 2009. Working in concert with other deployed VA staff, these Mobile Vet Centers provided assistance to over 6,600 Veterans, military service personnel, and family members.

VA is also increasing the number of Vet Centers. VA authorized an additional 23 Vet Centers in 2008 for a total of 232 Vet Centers and an additional 39 Vet Centers for 2009 for a total of 271 Vet Centers. A third expansion of 28 Vet Centers is underway for 2010. Collectively the three expansions will increase the number of Vet Centers from 209 in 2007 to 299 by the end of 2010. The Vet Centers on Puerto Rico and Guam, a new Vet Center planned for American Samoa, and the long established Vet Center outstations on American Indian reservations provide ethnic minority Veterans access to culturally sensitive services.

### **Suicide Prevention Efforts**

Preventing suicides is a top priority for VA. A suicide by a service member 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 service members.

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 service members, 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.

## **VA's Accomplishments**

As stewards of the public interest and bearing the responsibility for caring for America's Veterans, VA conducts ongoing analyses of its programs and continually asks itself how they can be improved. VA's mental health enhancements were designed to implement evidence-based practices. Evidence led VA to adopt specific requirements for follow-up care after hospital discharge, and to require depression care management. There also is evidence that VA's clinical programs are improving the lives and well-being of Veterans with mental health conditions. Several objective outcome measurements support this claim. To begin with, the number of homeless Veterans continues to decline. These data are gathered annually and show that those Veterans most in need are receiving the care and services necessary to re-establish their lives. Another outcome measure is that Veterans with serious mental illness, who use VA services, do not have the mortality gap that is present elsewhere. In this and other countries, individuals with serious mental illness have an average life expectancy approximately 20 years less than those without mental illness; however, in VA, the difference in life expectancy is within two years.

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.

### **Work Remaining for VA**

We are proud of our greatly expanded mental health services, including greater access to care and provision of care that is innovative, Veteran-centered, and driven by the strongest possible evidence base. We also are pleased with great progress in implementation of the *Uniform Mental Health Services Handbook*. At the same time, VA recognizes that there is further work to do to fully complete that implementation, and we are committed to continuing our efforts to ensure that full implementation is accomplished, guided by VA's Office of the Inspector General (OIG) findings and our careful internal monitoring of implementation. VA has been closely following its facilities' performance measures and monitors. We also have provided direct technical assistance in the early phases of the Handbook's implementation and have designed a program for ongoing technical assistance driven by repeated surveying of implementation efforts. VA welcomes the Committee's attention to the importance of monitoring and sustained efforts to ensure full implementation of VA's visionary *Uniform Mental Health Services Handbook*.

Furthermore, there is always more research to be done on the causes of and best treatments for mental health conditions. Mental illnesses are among the most prevalent conditions affecting Veterans of all generations, wars or conflicts. VA research continues its commitment to defining the most effective mental health treatments. VA investigators have generated many major findings related to behavioral and psychiatric disorders such as schizophrenia, depression, substance use (including alcohol, illicit drugs, and nicotine), suicide prevention, and PTSD. From conducting large clinical trials to supporting center-based research programs to improving care delivery, mental health research continues to be a major priority for the VA research program.

In one line of research, VA scientists are investigating factors related to improving adherence and compliance. This includes studies on anti-depressant adherence

among older Veterans, reducing the impact of drug side effects, and a patient-centered approach to improve screening for side effects of second-generation antipsychotics. Efforts to improve the quality of care for persons with severe mental illness have focused on the inclusion of family members as active participants in the patient's treatment. VA researchers are also evaluating how to best implement an integrated health care approach for Veterans with serious mental illness. Combined with a number of other behavioral and psychological intervention studies, VA has been at the forefront of mental health research that seeks to improve treatment options for clinicians and patients dealing with mental health care needs.

VA research is also striving to identify critical risk factors for major mental health disorders. One unique study is looking at Veterans who were deployed to Iraq as active duty Army, National Guard, or Reservists who had baseline physical and mental health assessments before deployment. Planned follow-up studies will determine the effect of the combat experience on mental health, emotions, reactions, and cognition – shortly after return from Iraq as well as over ensuing years. Research is also changing how care is provided to individuals with less access to treatment facilities or providers. VA investigators successfully adapted a collaborative/team care approach to treat depression in older Veterans using telemedicine to address rural health disparities. Subsequently, this study provided the support for implementing telemedicine-based collaborative care in hundreds of small rural CBOCs that do not have on-site mental health specialists.

Moreover, VA is working to better understand risk factors associated with suicide and the optimal means to prevent suicide. VA investigators focused on suicide prevention recently reported a correlation between chronic pain and suicide suggesting an important risk factor and highlighting a potentially at-risk group. Additional research is ongoing to evaluate the effectiveness of suicide hotline interventions, firearm safety, and how to care for Veterans receiving treatment for substance use disorder and depression who express suicidal thoughts.

### **Conclusion**

VA, as a system, is committed to improving the quality and availability of mental health care to Veterans. VA's mental health enhancements have included major initiatives – far too many to itemize completely, but including effective efforts to increase access to mental health care, increase the use of evidence-based psychotherapy for the treatment of PTSD and depression, enhance the safe use of psychotherapeutic medications, provide effective suicide prevention interventions, fully utilize psychosocial rehabilitation and recovery-oriented services, and ensure the appropriate level of trained staff are available to provide needed services. VA firmly believes that each eligible Veteran has earned an individual determination of the best treatment and routine follow up for his or her specific condition, and its clinical guidelines support this endeavor. Thank you again for the opportunity to appear, and my colleagues and I are available to address any questions from the Committee.