STATEMENT of

NAMI Montana

for the Record

U.S. Senate Committee on Veterans' Affairs

"#BeThere: What More Can Be Done to Prevent Veteran Suicide?"

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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 "#BeThere: What More Can Be Done to Prevent Veteran 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 life-cycle, 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. The Coalition seeks to work with VA and the Department of Defense (DoD) on immediate improvements to public-private partnerships for:

- Developing and validating PTSD and TBI biomarkers and diagnostics;
- Providing research access to PTSD and TBI datasets;
- Providing institution-wide support for PTSD clinical trials;
- Improving messaging of relevant policies and practice guidelines; and,
- Providing up-to-date education around clinical trial endpoints and drug therapy options.

The Coalition also seeks renewed investment in VA-funded PTSD research, and an expansion in the types of research supported. Through strategic collaboration between the public and private sectors, the Coalition believes that our nation can improve treatments for service members and veterans suffering from PTSD.

II. Suicide from the Montana Perspective

A. <u>Montana's Veteran Suicide Rate</u>

According to the U.S. Department of Veterans Affairs' recently released report, Montana has the highest veteran suicide rate in the country. This rate of 68.6 per 100,000 is significantly higher than both the National Veterans Suicide Rate of 38.4 per 100,000 and the Western Region Veteran Suicide Rate of 45.5 per 100,000.

Montana, Western Region[a], and National Veteran Suicide Deaths[bc], by Age Group, 2014

Age Group	Montana Veteran Suicides	Western Region Veteran Suicides	National Veteran Suicides	Montana Veteran Suicide Rate	Western Region Veteran Suicide Rate	National Veteran Suicide Rate
Total	58	1,970	7,388	68.6	45.5	38.4
18–34	<10	276	1,171	--	64.7	70.4
35–54	21	559	2,193	117.1	56.0	47.7
55–74	19	692	2,594	46.6*	35.9	30.4
75+	10–20	443	1,430	--	45.2	32.0

* Denotes that this rate was calculated with fewer than 20 in the numerator and the rate should be considered unreliable.

After accounting for differences in age, the Veteran suicide rate in Montana was significantly higher than the national Veteran suicide rate (p=0.0008)[d].

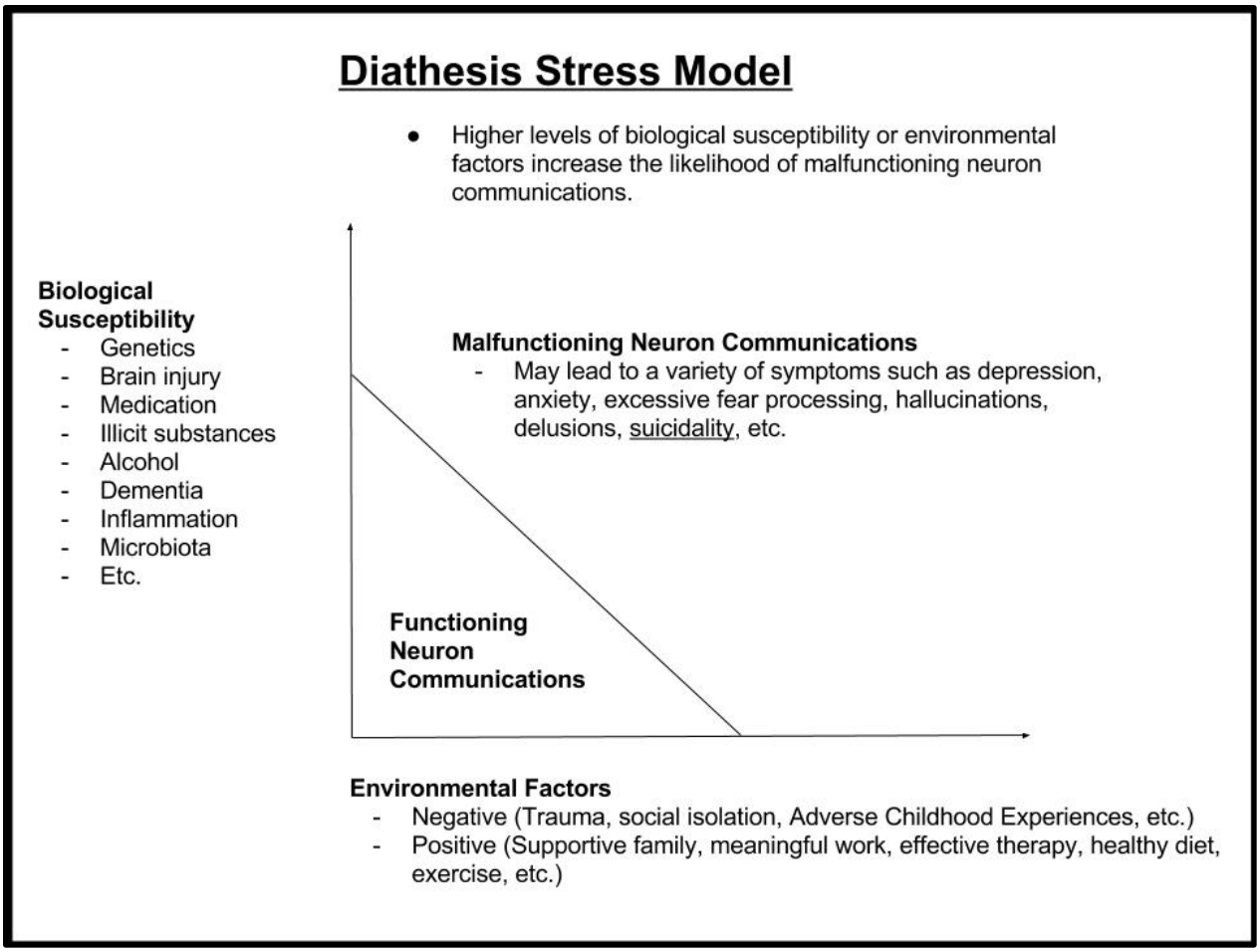
[1]

B. General Suicide Prevention Framework

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 prefer to use a version of the Diathesis Stress Model to explain how suicidal behavior arises via malfunctioning neuron communications that stem from a combination of biological susceptibility and environmental factors.[2] 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.

[1] Department of Veterans Affairs, "Veteran Suicide Data Sheets," https://www.mentalhealth.va.gov/docs/data-sheets/Suicide-Data-Sheets-VA-States.pdf.

[2] *See e.g.,* Gandubert, C., et al. "Biological and psychological predictors of posttraumatic stress disorder onset and chronicity. A one-year prospective study." *Neurobiology of stress* 3 (2016): 61-67; Goforth, Anisa N., Andy V. Pham, and John S. Carlson. "Diathesis-stress model." *Encyclopedia of Child Behavior and Development*. Springer US, 2011. 502-503.



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.

C. Treatment Challenge and Opportunities in Montana

Montana is the nation's fourth largest state with over 147,000 square miles, and just over one million people residing in Big Sky Country. We are honored to have one of the nation's highest per capita rates of military service in the country. Montana is home to more than 108,000 veterans, representing 16.2% of the total state adult population; the second highest population density of veterans in the United States.[3] Additionally, Montana is home to twelve tribal nations

[3] Taken from the State of Montana's recent grant application to HRSA

and seven reservations.[4] The reservations comprise nine percent of the state's land base. Montana is home to over 66,000 people of Native American heritage. The majority of Montana's native population live on reservations. Montana residents that qualify for Indian Health Services (IHS) are served by the Billings Area Indian Health Services, which delivers care to over 70,000 people in the states of Montana and Wyoming.[5]

The very rural nature of the state, with an average of fewer than six persons per square mile, creates unique challenges for our healthcare providers. It is very hard for rural Montana communities to recruit and retain healthcare workers. Our rural healthcare professionals have to walk a tightrope between finding enough patients to make a living and pay off their student loans, while not being overwhelmed by the workload. It is a difficult balance to strike due to variable patient rates and a shortage of relief for times of overflow.

These challenges are especially difficult for treating serious mental illness (SMI) because of the complex nature of these illnesses, the level of care required for mental health crises, and the ongoing treatment needs of persons living with these conditions. Our state is in desperate need of more mental health professionals, particularly in our more rural communities.

While the challenge of reducing Montana's veteran suicides can feel overwhelming due to the vast rural areas, it is important to point out that Montana's most recent *Suicide Mortality Review Report* illustrated that over half of Montana's veteran suicides, during the reporting period, occurred in Montana's six most populous counties.[6] [7] Lewis and Clark County is the least populous of those six counties in the state, and it hosts the Montana VA Healthcare System headquarters and hospital. The remaining five counties has either a Vet Center,[8] a VA Community-Based Outpatient Center (CBOC),[9] or both. These communities also have psychiatrists, psychiatric nurses, and therapists available through private nonprofit mental health centers and Federally Qualified Health Centers (FQHCs).

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[4] Indian Education for All, "Montana Indians: Their History and Location."(April 2009) http://opi.mt.gov/pdf/indianed/resources/MTIndiansHistoryLocation.pdf

[5] "Montana Department of Public Health and Human Services Report to the 2013 Legislature: The Montana Medicaid Program State Fiscal Years 2011 and 2012." http://www.dphhs.mt.gov/publications/2013medicaidreport.pdf

[6] 2016 Montana Suicide Mortality Review Report. Page 49. http://www.sprc.org/sites/default/files/resource-program/2016%20Montana%20Suicide%20Mortality%20Review%20Report.pdf

[7] "Montana Counties by Population," https://www.montana-demographics.com/counties_by_population

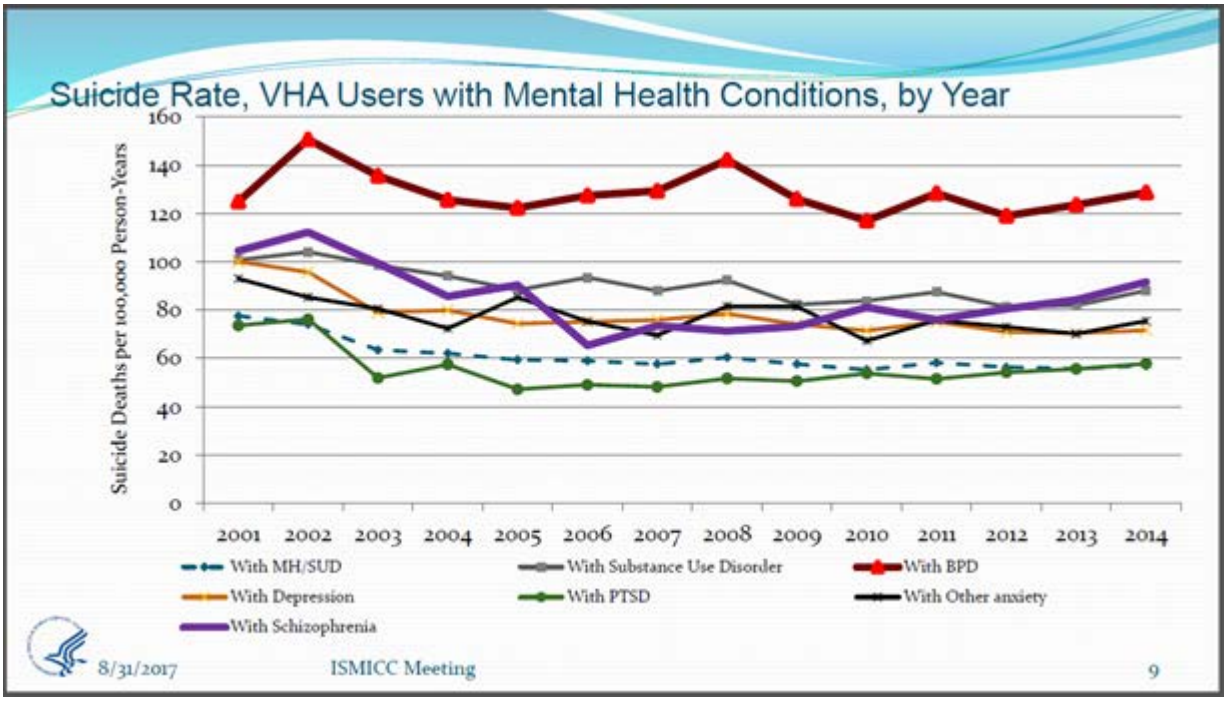
[8] "Montana VA Healthcare System," https://www.montana.va.gov/locations/other_facilities.asp

[9] "Montana VA Healthcare System," https://www.montana.va.gov/locations/Bozeman_VA_Community_Based_Outpatient_Clinic.asp

It is important to continue to extend effective care out into rural communities, but it is also clear that a lack of resources is not always the problem. There are many other areas that also need to be addressed.

III. Suicide Among U.S. Veterans

The Interdepartmental Serious Mental Illness Coordinating Council (ISMICC), created under the *21st Century Cures Act* of which NAMI is a non-federal member, received an initial presentation from John McCarthy, Ph.D., M.P.H. of VA Office of Mental Health and Suicide Prevention at the Council's first meeting. NAMI Montana and our national organization was particularly interested in the data presented regarding mental health conditions and suicidality among VHA users. As the Committee is well aware, only 6 of the 20 veterans (approximately 30%) who die each day by suicide receive any care from VHA. The data presented and shared below illustrates that bipolar disorder (BPD) is consistently the mental health condition affecting most veterans utilizing VHA who die by suicide.



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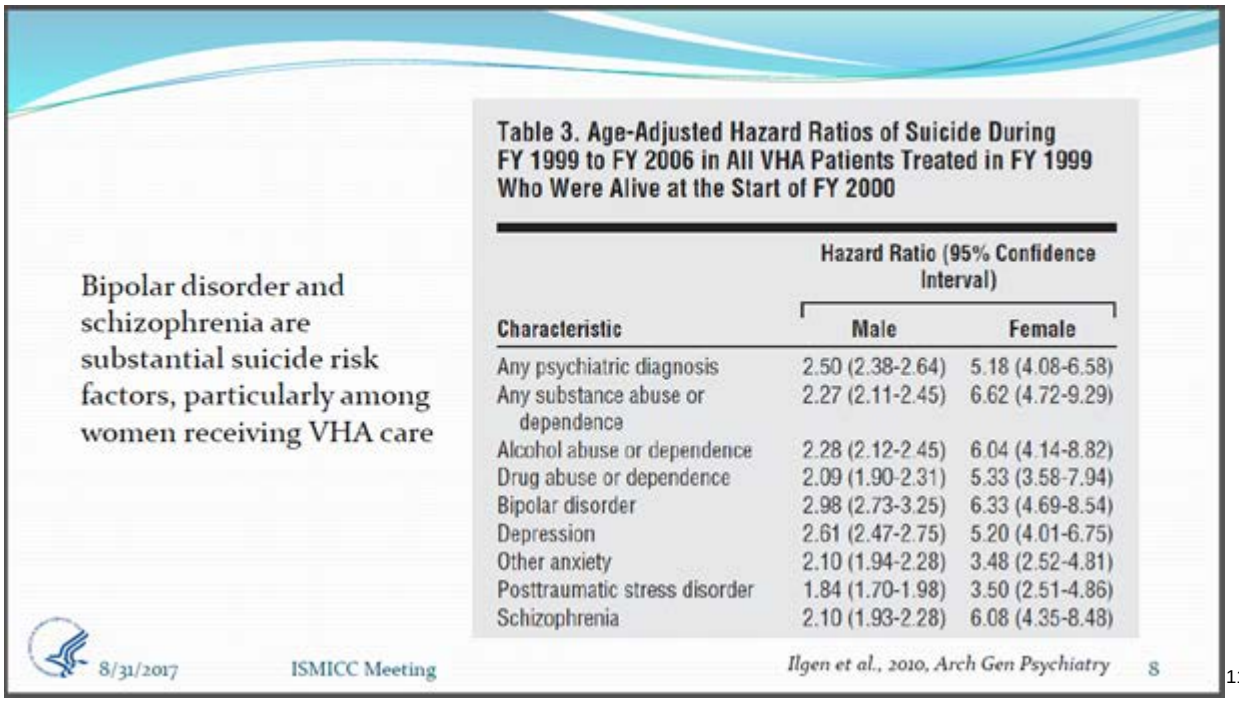
[10]McCarthy, John. (2017). U.S. Department of Veterans Affairs. "Federal Advances to Address Challenges in SMI and SED." [Powerpoint slides]. Retrieved from: https://www.samhsa.gov/sites/default/files/meeting/agendas/ismicc-morning-slides.pdf

Additionally, when examining only female veterans utilizing VHA care, the data presented in the corresponding table illustrates a statistically significant finding that BPD and schizophrenia are among the highest associated mental health conditions for suicide risk.



[11]

NAMI Montana would like to underscore that by highlighting this data, we're not suggesting any research funding or focus be removed from PTSD. Rather, we are seeking to draw the Committee's attention to this data to illustrate the need for a more holistic and comprehensive research approach around mental health conditions not typically associated with the veterans community.

NAMI Montana applauds Secretary Shulkin for identifying veteran suicide prevention as his top clinical priority for VA, and placing it among VA's top 5 priorities overall. Considering 70% of veterans who die by suicide are not under VA's care, we agree with his assessment that VA cannot alone solve this crisis, rather "[veteran suicide] is a national public health issue that requires a concerted, national approach."[12] While VA has taken positive steps to implement better suicide prevention programs at the national level, our organization firmly believes that we will not begin to truly make a positive, impact in ending this national tragedy until a national effort including all public, private and non-profit stakeholders are engaged and working together.

[11] Ilgen, et. al., "Psychiatric diagnoses and risk of suicide in veterans." (2010), Arch Gen Psychiatry.
[12] U.S. Department of Veterans Affairs. (March 9, 2016). "VA announces additional steps to reduce Veteran suicide." Retrieved from: http://www.blogs.va.gov/VAntage/26330/va-announces-additional-steps-reduce-veteran-suicide/

An effort we are interested in and believe may have promise to help in earlier identification is the REACH VET (Recovery Engagement and Coordination for Health -- Veterans Enhanced Treatment) Initiative launched by VA last fall. As the Committee is aware, REACH VET analyzes existing data from the health records of veterans to identify those at a statistically elevated risk for suicide, hospitalization, illness or other adverse outcomes--which allows providers to deliver, in some cases, pre-emptive care and support for veterans. As we know for certain and advocate for at NAMI Montana and throughout our larger NAMI organization, early identification and intervention of mental health conditions is a game changer in the ability to treat, and many times is the difference in life or death.

IV. Highlights and Recommendations

A. Offer Public Health Interventions Proven to Reduce Suicide During Critical Points of the Military and Veteran Experience

In April 2015, *The Lancet* published an article on the "The Saving and Empowering Young Lives in Europe" (SEYLE) study. The SEYLE study is a multicenter, cluster-randomized controlled trial with a sample which consisted of 11,110 adolescent pupils, median age 15 years (IQR 14-15), recruited from 168 schools in ten European Union countries. In this study, the Youth Aware of Mental Health (YAM) program demonstrated more than a 50% reduction of incident cases of suicide attempts, and of incident cases of severe suicidal ideation and plans, as well as a significant reduction by 30% of incident cases with moderate to severe depression was observed.[13]

Dr. Matt Byerly, MD and his team at the Center for Mental Health Research and Recovery at Montana State University and the University of Texas--Southwestern, brought this innovative five-hour intervention to high schools in Montana and Texas during the 2016-2017 school year. The evidence resulting from this program was incredibly positive and will hopefully spur further expansion into a large randomized controlled trial which would support a large-scale roll out of this critical intervention.

NAMI Montana supported the effort to bring YAM to the United States. While this particular course is focused on suicide prevention in adolescents, there does not appear to be any reason why a similar program could not be customized and offered to service members during Advanced Individual Training (AIT), and while discharging from the military. This five-hour course can be given over a series of three to five weeks. A program that had the similar effects as YAM on reducing suicide attempts, ideation, and depression among service members and

[13] Wasserman, Danuta, et al. "School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial." *The Lancet* 385.9977 (2015): 1536-1544.

veterans could be a great step forward in our shared long-term goal in reducing veteran suicides.

B. Establish a Clear Policy Goal to Improve the Diagnostic Treatment System

In NAMI Montana's experience, effective mental health treatment is essential to the long-term reduction of a person's risk of suicide. One of the largest challenges in obtaining effective treatment is receiving an early and accurate diagnosis. The federal government has invested a significant amount of funds in a variety of agencies to make the brain condition diagnostic process more tangible and accurate than the current process, which relies almost solely on patient survey questionnaires. However, none of the agencies have received a clear policy target from Congress for achieving this goal.

The target that NAMI Montana recommends for the Senate Veterans Affairs Committee is to task VA to work with DoD, the National Institute of Mental Health (NIMH), and private partners to identify and prepare two additional brain health diagnostic measurements for clinical work at all VA facilities by fall 2020. These tests are not to be based upon survey questions of the veteran or their family. Due to the short timeframe, the tests would have to be based upon existing technology that would support the current diagnostic process, rather than developing some new technology that would replace it.

These tests could be as relatively uncomplicated as a computerized executive functioning test, hair cortisol test, or blood inflammation test. Or they could be more complicated like an electroencephalography (EEG) or functional near infrared spectroscopy (fNIRS) test. Researchers at Cohen Veterans Bioscience have analyzed this proposal and agree that it is ambitious but doable with the current state of technology.

C. Expand the Availability of Telehealth and Automated Care Services as Broadly as Possible

(1) Expand Access to Telepsychiatry

Telepsychiatry and other telehealth services are essential to providing effective care throughout Montana and other rural states. These services have been expanding throughout Montana over the last decade through federal, state, and private investments and they appear to be hitting critical mass. The VA, AWARE Inc., American Telepsychiatry, and many other clinicians have all provided telepsychiatry services to Montanans suffering from SMI. The Montana Legislature recently passed a bill which requires all health insurers in the state to cover telemedicine services. Montana State Senator Ed Buttrey sponsored this legislation that easily passed both houses with bipartisan support. The federal government's investment in these services combined with a firm legal footing and ever-improving technology, has given telepsychiatry

momentum in the push to provide more rural Montanans with effective psychiatric coverage. The VA should support these efforts as much as possible.

(2) Make Online Cognitive Behavioral Therapy (CBT) available to all Veterans

Another innovative suicide prevention program in Montana is a research project led by Dr. Mark Schure, PhD at Montana State University which will complete a randomized controlled trial of THRIVE for adults across Montana. THRIVE is an interactive computerized Cognitive Behavioral Therapy program (cCBT) that helps people identify ways to improve their mood. It is accessed online via computer, tablet or smartphone. In other populations, THRIVE has been shown to decrease the frequency of depressive symptoms and improve quality of life.[14] In this study, participants will use the program for a year anonymously as often as needed during times of scheduled access.

This research project, funded by the National Institutes of Health (NIH), is a partnership between Montana State University (MSU) researchers, One Montana, and WayPoint Health Innovations, the program developer. This project is supported from MSU's Center for Mental Health Research and Recovery. The purpose of this research is to test the effectiveness of the THRIVE program to help Montanans decrease the frequency of depressive symptoms and improve their quality of life. While it is too early to tell the results of this particular iteration of cCBT research, the overall body of research of cognitive behavioral therapy (CBT) for health conditions that affect veterans is positive, including alcohol abuse.[15]

The VA should embark upon a process to make high-quality, engaging cCBT available to all veterans.

(3) VA Should Partner to Expand the Availability of Automated Suicide Risk Assessment Scales

Dr. Eric Arzubi, MD has brought the University of Vermont's Automated Suicide Risk Assessment Tool (Assessment Tool) to Montana's largest hospital system, the Billings Clinic. The Assessment Tool is designed to replicate the thinking of an experienced psychiatrist in the evaluation of near-term suicide risk.[16] The Assessment Tool uses a neural network-based

[14] *See e.g.,* Whiteside U, Richards J, Steinfeld B, et al. Online Cognitive Behavioral Therapy for Depressed Primary Care Patients: A Pilot Feasibility Project. *The Permanente Journal*. 2014;18(2):21-27. doi:10.7812/TPP/13-155.

[15] Kiluk, Brian D., et al. "Randomized Trial of Computerized Cognitive Behavioral Therapy for Alcohol Use Disorders: Efficacy as a Virtual Stand -Alone and Treatment Add Outpatient Treatment." *Alcoholism: Clinical and Experimental Research* 40.9 (2016): 1991-2000.

[16] Jennifer Nachbur, "Study Shows UVM Suicide Risk Assessment Tool Performs Like Psychiatrist" (June 8, 2016)

algorithm to assess suicide risk in emergency department and medical inpatients. For levels of suicide risk, the model tool takes less than a minute to predict a psychiatrist's assessment at between 91 and 94 percent.[17] Patients reported that the tool was easy to complete.

The VA can adopt the Assessment Tool, or a similar model tool, in its emergency settings and partner with the developers to ensure that it can be easily and seamlessly utilized in a variety of electronic health record systems throughout the U.S.

D. Develop a Plan for Treatment Resistant Mental Health Conditions

Treatment resistance in mental health conditions is a significant barrier to effective care for recovery from these potentially fatal conditions. It is estimated that one-third of people diagnosed with schizophrenia have a treatment-resistant form of the condition.[18] Treatment resistance is one of the "the biggest challenges" in treating bipolar disorder, which as noted above affects many veterans.[19] It is also estimated that roughly one-third of individuals with depression "continue to be resistant to available therapeutic options, and hence pose a major therapeutic challenge to mental health experts."[20]

From my position in Montana, it appears that VA does not have a strategy to care for veterans with treatment-resistant mental health conditions. As an example, VA does not have any means or tools available to treat veterans with treatment-resistant depression within the state of Montana. The best option that a Montana veteran with treatment resistant depression may have to receive care is to travel to Wyoming or another state for Electroconvulsive Therapy (ECT). ECT can be an effective option for treatment-resistant depression, but it is invasive and can be debilitating between treatments, so traveling out-of-state to receive care can be particularly difficult.

This issue is dear to my heart because I lost my dear friend, colleague, and fellow veteran Mike Franklin to treatment-resistant depression in September 2015. In the two years since Mike's suicide, private payers and providers in Montana have taken major strides in opening up options

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https://med.uvm.edu/com/news/2016/07/12/study_shows_uvm_suicide_risk_assessment_tool_performs_like_psychiatrist

[17] Desjardins, Isabelle, et al. "Suicide Risk Assessment in Hospitals: An Expert System-Based Triage Tool." *The Journal of clinical psychiatry* 77.7 (2016): e874-82.

[18] Sinclair, Diarmid, and Clive E. Adams. "Treatment resistant schizophrenia: a comprehensive survey of randomised controlled trials." *BMC psychiatry* 14.1 (2014): 253.

[19] Bauer, Isabelle E., et al. "The Link between Refractoriness and Neuroprogression in Treatment-Resistant Bipolar Disorder." *Neuroprogression in Psychiatric Disorders*. Vol. 31. Karger Publishers, 2017. 10-26.

[20] Al-Harbi, Khalid Saad. "Treatment-resistant depression: therapeutic trends, challenges, and future directions." *Patient preference and adherence* 6 (2012): 369.

for clients with treatment-resistant conditions such repetitive Transcranial Magnetic Stimulation (rTMS) and Ketamine infusions. Unfortunately, the Montana VA has not moved at the same brisk pace.

The Cooperative Studies Program within the U.S. Department of Veterans Affairs is launching a randomized control trial of rTMS for treatment-resistant major depression in veteran patients.[21] While this a positive step forward, I cannot help but wonder why this tool is not being adopted at a faster rate. I am increasingly frustrated by the puzzle of why Blue Cross Blue Shield of Montana has agreed that this treatment can be critical to the recovery of its members with treatment-resistant depression,[22] but the Montana VA has not. VA must work more expediently to provide access to this lifesaving treatment for veterans with treatment-resistant mental health conditions.

E. Prize for a Research Team to Create and Validate a Medical Screening Tool to Determine Which Patients are at Risk of Developing Side-Effects From Clozapine

The following block quote is taken in its entirety from the article "Clozapine: a distinct, poorly understood and under-used molecule" with references from Dr. Ridha Joober, MD and Dr. Patricia Boksa, PhD from the *Journal of Psychiatry & Neuroscience.*

> *Consensus of opinion is rare in psychiatry. Even in the field of clinical trials, where experimentation is tightly controlled and regulatory bodies scrutinize the proof, controversies are frequent and difficult to resolve.[23] One issue for which there is a widespread consensus is the unique place that clozapine occupies in the treatment of severe mental illnesses, particularly refractory schizophrenia. This molecule is distinct because of its effectiveness, numerous and sometimes mysterious pharmacologic characteristics, serious side effects and under use.*
>
> *Historically, clozapine was distinguished by one of its dangerous and sometimes lethal side effects, agranulocytosis, which almost caused its complete banishment from the psychiatric pharmacopoeia.[24] It was only rescued when its superior therapeutic effects compared with chlorpromazine in patients with*

[21] Mi, Zhibao, et al. "Repetitive transcranial magnetic stimulation (rTMS) for treatment-resistant major depression (TRMD) Veteran patients: study protocol for a randomized controlled trial." *Trials* 18.1 (2017): 409.
[22] Blue Cross Blue Shield of Montana: Behavioral Health Care Management Program, https://www.bcbsmt.com/provider/clinical-resources/behavioral-health-programs
[23] Blier P. Do antidepressants really work? J Psychiatry Neurosci. 2008;33:89–90.
[24] Marder SR, Van PT. Who should receive clozapine? Arch Gen Psychiatry. 1988;45:865–7.

refractory schizophrenia were demonstrated.[25] *Since its controlled comeback, clozapine has consistently demonstrated advantages in a variety of clinical situations. Its enhanced therapeutic profile in patients with schizophrenia who respond poorly to other antipsychotic medications, both typical*[26] [27] [28] *and atypical,*[29] [30] [31] *have been reported in many studies and encompass many dimensions of the schizophrenia syndrome.*[32] [33] *Positive symptoms are most consistently improved by clozapine, but there are also reports indicating that anxiety, mood and negative symptoms*[34] *as well as hostile behaviours*[35] *are better controlled with clozapine than with other neuroleptics, although the data are less consistent. Moreover, it has been reported that patients are more likely to remain compliant with clozapine than with other atypical antipsychotics.*[36] [37] [38] *Clozapine is also the only antipsychotic medication that*

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[25] Kane J, Honigfeld G, Singer J, et al. Clozapine for the treatment-resistant schizophrenic. A double-blind comparison with chlorpromazine. Arch Gen Psychiatry. 1988;45:789–96.
[26] *Id*.
[27] Kane JM, Marder SR, Schooler NR, et al. Clozapine and haloperidol in moderately refractory schizophrenia: a 6-month randomized and double-blind comparison. Arch Gen Psychiatry. 2001;58:965–72.
[28] Hong CJ, Chen JY, Chiu HJ, et al. A double-blind comparative study of clozapine versus chlorpromazine on Chinese patients with treatment-refractory schizophrenia. Int Clin Psychopharmacol. 1997;12:123–30.
[29] Kumra S, Kranzler H, Gerbino-Rosen G, et al. Clozapine and "high-dose" olanzapine in refractory early-onset schizophrenia: a 12-week randomized and double-blind comparison. Biol Psychiatry. 2008;63:524–9.
[30] Azorin JM, Spiegel R, Remington G, et al. A double-blind comparative study of clozapine and risperidone in the management of severe chronic schizophrenia. Am J Psychiatry. 2001;158:1305–13.
[31] Lewis SW, Davies L, Jones PB, et al. Randomised controlled trials of conventional antipsychotic versus new atypical drugs, and new atypical drugs versus clozapine, in people with schizophrenia responding poorly to, or intolerant of, current drug treatment. Health Technol Assess. 2006;10:iii–xi. 1.
[32] Elkis H. Treatment-resistant schizophrenia. Psychiatr Clin North Am. 2007;30:511–33
[33] Tandon R, Belmaker RH, Gattaz WF, et al. World Psychiatric Association Pharmacopsychiatry Section statement on comparative effectiveness of antipsychotics in the treatment of schizophrenia. Schizophr Res. 2008;100:20–38.
[34] Breier AF, Malhotra AK, Su TP, et al. Clozapine and risperidone in chronic schizophrenia: effects on symptoms, parkinsonian side effects, and neuroendocrine response. Am J Psychiatry. 1999;156:294–8.
[35] Citrome L, Volavka J, Czobor P, et al. Effects of clozapine, olanzapine, risperidone, and haloperidol on hostility among patients with schizophrenia. Psychiatr Serv. 2001;52:1510–4.
[36] Cooper D, Moisan J, Gregoire JP. Adherence to atypical antipsychotic treatment among newly treated patients: a population-based study in schizophrenia. J Clin Psychiatry. 2007;68:818–25.
[37] Nasrallah HA. The roles of efficacy, safety, and tolerability in antipsychotic effectiveness: practical implications of the CATIE schizophrenia trial. J Clin Psychiatry. 2007;68(Suppl 1):5–11.
[38] Ascher-Svanum H, Zhu B, Faries DE, et al. Adherence and persistence to typical and atypical antipsychotics in the naturalistic treatment of patients with schizophrenia. Patient Prefer Adherence. 2008;2:67–77.

has shown an anticraving effect for drugs of abuse,[39] a significant effect in reducing suicide rates in patients with schizophrenia[40] and an efficacy on refractory mood disorders.[41] Every clinician who has prescribed clozapine can recount a few experiences of seeing patients emerge from their chaotic psychotic experience. This is one of the most rewarding experiences that a psychiatrist can have in his or her professional life, and it is among the most important strikes we have made against one of the most devastating diseases affecting mankind.

Expiration of the patent on clozapine in 2007 has lessened the burden of economic constraints against the use of clozapine. However, side effects remain a major issue affecting the choice to use the drug.

As noted above, schizophrenia is a major risk factor for suicide among veterans. The goal of this recommendation is to spur innovation by establishing a major cash reward, similar to the original $10 million dollar X Prize that led to the commercialization of space flight, to incentivize the development of a medical screening tool to determine who can be prescribed Clozapine without any risk of developing dangerous side effects. An effective screening tool would make it easier for veterans with schizophrenia to access this potentially life-saving therapy. The relatively low cost of Clozapine, in comparison to similar medications, would likely also save VA critical resources. The potential positive effects of a Clozapine side effect screening tool would also dramatically improve the cost of caring for individuals with schizophrenia, which is generally covered by the Centers for Medicare and Medicaid Services (CMS). The cost savings could be dramatic as the current costs of caring for schizophrenia are increasingly expensive, with estimated "annual direct and indirect costs of up to US$102 billion."[42]

F. Better Utilize Non-VA Providers

(1) Develop an Advanced Analytics Online Directory that is Continuously Expanded and Culled by veterans and managed by VACO staff

[39] Green AI, Noordsy DL, Brunette MF, et al. Substance abuse and schizophrenia: pharmacotherapeutic intervention. J Subst Abuse Treat. 2008;34:61–71.

[40] Meltzer HY, Alphs L, Green AI, et al. Clozapine treatment for suicidality in schizophrenia: International Suicide Prevention Trial (InterSePT) Arch Gen Psychiatry. 2003;60:82–91.

[41] Suppes T, Webb A, Paul B, et al. Clinical outcome in a randomized 1-year trial of clozapine versus treatment as usual for patients with treatment-resistant illness and a history of mania. Am J Psychiatry. 1999;156:1164–9.

[42] Wang Y, Iyengar V, Hu J, et al. Predicting Future High-Cost Schizophrenia Patients Using High-Dimensional Administrative Data. *Frontiers in Psychiatry*. 2017;8:114. doi:10.3389/fpsyt.2017.00114

On Thursday, September 21 I helped assist a family who had a veteran in mental health crisis. The VA staff did an excellent job, and was able to receive the veteran into their emergency room, identified his need for inpatient treatment and transported him by ambulance to a private hospital to receive care. This was generally the correct result, but the hospital is an hour and a half away from the people that love this veteran on a day-to-day basis. They likely will be unable to get time off of work or find childcare in order to visit and support his care. The last update I received was that he was escalating a few days later on Saturday, September 23, and it was unlikely that anyone who cared about him was going to be able to get there to see him over the weekend.

The Montana VA chose not to use the Journey Home, a private nonprofit mental health crisis center, that is located in the same town as the emergency room the veteran first received care. There may have been a medical reason for him to be hospitalized in a different town. However, I have reviewed instances where the VA staff processing the veteran are simply not aware of the resources available in that veteran's community because the resources are either new, or for an unknown reason do not fit into the standard community resource manual.

Similarly, I recently helped assist a Vietnam veteran who had become suicidal. There were many real treatment issues involved, but there were also unrelenting life issues in that he could not afford meals and he was deeply lonely. Both of those issues could be partially addressed through the local Area Agency on Aging Senior Meals and Support programs. A fellow veteran brought the veteran in crisis there, and the services were greatly appreciated.

There are so many different local services, even in a sparsely populated state like Montana, that it is impossible for a single clinician, social worker, or peer support specialist to keep them straight. Thankfully, the technology for tracking and culling these services from a centralized location has gotten much easier.

For example, NAMI Montana was able to develop a resource guide for every county in Montana through the work of a single VISTA volunteer. We also developed a resource guide which included every inpatient mental health and substance abuse facility in the U.S. for the Family Support Foundation on Mental Illnesses. This resource guide is available online at treatmentscout.com, and was created by scouring open source information and combining publicly available resource guides.

While it sounds daunting, VA should develop a central resource guide for community services across the U.S., managed by VACO through a creative combination of an advanced analytics program and veterans working the phone lines.

(2) <u>Create a More Synergistic Relationship Between VA and the Community Health Centers (CHCs)</u>

There are over 1,300 CHCs distributed across the country.[43] For purposes of this testimony, CHCs include Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). CHCs care for a large number of patients across the country. In 2015 alone, CHCs had almost 97 million patient visits.

As mentioned above, 70 percent of veterans nationally who die by suicide had not previously been connected to VA care.[44] It is likely that a portion of the veterans who do not receive care through VA, do receive care through CHCs. These CHCs provide comprehensive primary care services, but also provide access to mental health and substance abuse treatment. Their standard of care is monitored closely by the Health Resources and Service Administration (HRSA). They also have a billing structure which allows them provide services in underserved rural areas, which would help close the gap in providing necessary mental health services to rural veterans.

In an era where we are struggling to figure out how to ensure veterans always receive access to high-quality care, Congress should take a serious look at how to ensure VA and the CHC's are able to seamlessly work together across the U.S. Congress acting on this recommendation will specifically enhance our ability to get America's veterans the best, mostly timely care.

G. Increase VA's Collaboration with Outside Researchers

In May, VA and Coalition member Cohen Veterans Bioscience announced a public-private partnership alliance, called the Research Alliance for PTSD/TBI Innovation and Discovery Diagnostics (RAPID-Dx), "to enable different institutions to coordinate efforts and integrate data across dozens of labs and leverage synergistic capabilities for a 'big data' team-science approach to discover and support development of first-generation validated biomarkers and diagnostics for PTSD and TBI."[45] The partnership will to develop new tools "to consistently and accurately diagnose" PTSD and TBI, then assess if treatment is working. The VA described this partnership as, "affirming our commitment to a new type of radically collaborative science

[43] "Community Health Center Delivery Sites and Patient Visits."Kaiser Family Foundation website, http://www.kff.org/other/state-indicator/community-health-center-sites-and-visits/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[44] Hope Yen, "VA data show veteran suicide highest in US West, rural areas," *Chicago Tribune*, September 17, 2017, http://www.chicagotribune.com/lifestyles/health/sns-bc-us--veterans-affairs-suicide-20170915-story.html

[45] Cohen Veterans Bioscience, Press Release CVB and the Veterans Health Administration Announce Landmark Partnership to Advance the Diagnosis and Treatment of Trauma-Related Brain Disorders (May 17, 2017), http://www.cohenveteransbioscience.org/2017/05/17/cohen-veterans-bioscience-and-the-veterans-healthadministration-announce-landmark-partnership-to-advance-the-diagnosis-and-treatment-of-trauma-related-braindisorders/

defined by data sharing and coordination of efforts toward our shared goal of finding clinically-useful diagnostics and treatments for these invisible wounds of war." Secretary Shulkin reiterated the view of the Working Group, noting that "we're able to accomplish so much more when we work strategically with our private and public sector partners." NAMI Montana and our national office agree with Secretary Shulkin--we will be able to serve our nation's veterans and address their mental health needs in a better, more comprehensive way engaging all public and private sector stakeholders.

We encourage this Committee to task VA to maximize the effectiveness of this new partnership, as well as the work of similar initiatives. This includes the Multidisciplinary Association for Psychedelic Studies (MAPS). MAPS, in conjunction with the National Institutes of Health (NIH) is conducting a rigorous analysis of several Schedule One substances to determine whether they can be clinically effective when well-regulated and monitored under a clinician's care. Some of MAPS efforts may be opening the door to new pathways to effective treatment.[46]

Additionally, we respectfully ask this Committee to work with VA to provide researchers outside of VA access to the veteran-specific PTSD datasets and biological samples, and provide institution-wide support for multi-site PTSD clinical trials.

H. Establish a Continuity of Care Pipeline for Veterans directly from DoD to VA/Community Providers

When service members leave the military, it can often be a time full of life transitions which can cause stress which can exacerbate mental health conditions. We have strong reason to believe that the lack of this continuity of care "pipeline" between DoD and VA healthcare systems is resulting in many veterans slipping through the cracks. Unfortunate consequences can result in this case, as the ability to early identify and provide pre-emptive intervention care for mental health conditions is severely delayed, thus making the conditions far worse.

We would like to respectfully recommend this Committee work with the Senate Armed Services Committee to task VA to develop a plan with DoD to develop a Continuity of Care Pipeline to minimize the number of veterans that miss the opportunity to take advantage of VA's potentially lifesaving mental health care.

[46] *See e.g.*, Griffiths RR, Johnson MW, Carducci MA, et al. Psilocybin produces substantial and sustained decreases in depression and anxiety in patients with life-threatening cancer: A randomized double-blind trial. J Psychopharmacol (Oxford). 2016;30(12):1181-1197.

VI. 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,

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