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Statement of

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Chairman Tillis, Ranking Member Gillibrand, and other distinguished Members of the Subcommittee, thank you for the opportunity to appear before you today with our colleagues from the Department of Veterans Affairs (VA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), and Harvard. Like you, we are very concerned about the suicide rates in our military. We look forward to discussing the Department of Defense's (DoD's) suicide prevention efforts, including the monitoring and reporting of data on suicide in our military community, the deliberate evidence-based strategies we are currently implementing, and the new promising practices we are piloting based on research advances from the civilian sector to enhance our public health approach to suicide prevention.

Our rates of suicide are not going in the desired direction. Every life lost is a tragedy and each one has a deeply personal story. With each death, we know there are families – and often children – with shattered lives. We know this is a shared challenge. Nationwide, suicide rates are increasing. None of us has solved this issue, and no single case of suicide is identical to another case. Though many have similar patterns, in a great number of other cases, even close friends and family members are surprised by an individual's suicide.

The DoD has the responsibility of supporting and protecting those who defend our country, and so it is imperative that we do everything possible to prevent suicide in our military community. Our commitment is from this lens, from the debt of gratitude that we owe to Service members and their families, to encourage help-seeking behaviors, eliminate stigma, and increase visibility and access to critical resources. Our efforts must address the many aspects of life that impact suicide, and we are committed to addressing suicide comprehensively through a public health approach to suicide prevention.

CALENDAR YEAR 2018 ANNUAL SUICIDE REPORT

Because data informs our ability to take meaningful steps and fulfill our commitment to

transparency with you and the American public, the Department has expanded our reporting on suicide-related data. This past September, the DoD published the Annual Suicide Report (ASR) for Calendar Year (CY) 2018. We were able to meet with many of you and your staff on the ASR findings, and we appreciate the continued interest and support on suicide prevention efforts. The ASR, along with the complementary DoD Suicide Event Report (DoDSER) Annual Report, provides increased transparency and frequency of reporting to strengthen our program oversight and policies.

The CY 2018 suicide rates are consistent with rates from the past two years across the military (for the Active Component, Reserve, and National Guard), and have been steady over the past five years for the Reserve and National Guard. However, we have seen a statistically significant increase in the Active Component over the past five years (since 2013). In CY 2018, there were 541 Service members who died by suicide. We are disheartened that the trends in the military, as in the civilian sector, are not going in the desired direction.

We are often asked how the military compares to the U.S. population. While hardly acceptable, military suicide rates are comparable to the U.S. population rates after accounting for age and sex differences, with the exception of the National Guard. The National Guard rate is statistically higher than the rate for the U.S. population, after accounting for age and sex differences. Consistent with prior years, Service members who died by suicide were primarily enlisted, male, and less than 30 years of age, regardless of whether they were serving in the Active Component, Reserve, or National Guard.

We are equally committed to the well-being of our military families. This was the first time the Department published suicide data for our military family members. This is an important step forward. These results integrate data from both departmental data sources and the most comprehensive U.S. population data available – the Centers for Disease Control and Prevention’s

National Death Index. The Department estimates there were 186 military spouses and dependents who died by suicide in CY 2017, which is the most recent data available on military family members. Suicide rates for military spouses and dependents in CY 2017 were comparable to, or lower than, the U.S. population rates after accounting for age and sex. The Department will continue to work to effectively capture military family suicide data and report out on this important information in a transparent and timely manner, reporting on these data each year.

The Department is focused on fully implementing and evaluating a multi-faceted public health approach to suicide prevention that targets our military populations of greatest concern – young and enlisted Service members, and members of the National Guard – and continue to support to our military families. Specific initiatives include:

- Young and Enlisted Service Members: We are piloting an interactive educational program to teach foundational skills early in one’s military career to help address life stressors, and to enable these individuals as they progress in their career to teach others these skills under their leadership. We will also teach young Service members how to recognize and respond to suicide “red flags” on social media – to help Service members recognize how they can reach out to help others who might show warning signs.
- National Guard Members: National Guard Service members face unique challenges in comparison to their Active Component counterparts, including geographic dispersion, significant time between drill activities, access to care, and healthcare eligibility. We are seeking ways to expand access to care and promote help-seeking behavior, for example through formal partnerships, such as with the VA to increase National Guard members’ accessibility to readjustment counseling services through VA Mobile Vet Centers during drill weekends. The VA mobile teams provide support services such as care coordination, financial support services, and readjustment counseling, including facilitating support to

Service members who are not eligible for other VA services. We are also working closely with National Guard Bureau (NGB) to better understand this unique and critical force, and assist in identifying unique protective factors, risks, and promising practices related to suicide and readiness in the National Guard. For example, we fully support their efforts to implement the new Suicide Prevention and Readiness Initiative in the National Guard (SPRING). This comprehensive initiative leverages predictive analytics and improved reporting protocols to allow NGB to pioneer a unified approach to data-driven decision-making and suicide prevention.

- Military Families: The Department is committed to the well-being of military families and ensuring families are best equipped to support their Service members and each other. We continue to pilot and implement initiatives focused on increasing family members' awareness of risk factors for suicide –to help our military community recognize when they are at risk so they seek help. We continue to develop initiatives on safe storage of lethal means (e.g., safely storing medications and firearms to ensure family safety), as well as how to intervene in a crisis – to help others who might show warning signs.
- Measuring Effectiveness: The Department has developed a joint program evaluation framework to better measure effectiveness of our non-clinical suicide prevention efforts. This evaluation will inform retention of effective practices and elimination of ineffective practices.

PUBLIC HEALTH APPROACH TO SUICIDE PREVENTION

We know suicide results from a complex interaction of many factors – environmental, psychological, biological, and social. There is no one fix. Our efforts must address the many aspects of life that impact suicide, and we are committed to addressing this issue – not only because it affects our missions – but, more importantly, because it is a moral responsibility to take

care of our people. We also know that no two individuals have identical experiences in life, which is why the DoD has taken a comprehensive, public health approach to suicide prevention. This approach focuses on reducing suicide risk of all Service members and their families by attempting to address the myriad of underlying risk factors and socio-demographic factors (e.g., reluctance towards help-seeking and relationship problems), while also enhancing protective factors (e.g., social connections, problem-solving, and coping skills). A public health approach looks at promoting health and prolonging life through the strength of a connected and educated community – it includes medical care and treatment, as well as community-based prevention efforts involving military leaders, family, peers, spouses, and chaplains. We all have a role to play in suicide prevention for both our military community and the Nation as a whole.

Guided by the Defense Strategy for Suicide Prevention, the DoD has many efforts underway as we strive to implement a comprehensive public health approach. Below we describe multiple initiatives – highlighting both institutionalized, ongoing efforts, as well as new promising practices from the civilian sector that we are currently piloting and evaluating. These examples are by no means an exhaustive list of current initiatives. In alignment with the joint program evaluation framework developed to better measure effectiveness of our non-clinical suicide prevention efforts, we are dedicated to evaluating the effectiveness of our policies and programs to retain effective practices and eliminate ineffective practices.

Strengthening Economic Supports. Financial stress (or anticipation of future financial stress) may increase one’s overall stress; and, when combined with other factors, may increase risk for suicide. The Department is continuing to provide relevant programs, resources, and professional support to help Service members achieve financial readiness, maintain skills to make informed financial decisions, and meet personal and professional goals throughout the military lifecycle.

Strengthen Access and Delivery of Suicide Care. While most people with mental health problems do not attempt or die by suicide, and the level of risk conferred by different types of mental illness varies, mental illness is an important risk factor for suicide. Access to and receiving quality mental health care is critical.

The DoD recently partnered with VA to complete a Clinical Practice Guideline on the assessment and management of suicide. This evidence review found clinical practices that can reduce suicide - particularly in specific high-risk patient populations. It is important to note that all of the clinical practices listed below have small effect sizes, meaning that a clinician must treat several patients to achieve one changed outcome. These interventions include: Cognitive Behavioral Therapy-based interventions focused on suicide prevention for patients with a recent history of self-directed violence; Dialectical Behavioral Therapy for individuals with borderline personality disorder and recent self-directed violence; and crisis response plans for individuals with suicidal ideation or a lifetime history of suicide attempts. Additionally, other clinical practices are promising, such as problem-solving based therapy for patients with a history of more than one incident of self-directed violence to reduce repeat incidents of self-directed violence, patients with a history of recent self-directed violence to reduce suicidal ideation, and patients with hopelessness and a history of moderate to severe traumatic brain injury.

Medications also have some effect in patients with the presence of suicidal ideation and major depressive disorder, such as ketamine infusion as an effective adjunctive treatment for short-term reduction in suicidal ideation. Lithium alone (among patients with bipolar disorder) or in combination with another psychotropic agent (among patients with unipolar depression or bipolar disorder) decreases the risk of death by suicide in patients with mood disorders. Clozapine decreases the risk of death by suicide in patients with schizophrenia or schizoaffective disorder and either suicidal ideation or a history of suicide attempt. Lastly, caring contacts have evidence of

effectiveness. This could include periodic caring communications (e.g., postcards) or home visits after a suicide attempt.

Note that a commonly used method for suicide attempts is medication. Access to opioid medications has been associated with increased rates of intentional and unintentional overdose death. DoD has an opiate overdose death rate that is one-fourth of the civilian rate, and its successful efforts can be considered a successful suicide prevention initiative. Examples of those efforts include: random drug testing for all Service members; pharmacy controls for all opiate medications; ready access to stepped pain care for all individuals (100% of Service members receive medical care annually); and wide availability of the opiate reversal medication, naloxone.

Likewise, within the realm of clinically-focused efforts, an increased use of administrative separation for personality disorder may help. A review of data shows a trend between the decrease in administrative separations for personality disorder and an increase in suicide, which may stem from persons with personality disorders having high rates of suicidality, or their suicidality having contagion effects.

In addition to ensuring access to, and participation in, evidence-informed clinical care, we must also address the perceived stigma we know our Service members face when deciding if and when to get help to be successful in suicide prevention. Among Service members who experienced significant distress, the greatest barrier to receiving care is stigma. Stigma reduction efforts need to be messaged with real data that make someone likely to seek care. A common misconception is that accessing credentialed mental health care will result in loss of one's security clearance. The reality is that among several million security clearance application questionnaires, only a small handful of individuals lost a security clearance by answering "yes" to questions about mental health history. Furthermore, about 25% of Service members access credentialed mental health care in the year before they separate, and far more access these services over the course of

their career. The chance of being separated for a self-referred mental health condition, particularly one that is not a disability, is low.

The Department has launched several pilot initiatives striving to reduce stigma and strengthen access and delivery of care. For example, the Department is piloting a barrier reduction training designed to address the most prevalent help-seeking concerns of Service members (e.g., career and security clearance loss concerns, loss of privacy and confidentiality), and encourage Service members to seek help early on, before life challenges become overwhelming.

Creating Protective Environments. Prevention efforts that focus not only on individual behavior change (e.g., help-seeking, treatment intervention), but on changes to the environment, can increase the likelihood of positive behavioral and health outcomes. We know that the act of suicide can be impulsive. Research has shown that the time a person goes from thinking about suicide to acting on it can be less than ten minutes – so putting time and distance between an individual and a lethal means may save a life. As such, the Department has several new initiatives focused on means safety for Service members and their families.

For example, the Department is currently piloting training to help non-medical military providers, such as Military and Family Life Counselors, implement counseling strategies to reduce accessibility to lethal means (e.g., promoting safe storage) for individuals at risk for suicide. The Department is also developing a collaborative communication campaign to promote social norms for safe storage.

Promoting Connectedness. Our data show relationship stressors, such as failed or failing intimate partner relationships, are frequently cited risk factors for suicide, and research suggests strong social connections protect against suicide, along with enhancing the quality of life. By facilitating access to additional support by phone or web, or implementing active contacts from health professionals after a crisis, promoting connectedness may have multi-faceted, positive

effects. The Department provides access to non-medical counselors through Military OneSource and Military and Family Life Counseling, including embedded Military Family Life Counselors to provide assistance to our members and families with an additional ability to “surge” if necessary to locations where there is a heightened need.

Teaching Coping and Problem-Solving Skills. Building life skills prepares individuals to successfully tackle every day challenges and adapt to stress and adversity. Addressing coping and problem-solving, particularly among young Service members at this formative stage in life, may normalize how Service members address stress, seek help when needed, and solve problems without violence or self-harm. The Department is piloting an interactive educational program to teach foundational skills, such as rational-thinking, emotion regulation and problem-solving, early in one’s military career to help address life stressors.

Identifying and Supporting People at Risk. To identify and support people at risk, the Department is building on existing training to identify and intervene with Service members at risk of suicide by teaching young Service members how to recognize and to respond to warning signs of suicide on social media and intervening in an effective manner. With respect to the National Guard, we fully support their efforts to implement the new Suicide Prevention and Readiness Initiative in the National Guard (SPRING), as well as the establishment of their new Warrior Resilience and Fitness Program Office to synchronize their multiple lines of prevention efforts into a holistic and integrated model to enhance the readiness and resilience of their total force. As a final example, the Department is piloting a training program to teach military chaplains cognitive behavioral strategies aimed at reducing suicide risk.

Lessening Harms and Preventing Future Risk. Risk of suicide has been shown to increase among people who have lost a friend/peer, family member, co-worker, or other close contact to suicide. Also, how suicide is discussed in the media, in a town hall, or informally in a group of

individuals may add to this risk among vulnerable individuals. The Department has several efforts underway to lessen these potential harms and prevent future risk. For example, we are continuing to provide training, education, and to engage with DoD Public Affairs Officers, military senior leaders, and media sources on how to safely talk about suicide prevention and a suicide death, as well as how to have conversations that will encourage those at risk of suicide to seek help.

Whether in media or other communications, sharing stories of hope and resilience, and support resources available, has been found to increase coping skills and increase help-seeking. As another example initiative, the Department is developing a comprehensive resource guide for DoD postvention providers (e.g., commanding officers, chaplains, casualty assistance officers, Suicide Prevention Program Managers, and military first responders) regarding evidence-informed practices for delivery of bereavement and postvention services to unit members and next of kin who survive a military suicide loss.

PARTNERSHIPS ENHANCE A PUBLIC HEALTH APPROACH TO SUICIDE

Partnerships with national and local organizations, such as other Federal agencies, non-profit organizations, and academia, are essential in creating a robust safety net for our military community and advancing our public health approach to suicide prevention. These partnerships are especially important for the Reserve and National Guard and their families, who usually do not have ready access to installation-level resources. We work closely with leadership across the Reserve Component to ensure we understand the unique challenges of this population and remove barriers to care.

Our partnerships with other Federal agencies are also critical to implementing a public health approach to suicide prevention. For example, our partnership with the National Institute of Mental Health, which includes *ex officio* membership in its National Advisory Council, guides research priorities for suicide prevention in a National Research Action Plan. We partner with the

SAMHSA in multiple forums, such as the Suicide Prevention Federal Working Group. The DoD has particularly close collaborations with the VA. In addition to the Suicide Data Repository, we share a military suicide research consortium. We co-develop clinical practice guidelines, not just for suicide, but for conditions that increase suicide risk such as Post Traumatic Stress Disorder, Traumatic Brain Injury, depression, and substance use disorders. The DoD and VA host a biennial suicide prevention conference - representing the only national conference that specifically addresses suicide in military and veteran populations. The conference provides an opportunity for leaders, Service members, clinicians, behavioral health and suicide prevention experts, and community health providers to share their expertise and learn about the latest research and promising practices for preventing suicide in our military and veteran communities.

The Department also has a robust effort with the VA and the Department of Homeland Security (DHS) focusing on the higher risk population of transitioning Service members. In 2017, DoD and VA leadership created an interagency governance structure to address this higher-risk population. These efforts received a boost when the President signed Executive Order (E.O.) 13822 in January 2018, requiring the Secretaries of DoD, VA, and DHS to work together to create a robust Joint Action Plan to ensure seamless access to mental health care and suicide prevention resources for transitioning Service members and Veterans during their first year after retirement or separation from the military. Examples of completed initiatives to date include expanding Military OneSource to provide confidential counseling to Service members and their families from 180 days to 365 days after the date of separation or retirement; extending a warm handover (e.g., to VA or Military OneSource) for transitioning Service members in need of additional psychosocial support; and instituting a mandatory separation health assessment. Moreover, the VA, DoD, and DHS continue strong collaborative efforts (in partnership with other Federal agencies) via E.O. 13861, focusing on developing a comprehensive public health roadmap for the prevention of suicide at the national and

community level. The Department is working in close collaboration with other Federal agencies, state and local governments, as well as stakeholders from the private sector on this important endeavor.

CONCLUSION

In closing, we would like to reaffirm that we are grateful for the opportunity to speak with you today and discuss the Department's suicide prevention efforts. We fully recognize we have more work to do, and much more progress to make, to prevent this devastating loss of life. We take this charge very seriously. We will do more to target our initiatives to our Service member populations of greatest concern, while continuing to support our military families. Our efforts will continue to address the many aspects of life that impact suicide, and we are committed to addressing suicide comprehensively through a public health approach to suicide prevention. In closing, Mr. Chairman, we thank you, Ranking Member Gillibrand, and the other members of this subcommittee for your unwavering dedication and support of the men, women, and their families who proudly support, protect, and defend our great Nation.