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Chairwomen Speier and Brownley, Ranking Members Kelly and Dunn, and distinguished Members of the Subcommittees, thank you for the opportunity to appear before you today, with our colleagues from the Department of Veterans Affairs (VA), to discuss the Department of Defense's (DoDs) suicide prevention efforts. We look forward to discussing what we are currently doing, including monitoring and planned reporting of data on suicide in the Armed Forces, deliberate efforts the Department has made to prevent suicide in its ranks, research advances and the evidence base for suicide prevention, what we plan to do, and our enduring commitment to protect our Country's defenders and their families.

The statistics are daunting – and unacceptable. And though our data helps to drive and improve our efforts in this space, as leaders in the Department, my colleagues and I know that every life lost is a tragedy – every one of them has a deeply personal story. Behind each death, we know there are families with shattered lives and we cannot rest until we have created every opportunity to prevent this tragedy among our Nation's bravest.

We at the DoD have vowed, time and again, to ensure that we do everything possible to support our Service members – and all of us are working tirelessly to do just that. Yet, the data is devastating and not going in the desired direction.

None of us has solved this issue, and no single case of suicide is identical to another case. Though many have similar patterns, which we can discuss today, in a great number of other cases, even the close friends and family members are initially surprised by an individual's suicide.

Scientific research surrounding prevention of suicides is both complex and ever-evolving. We leverage scientific, evidence-informed practices; partnership with Congress, Military/Veterans Service Organizations, research institutions, and other government agencies such as the Centers for Disease Control and Prevention – to constantly pull every idea, every possible effective initiative, into our toolkit to help Service members and their families.

The DoD supports and protects our country's defenders, so we must do everything possible to prevent suicide among their ranks. Underpinning our efforts is a recognition that most suicides, especially at the population level, are preventable. The challenge for DoD and the Nation is that suicide is the culmination of complex interactions between biological, social, and psychological factors operating at individual, community, and societal levels. But the DoD's commitment is absolute.

The DoD is dedicated to transparency in the reporting of surveillance data on suicide mortality. Nationwide, suicide rates are alarming, and increasing – a trend also evident among our Armed Forces. We provide below, in Tables 1 and 2, our most recent *counts* and *rates* for the Active Component, Reserves, and National Guard.

Table 1. Service and Component Suicide Counts, CY 2011-2018 Q3 [1-3]

	2011	2012	2013	2014	2015	2016	2017	2018 Q3
Active Component	**267**	**321**	**256**	**276**	**266**	**280**	**286**	**231**
Army	141	165	121	126	120	130	116	103
Marine Corps	31	48	46	34	39	37	43	40
Navy	52	58	41	54	43	52	65	48
Air Force	43	50	48	62	64	61	62	40
Reserve	**69**	**72**	**86**	**79**	**89**	**80**	**93**	**56**
Army Reserve	44	50	59	42	55	41	63	38
Marine Corps Reserve	7	11	11	12	11	19	10	9
Navy Reserve	7	8	5	15	14	10	9	8
Air Force Reserve	11	3	11	10	9	10	11	1
National Guard	**116**	**132**	**134**	**91**	**125**	**122**	**136**	**88**
Army National Guard	99	22	14	14	21	14	12	8
Air National Guard	17	110	120	77	104	108	124	80

1. Source: CY 2011-2018 Q3 suicide counts were obtained from the Armed Forces Medical Examiner System (AFMES); Suicide counts for CY 2018 only include deaths occurring in Quarters 1-3. The data presented represents the most recent published data available from the DoD Quarterly Suicide Report (QSR)).
2. Official CY 2017 and 2018 counts will become available in the inaugural Annual Suicide Report (summer 2019)
3. Data prior to CY 2011 was not standardized for all components to allow for trend analysis for the total force. Starting in CY 2011, the DoDSER included information on the non-activated Reserve and National Guard.

Table 2. Service and Component Suicide Rates (per 100,000), CY 2011-2016 [1-4]

	2011	2012	2013	2014	2015	2016
Active Component	**18.7**	**22.9**	**18.5**	**20.4**	**20.2**	**21.1**
Army	24.8	29.9	22.7	24.6	24.4	26.7
Marine Corps	15.4	24.3	23.6	17.9	21.2	20.1
Navy	15.9	18.1	12.7	16.6	13.1	15.3
Air Force	12.9	15.0	14.4	19.1	20.5	19.4
Reserve	**18.1**	**19.3**	**22.8**	**21.6**	**24.7**	**22.0**
Army Reserve	21.4	24.7	29.6	21.4	27.7	20.6
Marine Corps Reserve	*	*	*	*	*	*
Navy Reserve	*	*	*	*	*	*
Air Force Reserve	*	*	*	*	*	*
National Guard	**24.8**	**28.1**	**28.9**	**19.8**	**27.5**	**27.3**
Army National Guard	27.4	30.8	33.7	21.8	29.8	31.6
Air National Guard	*	19.1	*	*	19.9	*

1. Source: Suicide counts were obtained from the Armed Forces Medical Examiner System (AFMES); end strength counts (for rate calculations) obtained from the Defense Manpower Data Center (DMDC).
2. Data presented represents the most recent published data available from the Department of Defense Suicide Event Report (DoDSER). For example, data for CY 2014-2016 is published in the 2016 DoDSER.
3. Per DoDI 6490.16, rates are not reported when counts are less than 20 due of statistical instability. This is indicated by an asterisk (*).
4. Data prior to CY 2011 was not standardized for all components to allow for trend analysis for the total force. Starting in CY 2011, the DoDSER included information on the non-activated Reserve and National Guard.

The DoD has traditionally reported the suicide rates, and other pertinent data, for our Service members using the DoD Suicide Event Report (DoDSER). This report provides extensive data and analyses on suicides and suicide attempts to facilitate assessment of risk factors that includes a myriad of underlying risk factors and socio-demographic factors (e.g., reluctance towards help-seeking, relationship problems, financial difficulties, mental health issues, unhealthy alcohol or drug use, and access to lethal means). Over the past five years, the DoD has improved the quality of suicide-related data, and published guidance to ensure reliability and comparability of surveillance data across the military Services, including Reserves and National Guard. The DoD and the VA have jointly created a DoD/VA interagency Suicide Data Repository (SDR), which improves our ability to understand patterns of suicide both before and after military separation.

Data in both the DoDSER and SDR are made readily available to DoD and VA researchers in order to better understand the phenomenology of suicide and be better able to identify vulnerable populations prospectively in order to deliver evidence-based treatments.

The DoDSER provides extensive data and findings, which often take time to collect and analyze. In order to share transparent and timely top-line rates and counts of suicide, including data on dependents, the Department will release its first-ever *Annual Suicide Report* (ASR) this summer, with more up-to-date counts, rates, and trends of military suicide in order to better assess our progress and identify areas of concern in real-time. The DoDSER will follow to provide in-depth details of suicide events and deeper analyses in order to further expand our understanding of military suicides. The increased transparency and frequency of reporting will strengthen our program oversight and policies.

The Department's suicide prevention efforts are guided by the Defense Strategy for Suicide Prevention (DSSP), which was signed in December 2015, and created the foundation and alignment of efforts to focus on prevention activities with the greatest potential to prevent suicide. When developing the DSSP, we worked with the experts in the field and aligned our strategy to the National Strategy for Suicide Prevention (NSSP), as published in 2012 by the Department of Health and Human Services, Office of the U.S. Surgeon General. The DSSP uses the public health framework laid out in the NSSP. Hence, the DoD embraces both community-based prevention efforts and medical care and treatment to address suicidal thoughts and risk behaviors.

In November 2017, DoD published its first ever Department-wide policy on Suicide Prevention, the "*Defense Suicide Prevention Program*" (DoD Instruction 6490.16). This DoD policy establishes a public health approach model, inclusive of mental health treatment efforts, to address suicide risk and prevention across all Military Services. To that end, the Department's major lines of effort within the public health approach are: policy and advocacy, data and

surveillance, program assessment and evaluation, clinical interventions, and outreach and education.

Research, supporting whole population approaches that have shown to reduce suicide rates in various populations across the globe and DoD, continues to be assessed for feasibility and piloted. This includes a focus on:

- Messaging campaigns on how to talk about safe storage of lethal means of suicide in the military culture.
- How to safely talk about suicide prevention and a suicide death by working with public affairs, journalists, and Commanders. This includes strategies to refrain from glorifying or sensationalizing the death, or suggesting that suicide is an "easy way out" and instead talking about how asking for help early on can help mitigate crises.
- Ensuring every Service member, Commander, family member, and support personnel are part of the solution by:
    - Teaching emotion regulation, problem solving, and self-care skills, particularly to new recruits.
    - Training Service members and Commanders on how to identify the risk and warning signs of suicide on social media and intervening in an effective manner.
    - Working with Commanders to assess their unit connectedness and learning ways to increase connectedness.

As part of the public health model, clinical practices are also used, based on best-practices, to reduce suicide particularly in specific high-risk patient populations. It is important to note that all of the clinical practices noted to be somewhat effective 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, which reduces incidents of future

self-directed violence.

- Dialectical Behavioral Therapy for individuals with borderline personality disorder and recent self-directed violence.
- Crisis response plans for individuals with suicidal ideation or a lifetime history of suicide attempts.
- 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; a history of recent self-directed violence to reduce suicidal ideation; and/or hopelessness and a history of moderate to severe traumatic brain injury.
- Ketamine infusion, in patients with the presence of suicidal ideation and major depressive disorder, has been shown to be 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) to decrease the risk of death by suicide in patients with mood disorders.
- Clozapine to decrease the risk of death by suicide in patients with schizophrenia or schizoaffective disorder and either suicidal ideation or a history of suicide attempt.
- Periodic caring communications (e.g., postcards) as indicated for 12-24 months in addition to usual care after psychiatric hospitalization for suicidal ideation or a suicide attempt.
- Home visits to support reengagement in outpatient care is indicated among patients not presenting for outpatient care following hospitalization for a suicide attempt.

Much discussion has also focused on the value of predictive analytics for suicide, and indeed DoD's investment with the National Institutes of Health has yielded a multitude of useful

published studies on suicide that should help us better understand suicide and develop effective interventions. As an example, the Army Study to Risk and Resilience in Service members (Army STARRS) and its follow-on longitudinal study, STARRS-LS, has already generated more peer-reviewed publications than many of the most foundational medical studies in our history. Although this research has contributed to our knowledge base, it has not yet produced clinically proven suicide prevention interventions. Thus, while we all strive to prevent every Soldier, Sailor, Airman, and Marine from suicide, predicting who will ultimately make this decision, who will come to seek help, and who will stand resilient in the face of such desperation is currently more of an art than a science, but this science is ever-evolving as we learn more.

Our collaborative efforts with non-profit organizations, academia, the Military Services, and other federal agencies are critical to advancing our suicide prevention efforts. Partnerships with national and local organizations are essential in creating a robust safety net for our Service members and Veterans. These partnerships are especially important for the Reserve Component and National Guard members, who do not traditionally have as easy access to installation-level resources as the Active Component. We work closely with leadership in the Reserve and National Guard Bureau to ensure we understand the unique challenges of this population, and remove barriers to care. In addition, our partnership with the National Institute of Mental Health, which includes *ex oficio* membership in its National Advisory Council, guides research priorities for suicide prevention in a National Research Action Plan.

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. DoD and VA holds a biennial suicide prevention conference. This event is the only national suicide prevention

conference that specifically addresses suicide in military and veteran populations. In recent years, we have extended our suicide prevention conference reach by partnering with stakeholders across the suicide prevention space. 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 DoD 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, which provided a formalized structure to facilitate cooperation and collaboration between the DoD and VA. 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 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. Completed initiatives to date include expanding Military OneSource to provide confidential counseling to Service members and their families from 180 days to now up to 365 days after separation or retirement and extending a warm handover to transitioning Service members in need of additional psychosocial support. Moreover, the VA, DoD, and DHS will continue strong collaborative efforts (in partnership with other federal agencies) specified in the recently signed E.O. 13861, focusing on veteran suicide prevention.

Whether within the DoD or the VA, we know that the more Service members, veterans, and family members we can encourage to come forward during dark times, the better able we are to support them. The Military and Veteran Crisis Line is a state-of-the-art system, and the line generates 50 assessments of individual welfare every day. However, a client on a phone gives a

practitioner far less information than a face to face encounter, and it's therefore harder to make adequate judgments about imminent potential for harm to self or others, treatment, and disposition. So we're creating messaging with our VA partners that emphasizes that care for suicidality is available in emergency rooms, mental health departments, and in primary care clinics.

To be successful in these endeavors, we must also address the perceived stigma we know our Service members and veterans face when deciding if and when to get help. 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.

Gatekeepers are also a critical part of our solution for suicide. In a deployed setting, chaplains and mental health practitioners have a longstanding and critical alliance, with referrals between the practices both robust and nimble. Parent training by our base counselors and social workers has vast potential to support salutary outcomes for both military parents and military children, who form a large portion of our accession cohorts. We also have embedded Military Family Life Counselors to provide assistance to our members and families with an additional ability to "surge" if needed to locations where there is a heightened concern. Additionally, we are working with the Family Advocacy Program to ensure that families with children create safe environment—developing strategies with each family to secure poisons, medications, sharp objects, and firearms, and referrals from our community providers to our mental health system for mental health

conditions, imminent suicidality, and overdose potential. Drug overdoses are a commonly used method for suicide among Veterans and military Service Members. 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. The pillars of success are:

-Random drug testing for all Service members

-Pharmacy controls for all opiate medications

-Ready access to stepped pain care for all individuals (100% of SMs get medical care annually)

-Wide availability of the opiate reversal medication, naloxone

We are grateful for the opportunity to speak with you today and discuss the Department's suicide prevention efforts. This is a complex problem. The root causes vary from one individual to another, and the signs are often difficult to detect for friends and family members, and even for clinicians themselves. As is the case with all of the programs within our purview, this is a national and a global issue that no one has solved. If there were a single solution, we would have found it and implemented it already. But we will not rest. Many of you have heard us say it before, but it bears repeating; we must show as much commitment and dedication to the well-being of our Service members as they demonstrated on the day they stepped forward to volunteer and serve our country. We must meet that sacred obligation.

In closing, Chairwomen, we thank you, the Ranking members, and the members of your subcommittees for your steadfast dedication and support of the men, women, and their families who defend our great Nation.