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SERVICEMEMBER, FAMILY, AND VETERAN SUICIDES AND PREVENTION STRATEGIES

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BEFORE THE

SUBCOMMITTEE ON PERSONNEL

OF THE

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UNITED STATES SENATE

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CONTENTS

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WEDNESDAY, DECEMBER 4, 2019

UNITED STATES SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The Subcommittee met, pursuant to notice, at 3:19 p.m. in Room SR–222, Russell Senate Office Building, Senator Thom Tillis (chairman of the Subcommittee) presiding.

Committee Members present: Senators Tillis, McSally, Scott, and Gillibrand.

Other senators present: Senator Sullivan.

OPENING STATEMENT OF SENATOR THOM TILLIS

Senator TILLIS. The hearing will come to order.

Senate Armed Services Subcommittee on Personnel meets this afternoon to receive testimony about servicemember, family, and veteran suicides, and to learn about effective evidence-based suicide prevention strategies.

We're fortunate today to have a panel of experts from government and academia. We will hear from five witnesses: Captain Michael Colston, M.D., U.S. Navy, Director for Mental Health Programs for the Health Services Policy and Oversight Office at the Department of Defense (DOD); Dr. Orvis, Director, Defense Suicide Prevention Office for the Office of Force Resiliency at the Department of Defense; Dr. Miller, Acting Director of the Suicide Prevention Program at the Department of Veterans Affairs (VA); Dr. McKeon, Suicide Prevention Branch Chief, Center for Mental Health Services of Substance Abuse and Mental Health Services Administration (SAMHSA) at the Department of Health and Human Services (HHS); and Dr. Kessler, McNeil Family Professor of Health Care Policy, Department of Health Care Policy at the Harvard Medical School.

Thank you all for being here, and we're sorry we are a bit late.

Our topic today is a heavy one, one that is difficult to discuss, but we must address it to ensure the readiness and the well-being of our troops, their families, and veterans. Suicide is a homefront threat to servicemembers and veterans. Tragically, rates of suicide for Active Duty servicemembers and veteran populations have increased in the latest reports, particularly affecting young men under 30, who make up nearly half the military. Veteran suicide is a national epidemic. As a member of the Veterans Affairs Com-

mittee, working to reduce the number of veterans who die by suicide is one of my top priorities.

The Departments of Defense and Veterans Affairs have improved capacity and access to mental health and other services, yet the rates of suicide have not decreased. I see today as an opportunity to understand what more we can do as a subcommittee to take—make a positive impact in this area.

Military families are also affected by suicide. For the first time, the Department of Defense released data on suicides by spouses and dependents. I hope to hear more about how the DOD will track and support spouses and dependents affected by suicide in the future.

While suicide represents a growing public health challenge in the civilian world, the unique composition and mission of our military makes this challenge one of particular importance that we must address. Ensuring adequate care and support for servicemembers, families, and veterans facing stressors of deployments, transitions, financial difficulties, and access to healthcare, it must be a top priority.

I look forward to hearing from the DOD and VA witnesses on how they're developing evidence-based suicide prevention methods to combat the rise in suicides among servicemembers, veterans, and their families, and also from Dr. McKeon and Dr. Kessler about civilian suicide prevention research and methods and strategies that can help combat suicide in the military.

I want to thank all the witnesses for being here today. I look forward to your testimony.

I now turn to Ranking Member Gillibrand for an opening statement.

STATEMENT OF SENATOR KIRSTEN E. GILLIBRAND

Senator GILLIBRAND. Thank you, Chairman Tillis, for holding this important hearing.

Suicide in the military is a serious and growing problem. Not enough is being done to address the factors that contribute to this tragedy.

To all of our witnesses, welcome, and thank you for sharing your expertise with us today. Your insight of the prevalence and contributing factors of these suicides is crucial to helping our committee support our servicemembers.

I appreciate, Mr. Chairman, you inviting an expert from the Veterans Administration, as it's critical for us to understand the connections and distinctions between military and veteran suicides to be able to address both.

According to the 2019 Department of Defense Annual Suicide Report, the rate of suicide experienced by our servicemembers has steadily increased over the last 6 years, spiking in 2018 by over 6 percent from 2013. There's been a narrative for a long time that military suicide is due primarily to PTSD and combat missions, and we must take—and we must take the toll of combat on military members very seriously. But, the report clearly demonstrates that combat missions are not directly correlative to the servicemembers who die by suicide. Suicide is complex and individual.

There are a multitude of factors that lead to mental health challenges and can, in turn, lead to the devastation of suicide. Military service is very difficult. Our services—our servicemembers make sacrifices that are hard for some of us to even fathom. When Americans enter into military service, they lose control of where and how often they must relocate, the kind of housing they will live in, which schools their children will attend. It's often impossible to maintain a healthy work/life balance, and frequently our servicemembers are expected to sacrifice the needs of their families to accomplish a mission.

Our gratitude for their sacrifices isn't enough. We must also recognize the unique burdens that they face, and that those burdens can lead to persistent mental health challenges, like chronic anxiety and depression. And too often those mental health challenges can contribute to suicidal ideations.

Of course, some of the burdens are integral to the way of the military—to the way the military functions and to ensuring that our servicemembers learn critical skills and are prepared to serve in a war zone. But, it's incumbent upon the leaders in this committee to determine when such factors are problematic enough that a greater system of support must be provided. Military and civilian leaders also must determine when factors are most disruptive than is necessary to accomplish the mission, so that they can develop more appropriate strategies for today's military.

The military and the Department of Defense spend more and more each year on suicide prevention, but the results are not nearly good enough. I'd like to challenge our civilian and military leaders to think about military suicide in a more holistic way, understanding the factors that contribute to mental health challenges and to suicide. If the military is able to understand how the day-to-day stressors of serving can impact servicemembers, they can work to minimize those stressors based on mission requirements and create the systems of support servicemembers need to be successful.

This also means taking a real look at the existing systems of support. Currently, the Department of Defense has a policy that requires mental health professionals to report many cases of mental health concerns of servicemembers to a commander. This policy leads to mistrust and acts as a barrier to treatment, because servicemembers fear the repercussions to their career if they come forward with their mental health challenges.

Of course, DOD must have policies to keep their servicemembers and colleagues safe, but their standards for reporting mental health challenges are vague and go much further than the standards for civilian mental health professionals or even military chaplains. This policy is more likely to force servicemembers to suffer in silence, and does nothing to help commanders maintain good order and discipline. I urge the Department of Defense to review the reporting rules for mental health professionals to ensure that they are allowing for maximum confidentiality for our servicemembers while also protecting them from those around them. If we can eliminate the barriers that stand between our servicemembers and access to mental health care, I believe we can begin to make progress towards addressing our suicide rate.

Mr. Chairman, I look forward to hearing from our witnesses, and I'm committed to working with you, our colleagues on the committee, the military, the DOD, to further support our servicemembers and their well-being.

Senator TILLIS. Thank you, Senator Gillibrand.

We'll just start from left to right.

Dr. Orvis.

STATEMENT OF KARIN A. ORVIS, PH.D., DIRECTOR, DEFENSE SUICIDE PREVENTION OFFICE, OFFICE OF THE SECRETARY OF DEFENSE, DEPARTMENT OF DEFENSE

Dr. ORVIS. Chairman Tillis and Ranking Member Gillibrand, thank you for the opportunity to be—appear before you with our colleagues from VA, SAMHSA, and Harvard University.

With me today is my colleague, Captain Mike Colston, the Director of Mental Health Programs. Like you, we are very concerned about the suicide rates in our military, and we look forward to discussing the Department's suicide prevention efforts.

We are disheartened that the rates of suicide in our military are not going in the desired direction. The loss of every life is heartbreaking, and each one has a deeply personal story. With each death, we know there are families, and often children, with shattered lives. The DOD has the responsibility of supporting and protecting those who defend our country, and it's imperative that we do everything possible to prevent suicide in our military community.

Because data informs our ability to take meaningful steps and fulfill our commitment to transparency, the Department has expanded our reporting on suicide-related data. This past September, we published our first Annual Suicide Report, or ASR, to supplement our longstanding DOD Suicide Event Report. In brief, the calendar year 2018 suicide rates are consistent with the prior 2 years across all components. When compared to the past 5 years, the rates have been steady for the Reserve and the National Guard; however, we've seen a statistically significant increase for the Active component. 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. We continue to observe heightened risk for our youngest servicemembers and our National Guard members.

As part of the ASR, the Department published suicide data for our military family members for the first time. Suicide rates for our military spouses and dependents in calendar year 2017 were comparable to or lower than the U.S. population rates after accounting for age and sex. Based on the ASR findings, the Department must, and will, do more to target our areas of greatest concern—our young and enlisted members and our National Guard members—as well as continue to support our families.

We know suicide is a complex interaction of many factors, and our efforts must address the many aspects of life that impact suicide. We're committed to addressing suicide comprehensively through a public health approach.

Guided by the Defense Strategy for Suicide Prevention, the DOD has many ongoing and future efforts underway. These efforts sup-

port seven evidence-informed strategies, which include identifying and supporting people at risk, strengthening access and delivery of suicide care, teaching coping and problem-solving skills, creating protective environments, strengthening economic supports, and lessening harms and preventing future risk.

To provide a few examples, take for example identifying and supporting people at risk. We will be teaching young servicemembers how to recognize and respond to suicide red flags on social media to help others who might be showing warning signs.

With respect to strengthening access and delivery to suicide care, we're partnering with the VA to increase National Guard members' accessibility to mental health care via Mobile Vet Centers during drill weekends.

With respect to teaching coping and problem-solving skills, we are piloting an interactive educational program to teach foundational skills early in a member's career to help with everyday life stressors.

As a final example with respect to creating protective environments, we're developing a communications campaign to promote social norms for safe storage of firearms and medication to ensure family safety.

In our written testimony, we provide additional current efforts, as well as new promising practices we are piloting and evaluating that align to these seven strategies. I'm happy to discuss any of these in more detail. We also have developed an enterprise-wide program evaluation framework to better measure effectiveness of our suicide prevention efforts.

Partnerships are integral to reaching our goals. We work closely with the Federal, State, local, and other nongovernmental stakeholders to continue to enhance our toolkit and ensure availability of suicide prevention resources for our servicemembers and their families.

In closing, I thank you for your unwavering dedication to the support of our men, women, and families who defend our great Nation. I welcome your insights, your input, and your partnership. I fully recognize that we have more to do, and I take this charge incredibly seriously, and I look forward to your questions.

Senator TILLIS. Captain Colston.

STATEMENT OF CAPTAIN MICHAEL J. COLSTON, M.D., USN, DIRECTOR FOR MENTAL HEALTH PROGRAMS, HEALTH SERVICES POLICY AND OVERSIGHT OFFICE, DEPARTMENT OF DEFENSE

Dr. COLSTON. Chairman Tillis, Ranking Member Gillibrand, Members of the Subcommittee, thank you for the opportunity to discuss DOD's public health challenge: suicide. I'm honored to be here with our suicide prevention directors, our SAMHSA colleague, and Dr. Kessler.

Every life lost is a tragedy. As a physician and former line officer, I've been shaken by suicides, so let me discuss what I've seen.

Our military suicide rate was once low. When I was a resident at Walter Reed in 2001, our Active Duty suicide rate was half the rate of a similar population. But, like the rest of America, DOD has seen suicides increase. Even as we created a centralized suicide

prevention infrastructure and enlarged community care, our Active Duty suicide rate now approaches 25 per 100,000. The National Guard rate is yet higher.

So, what are we doing? First, we're being transparent. We've been working, over the past 10 years, to decrease the suicide rate, and clearly our rates show more needs to be done.

How might we reach our goal? By ensuring all evidence-based interventions for suicide are used and evaluated in regard to suicide outcomes.

Our VA/DOD Clinical Practice Guideline for Suicide Risk, shaped with me by co-champions Dr. Lisa Brenner, renowned VA suicidologist, and Dr. Amy Bell, chair of Army's Public Health Review Board, was recently refereed, published, and synopsized in the "Annals of Internal Medicine," found evidence for cognitive behavioral therapy, crisis response planning, and lethal-means restriction as avenues to prevent suicide. On the other hand, our evidence base remains thin. Many domains of intervention require evidence development, and the effect sizes of interventions are small. This means we need to treat a number of people with a treatment that's been proven to work to achieve a single changed outcome.

We need to translate public health successes from other domains into the management of suicide. DOD stemmed an opiate crisis in its ranks with evidence-based practice, achieving a death rate from intentional and accidental overdoses under one-fourth of the national rate, along with low rates of addiction and positive drug screens. Our public health effort included hard assessments of policies, pain protocols, screening, pharmacy controls, and training efficacy. Implemented policies and procedures stem from outcomes. Our efforts saved lives.

We need to continue work on precipitants of suicidal behavior. As a line officer, I found enlistees, like other young Americans, were easily separated from their money, placing them in financial peril. There are more ways for servicemembers to find trouble today. Despite our gains on drug abuse, the force still uses too much alcohol, and I never anticipated that mentoring sailors on safe relationships would be a leadership skill, but it remains so. We must rid our Nation of intimate-partner violence, sexual trauma, and child abuse. Our partners and kids are a source of strength, and our children sustain military culture.

Interventions we leverage now are critical. Veterans who get healthcare at VA die less by suicide. So, we aid transition into VA care as we share 130 clinical spaces. When I served at Lovell Federal Health Care Center in north Chicago, shared clinical spaces worked.

Finally, we'll stay focused on the people in front of us. The hopelessness of suicide can stem from a loss of belonging. All of us and our families can bring meaning to one another as we protect freedom worldwide.

Thank you. I look forward to answering your questions.

[The prepared joint statement of Dr. Karin A. Orvis and Dr. Colston follows:]

PREPARED JOINT STATEMENT BY DR. KARIN A. ORVIS AND DR. MIKE COLSTON

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 servicemembers 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 calendar year 2018 suicide rates are consistent with rates from the past 2 years across the military (for the Active component, Reserve, and National Guard), and have been steady over the past 5 years for the Reserve and National Guard. However, we have seen a statistically significant increase in the Active component over the past 5 years (since 2013). In calendar year 2018, there were 541 servicemembers 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, servicemembers 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 calendar year 2017, which is the most recent data available on military family members. Suicide rates for military spouses and dependents in calendar year 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 servicemembers, and members of the Na-

tional Guard—and continue to support to our military families. Specific initiatives include:

- *Young and Enlisted Servicemembers:* 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 servicemembers how to recognize and respond to suicide "red flags" on social media—to help servicemembers recognize how they can reach out to help others who might show warning signs.
- *National Guard Members:* National Guard servicemembers 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 servicemembers who are not eligible for other VA services. We are also working closely with the 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 servicemembers 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 servicemembers 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 servicemembers 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 servicemembers; pharmacy controls for all opiate medications; ready access to stepped pain care for all individuals (100 percent of servicemembers 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 servicemembers face when deciding if and when to get help to be successful in suicide prevention. Among servicemembers 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 percent of servicemembers 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 servicemembers (e.g., career and security clearance loss concerns, loss of privacy and confidentiality), and encourage servicemembers 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 10 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 servicemembers 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 servicemembers at this formative stage in life, may normalize how servicemembers 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 servicemembers at risk of suicide by teaching young servicemembers 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 installa-

tion-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, servicemembers, 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 servicemembers. 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 servicemembers 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 servicemembers 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 servicemembers 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 servicemember 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.

Senator TILLIS. Thank you.

Dr. Miller.

STATEMENT OF MATTHEW A. MILLER, PH.D., ACTING DIRECTOR, SUICIDE PREVENTION PROGRAM, DEPARTMENT OF VETERANS AFFAIRS

Dr. MILLER. Good afternoon, Chairman Tillis, Ranking Member Gillibrand.

I'd like to submit this letter, written by the Secretary of the VA, for the record, if I may.

Senator TILLIS. Without objection.

[The information referred to follows:]

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

December 3, 2019

The Honorable Thom Tillis
Chairman
Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Suicide is a national public health crisis that disproportionately affects those who served in the Armed Forces. Preventing suicide among Veterans remains the Department of Veterans Affairs (VA) top clinical priority. The Veterans Health Administration helps Veterans establish and maintain a healthy, whole life balance to empower them to live their fullest lives. But we cannot do this alone. Although we have partnered with the Department of Defense and the Department of Health and Human Services, we continue to call on community partners to join us in this growing national effort.

Sixty percent of Veterans who die from suicide have no relationship with VA. To reach them, VA is calling for a national effort where Government expands and deepens relationships with appropriate and qualified community partners who can find Veterans where they live, facilitate the proper level of triage and clinical support, then, wherever necessary, refer eligible Veterans to the VA for follow on services. There are community entities large and small who do this well in urban and rural communities. The feedback from basic reporting from these community encounters and the aid provided to Veterans can help us understand methods and best practices for Veterans. We can also use the data to better understand how such programs may help non-Veterans who are at risk of suicide.

VA sees Congress as an ally in enabling VA to reach vulnerable Veterans. The Improve Well-Being for Veterans Act (S. 1906 and H.R. 3495) would authorize VA to award financial assistance to eligible entities through a pilot program of grants that will provide and coordinate services to Veterans and their families to reduce the risk of suicide among Veterans. This grant model is based on VA's Supportive Services for Veteran Families program. In addition, the legislation would require VA to consult with Veterans Service Organizations and various national, state, and local organizations on the operational design and implementation of this proposed grant program. This common-sense approach could help us reach many more Veterans at risk in the years to come.

Thank you for your continued support of our mission.

Very well done, RLW

Sincerely,

Robert L. Wilkie

Robert L. Wilkie

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

December 3, 2019

The Honorable Kirsten Gillibrand
Ranking Member
Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

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Thank you for your continued support of our mission.

Sincerely,

Robert L. Wilkie

Robert L. Wilkie

Dr. MILLER. I appreciate the opportunity you have both created——

[Audio malfunction.]

Dr. MILLER.—deaths of my fellow veterans to suicide. I'm honored to be in attendance today among this distinguished panel as part of our collaborative efforts addressing veteran suicide.

Within my position, I'm often asked "Why?" in the context of suicide. I've asked this question myself for several years after losing my friend and my colleague, a Marine Cobra driver, to suicide during OEF/OIF [Operation Enduring Freedom/Operation Iraqi Freedom]. In my quest to learn what I may have done wrong or what I may have missed with John, it's become clear to me that suicide is a complex issue, with no single cause. Beyond, it's a national

issue that affects people from all walks of life, not just veterans and servicemembers. Suicide is often the result of a complicated combination of risk and protective factors at the personal, communal, and societal levels. Thus, I have wholeheartedly signed on to fully commit heart and mind to the secretaries, to the executive in charge, and to the VA's top clinical priority: suicide prevention.

In response and in daily action, the VA is implementing a comprehensive public health approach to reach all veterans, including those who do not receive VHA [Veterans Health Administration] health services. In this context, we look to the 2019 National Veteran Suicide Annual Report to inform our current situational awareness.

One of the key ways in which this year's report is different from those in prior year is that it places veteran suicide in the broader context of suicide deaths in America. From the report, we know that the suicide rate is alarmingly rising in and across our Nation. The average number of adult suicides per day rose from 86.6 in 2005 to 124.4 in 2017. These numbers included 15.9 veteran suicides per day in 2005 and 16.8 per day in 2017. We know that suicide is one of the leading causes of death in the United States. As the father of four young daughters, the fact that suicide has become the second leading cause of death within their current age demographic is difficult for me to even comprehend.

Amidst the haunting questions and the daunting data, there is hope. Although the rates of suicide are increasing across the Nation, we know that the rate of suicide is rising more slowly for veterans engaged in VHA care compared to those not engaged in care. We know that depression and suicide all too often share a tragic relationship, but suicide rates have meaningfully decreased among veterans with a diagnosis of depression and who are engaged in recent VHA care. This rate of decrease translates to 87 veteran lives saved in 2017, compared to 2016. Although female veterans are at higher risk for suicide than their nonveteran peers, there was not an increase in suicide among female veterans with recent VHA care, compared to the rising rate of suicide in female veterans not recently using VHA services.

We know that evidence-based treatments can effectively address suicide. The VA is, therefore, a national leader in advancing best practice in universal screening for suicide, as well as same-day access in mental health and primary care services. Over 4 million veterans have been screened for suicide within the last year alone. Over 1 million same-day-access mental health appointments have been fulfilled in 2018.

We know that providing around-the-clock, unfailing access to suicide crisis prevention services is meaningful. Often, the time between the decision to enact suicide and suicide attempt or death can be as brief as 50 to 60 minutes. The VA, therefore, has become the worldwide leader in the provision of crisis services through the Veterans and Military Crisis Line, 1800 calls per day answered within an astounding average of 8 seconds.

Amidst positive anchors of hope and progressive actions, we fully acknowledge and commit to the fact that more must be done in the name of suicide prevention. The mission is obviously and painfully far from complete. One life lost to suicide is one too many. We,

therefore, appreciate this committee's partnership with the VA, DOD, and beyond to facilitate crosscutting and silo-breaking evidence-based clinical and community suicide prevention strategies.

This concludes my testimony. I'm prepared to answer any questions.

[The prepared statement of Dr. Miller follows:]

PREPARED STATEMENT BY MATTHEW MILLER, PHD, MPH

Good afternoon, Chairman Tillis, Ranking Member Gillibrand, and Members of the subcommittee. I appreciate the opportunity to discuss the critical work VA is undertaking to prevent suicide among our Nation's veterans. I am pleased to be in attendance with Dr. Karin Orvis and CAPT Michael Colston of the U.S. Department of Defense (DOD), Dr. Ronald C. Kessler, a McNeil Family Professor of Health Care Policy of Harvard Medical School, and Dr. Richard McKeon, the Director, Mental Health Services of the Substance Abuse Mental Health Services Administration.

INTRODUCTION

Suicide is a complex issue with no single cause. It is a national public health issue that affects people from all walks of life, not just veterans. Suicide is often the result of a multifaceted interaction of risk and protective factors at the individual, community, and societal levels. Thus, VA has made suicide prevention our top clinical priority and is implementing a comprehensive public health approach to reach all veterans—including those who do not receive VA benefits or health services.

Our promise to veterans remains the same: to promote, preserve, and restore veterans' health and well-being; to empower and equip them to achieve their life goals; and to provide state-of-the-art treatments. Veterans possess unique characteristics and experiences related to their military service that may increase their risk of suicide. They also tend to possess skills and protective factors, such as resilience or a strong sense of belonging to a group. Our Nation's veterans are strong, capable, valuable members of society, and it is imperative that we connect with them early as they transition into civilian life, facilitate that transition, and support them over their lifetime.

The health and well-being of the Nation's men and women who have served in uniform is the highest priority for VA. VA is committed to providing timely access to high-quality, recovery-oriented, evidence-based health care that anticipates and responds to veterans' needs and supports the reintegration of returning servicemembers wherever they live, work, and thrive.

These efforts are guided by the National Strategy for Preventing Veteran Suicide. Published in June 2018, this 10-year strategy provides a framework for identifying priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among veterans through a broad public health approach with an emphasis on comprehensive, community-based engagement. This approach is grounded in four key focus areas as follows:

- Primary prevention that focuses on preventing suicidal behavior before it occurs;
- Whole Health offerings that consider factors beyond mental health, such as physical health, social connectedness, and life events;
- Application of data and research that emphasizes evidence-based approaches that can be tailored to fit the needs of veterans in local communities; and
- Collaboration that educates and empowers diverse communities to participate in suicide prevention efforts through coordination.

Through the National Strategy we are implementing broad, community-based prevention initiatives, driven by data, to connect veterans in and outside our system with care and support at both the national and local facility levels.

VA AND DOD VETERAN SUICIDE DATA TRACKING AND REPORTING

The veteran and non-veteran U.S. population is changing. The overall population is increasing while the veteran population is decreasing over time. Still, suicide is one of the leading causes of death in the U.S. In 2017, 45,390 American adults died from suicide, including 6,139 U.S. veterans.

Each year, VA and DOD produce separate annual reports on veteran and current servicemember suicide mortality, respectively. VA and DOD partner in preventing suicide for all current and former servicemembers, but do not use the same data sources for suicide surveillance reporting, with VA reporting on veterans and former

servicemembers, and DOD reporting on current servicemembers. This allows VA's report to focus on former servicemembers who most closely meet the official definition of veteran status that is used by VA and other Federal agencies. For this report, a veteran is defined as someone who had been activated for Federal military service and was not currently serving. In addition, the report includes information in a separate section on suicide among former National Guard or Reserve members who were never Federally activated.

For VA suicide surveillance reporting, VA and DOD partner to submit a search list of all identified current and former servicemembers to the Centers for Disease Control and Prevention's (CDC) National Death Index (NDI) each fall. After processing, which can take several months, NDI returns all potentially matching mortality information. Additionally, internal processing and coordination occurs between VA and DOD to identify veteran and servicemember deaths, finalize mortality information, conduct statistical analyses, and interpret results.

Due to the different data sources, DOD data on mortality among current servicemembers is available in a more timely fashion. DOD uses the Armed Forces Medical Examiner System (AFMES) as its data source for current Active Duty servicemember suicide mortality information. A data source similar to AFMES is not available to VA, so VA relies on national reporting to identify dates and causes of death per State death certificates, through NDI, which are reported up through local medical examiners and coroners to respective states and territories.

VA 2019 National Veteran Suicide Prevention Annual Report

The 2019 National Veteran Suicide Prevention Annual Report is VA's most recent analysis of veteran suicide data from 2005 to 2017. It reflects the most current national data available through CDC's 2017 NDI.

One of the key ways in which this year's report is different is that it sets veteran suicide in the broader context of suicide deaths in America and the complex cultural context of suicide. From the report, we know the average number of suicides per day among U.S. adults rose from 86.6 in 2005 to 124.4 in 2017. These numbers included 15.9 veteran suicides per day in 2005 and 16.8 in 2017. The report highlights suicide as a national problem affecting veterans and non-veterans, and VA calls upon all Americans to come together to take actions to prevent suicide.

The data presented in the report is an integral part of VA's comprehensive public health strategy and enables VA to use tailored suicide prevention initiatives to reach various veteran populations. The report includes a section on key initiatives that have been developed since 2017 to reach all veterans. The report is designed for action based upon a stratification with the public health classification of universal (all), selective (some), and indicated (few) population framework as noted in National Strategy.

When we look at our data, there are indicators that trends among veterans in VA care offer anchors of hope that we can continue to build upon. For example, suicide rates among veterans in recent VHA care, (veterans who had a VHA health encounter in the calendar year of interest or in the prior calendar year), with a diagnosis of depression have decreased from 70.2 per 100,000 in 2005 to 63.4 per 100,000 in 2017. After adjusting for age and sex, between 2016 and 2017, the suicide rate among veterans in recent VHA care increased by 1.3 percent while increasing by 11.8 percent among veterans who did not use VHA care. We have seen a notable increase in women veterans coming to us for care. Women are the fastest-growing veteran group, comprising about 9 percent of the U.S. veteran population, and that number is expected to rise to 15 percent by 2035. Although women veteran suicide counts and rates decreased from 2015 to 2016 and did not increase for women veterans in VHA care between 2016 and 2017, women veterans are still more likely to die by suicide than non-veteran women.

This data underscores the importance of our programs for this population. VA is working to tailor services to meet their unique needs and has put a national network of Women's Mental Health Champions in place to disseminate information, facilitate consultations, and develop local resources in support of gender-sensitive mental health care.

Efforts are already underway to better understand this population and other groups that are at elevated risk, such as never Federally-activated Guard and Reserve members, recently separated veterans, and former servicemembers with Other Than Honorable (OTH) discharges.

We need to consider the social determinants of health, defined broadly as well-being, and look at how things like economic disparities, homelessness, and social isolation may create a context that markedly increases someone's risk. Veterans who are employed, have a stable place to live, and are affiliated with a community

of veterans and others for support are more likely than others to be optimistic about their future.

For all groups experiencing a higher risk of suicide, including women, VA also offers a variety of mental health programs such as outpatient services, residential treatment programs, inpatient mental health care, telemental health, and specialty mental health services that include evidence-based therapies for conditions such as post-traumatic stress disorder (PTSD), depression, and substance use disorders. While there is still much to learn, there are some things that we know for sure: suicide is preventable, treatment works, and there is hope.

EVIDENCE-BASED SUICIDE PREVENTION STRATEGIES

VA–DOD Collaboration for Suicide Prevention Among servicemembers in Transition

VA collaborates closely with DOD to provide a single system experience of lifetime services for the men and women who volunteer to serve in our Military Services. Our partnership with DOD and the Department of Homeland Security (DHS) is exemplified by the successful implementation of Executive Order (EO) 13822, Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life. EO 13822 was signed by President Trump on January 9, 2018. The EO focused on transitioning servicemembers (TSM) and veterans in the first 12 months after separation from service, a critical period marked by a high risk for suicide.

The EO mandated the creation of a Joint Action Plan by DOD, DHS, and VA for providing TSMs and veterans with seamless access to mental health treatment and suicide prevention resources in the year following discharge, separation, or retirement. VA provides several outreach programs and services that facilitate enrollment of veterans who may be at risk for mental health needs, to include VA liaisons stationed at 21 military medical treatment facilities (MTF) as well as multiple outreach programs to support enrollment in mental health services at VA or in the community. The Joint Action Plan was accepted by the White House and published in May 2018, and has been under implementation since that time. All 16 tasks outlined in the Joint Action Plan are on target for full implementation and 10 out of the 16 items are completed and in data collection mode. Some of our early data collection efforts point towards an increase in TSM and veteran awareness and knowledge about mental health resources, increased facilitated health care registration, and increased engagement with peers and community resources through the Transition Assistance Program (TAP) and Whole Health offerings. TAP curriculum additions and facilitated registration have shown that in the third quarter of fiscal year 2019, 86 percent of 11,226 TSM respondents on the TAP exit survey reported being informed about mental health services.

VA and DOD are united by a shared goal: to deliver compassionate support and care, whenever and wherever a servicemember or veteran needs it. This includes collaborating to implement programs that facilitate enrollment and transition to VA health care; increasing availability and access to mental health resources; and decreasing negative perceptions of mental health problems and treatment for servicemembers, veterans, and providers. Through the coordinated efforts of VA, DOD, and DHS, the following actions took place:

- Any newly-transitioned veteran who is eligible can go to a VA medical center (VAMC), Vet Center, or community provider, and VA will connect them with mental health care if they need it;
- In December 2018, VA mailed approximately 400,000 outreach letters to former servicemembers with OTH discharges to inform them that they may receive emergent mental health care from VA, and certain former servicemembers with OTH discharges are eligible for mental health care for conditions incurred or aggravated during Active Duty service;
- Some DOD resources available to servicemembers, such as Military OneSource, is now available to veterans for 1 year following separation; and
- Veterans will also be able to receive support through VA partners and community resources outside of VA, like veteran service organizations (VSO).

EO 13822 was established to assist in preventing suicide in the first year post transition from service; however, the completed and ongoing work of the EO impacts suicide prevention efforts far beyond its first year through increasing coordinated outreach, improving monitoring, increasing access, and focusing beyond just the first year post transition and into the years following transition. VA is working diligently to promote wellness, increase protection, reduce mental health risks, and promote effective treatment and recovery as part of a holistic approach to suicide prevention.

Public Health Approach to Suicide Prevention

Maintaining the integrity of VA's mental health care system is vitally important, but it is not enough. We know that some veterans may not receive any or all of their health care services from VA, for various reasons, and we want to be respectful and cognizant of those choices. This highlights that VA alone cannot end veteran suicide.

As VA expands its suicide prevention efforts into a public health approach while maintaining its crisis intervention services, it is important that VA revisit its own infrastructure and adapt to ensure it can lead and support this effort. VA has examined every aspect of the problem, looking at it through the lens of each subgroup, level, and model, and VA is putting changes into place that leverage thoughtful investments of new practices, approaches, and additional staffing models. It is only through this multi-pronged strategy that VA can lead the Nation in truly deploying a well-rounded, public health approach to preventing suicide among veterans.

Preventing suicide among all of the Nation's 20 million veterans cannot be the sole responsibility of VA; it requires a Nation-wide effort. Just as there is no single cause of suicide, no single organization can tackle suicide prevention alone. VA developed the National Strategy with the intention of it becoming a document that could guide the entire Nation. It is a plan for how everyone can work together to prevent veteran suicide.

Suicide prevention requires a combination of programming and the implementation of strategies and initiatives at the universal, selective, and indicated levels. This "All-Some-Few" strategic framework allows VA to design effective programs and interventions appropriate for each group's level of risk. Not all veterans at risk for suicide will present with a mental health diagnosis, and the strategies below employ a variety of tactics to reach all veterans:

- Universal strategies aim to reach all veterans in the U.S. These include public awareness and education campaigns about the availability of mental health and suicide prevention resources for veterans, promoting responsible coverage of suicide by the news media, and creating barriers or limiting access to hotspots for suicide, such as bridges and train tracks;
- Selective strategies are intended for some veterans who fall into subgroups that may be at increased risk for suicidal behaviors. These include outreach targeted to women veterans or veterans with substance use disorders, gatekeeper training for intermediaries who may be able to identify veterans at high-risk, and programs for veterans who have recently transitioned from military service; and
- Indicated strategies are designed for the relatively few individual veterans identified as having a high risk for suicidal behaviors, including some who have made a suicide attempt.

Current VA efforts regarding lethal means safety highlight this model. From education on making the environment safer for all, to training on how to increase effective messaging around firearms in rural communities, to the creation of thoughtful interventions around lethal means safety by clinicians when someone is in crisis, the "All-Some-Few" framework permeates the work that we do.

Guided by this framework and the National Strategy, VA is creating and executing a targeted communications strategy to reach a wide variety audiences. Our goals include the following:

- Implementing research-informed communication efforts designed to prevent veteran suicide by changing knowledge, attitudes, and behaviors;
- Increasing awareness about the suicide prevention resources available to veterans facing mental health challenges, as well as their families, friends, community partners, and clinicians;
- Educating partners, the community, and other key stakeholders (e.g., media and entertainment industries, other government organizations) about the issue of veteran suicide and the simple acts we can all take to prevent it;
- Promoting responsible media reporting of veteran suicide, accurate portrayals of veteran suicide and mental illnesses in the entertainment industry, and the safety of online content related to veteran suicide;
- Explaining VA's public health approach to suicide prevention and how to implement it at both the national and local level; and
- Increasing the timeliness and usefulness of data relevant to preventing veteran suicide and getting it into the hands of intermediaries who can save veterans' lives.

PROMOTING VA SUICIDE PREVENTION AND MENTAL HEALTH SERVICES

VA is dedicated to designing environments and resources that work for veterans so that people find the right care at the right time before they reach a point of cri-

sis. Established in 2007, the Veterans Crisis Line provides confidential support to veterans in crisis. Veterans, as well as their family and friends, can call, text, or chat online with a caring, qualified responder, regardless of eligibility or enrollment for VA. VA is dedicated to providing free and confidential crisis support to veterans 24 hours a day, 7 days a week, 365 days a year. However, we must do more to support veterans before they reach a crisis point, which is why we are working with internal partners like VA's Homeless Program Office and Office of Patient Centered Care and Cultural Transformation in their deployment of Whole Health initiatives, as well as with multiple external partners and organizations. In an effort to increase resiliency, VA must empower and equip veterans, through internal and external partners like these to take charge of their health and well-being and to live their life to the fullest.

VA acknowledges and appreciates Congress as an important ally in reaching vulnerable veterans. The Improve Well-Being for Veterans Act, *(S. 1906,* and its companion bill, H.R. 3495), would require VA to provide financial assistance to eligible entities approved under this section through the award of grants to provide and coordinate the provision of services to veterans and veteran families to reduce the risk of suicide. This grant model is premised on VA's Supportive Services for Veteran Families (SSVF) program. The proposed legislation modifies elements of the SSVF program to address the suicide epidemic among veterans. In addition, the legislation would require VA to consult with VSOs and various national, State, and local organizations on the selection criteria, metrics, and plan for the design and implementation of this new grant program.

There is no single medical or clinical diagnosis that is all-encompassing to identify persons at risk from suicide. The Department and its stakeholders, including Congress, seek to position this type of "closest to the veteran" community level engagement between grantees and veterans. VA recognizes that suicidal propensities are not simply associated with a mental health disorder but can be brought on by other factors such as the following: financial instability, loss of a loved one, loss of freedom, divorce or separation, homelessness, addiction, or other factors not medical in nature. Community partners and services may be in a better position to identify and help veterans with these risk factors or concerns. This grant program aims to use partners within a veteran's community to help prevent suicides and focus on the root causes, rather than when a veteran is in crisis.

Veterans must also know how and where they can reach out and feel comfortable asking for help. VA relies on proven tactics to achieve broad exposure and outreach while also connecting with hard-to-reach targeted populations. Our target audiences include, but are not limited to, women veterans; male veterans age 18 to 34; former servicemembers; men age 55 and older; veterans' loved ones, friends, and family; organizations that regularly interact with veterans where they live and thrive; and the media and entertainment industry, who have the ability to shape the public's understanding of suicide, promote help-seeking behaviors, and reduce suicide contagion among vulnerable individuals.

VA uses an integrated mix of outreach and communications strategies to reach audiences. We proactively engage partners to help share our messages and content, including Public Service Announcements (PSA) and educational videos, and we also use paid media and advertising to increase our reach.

Through the Clay Hunt SAV Act (Public Law 114–2), VA instituted the pilot peer support community outreach program to engage veterans in care. The program commenced in January 2016. As of September 31, 2018, ten Veterans Integrated Service Networks (VISN) (6, 7, 9, 15, 16, 17, 19, 20, 22, and 23) had pilot programs and community partnerships in place. A final report on the pilot programs was sent to Congress on January 3, 2019.

Outreach efforts include care enhancements for at-risk veterans, the #BeThere campaign, and in partnership with Johnson & Johnson, releasing a PSA titled "No Veteran Left Behind," featuring Tom Hanks through social media. VA continues to use the #BeThere Campaign to raise awareness about mental health and suicide prevention and educate veterans, their families, and communities about the suicide prevention resources available to them.

During Suicide Prevention Month 2019, VA's #BeThere campaign reminded audiences that everyone has a role to play in preventing veteran suicide. It also emphasized that even small actions of support can make a big difference for someone going through a challenging time and can ultimately help save a life. Through shareable content and graphics, VA reached over 200 partners and potential partners through a news bulletin and quarterly newsletter emails. In partnership with Twitter, a custom icon—an orange awareness ribbon—was linked to the #BeThere hashtag in tweets. This positioned veterans as part of the global Twitter conversation about Suicide Prevention Month. Veteran-specific posts that used the #BeThere hashtag

had almost 84 million potential impressions. Government agencies, VSOs, and VA partners were among the many organizations that used #BeThere during September. Examples of accounts with a significant number of followers that used #BeThere included the following:

- U.S. Department of Defense (@DeptofDefense)—5.9 million followers;
- U.S. Army (@USArmy)—1.4 million followers;
- U.S. Department of Health and Human Services (@HHSGov)—781,000 followers; and
- Senator Tammy Duckworth (@SenDuckworth)—555,000 followers.

As noted earlier, data is integral to our strategy and interventions, including our outreach approach. Each element of our strategy is designed to drive action; these elements are intended to be collectively, and wherever possible, individually measurable so that VA can continually assess results and modify approaches for optimum effect.

We are leveraging new technologies and working with partners on social media events while continuing our digital outreach through online advertising. However, VA also continues to rely on our traditional partners like VSOs, non-profit organizations, and private companies to help us spread the word through their person-to-person and online networks.

VA's premier and award-winning digital mental health literacy and anti-stigma resource, Make the Connection (www.MakeTheConnection.net), highlights veterans' true and inspiring stories of mental health recovery and connects veterans and their family members with local VA and community mental health resources. Over 600 videos from veterans of all eras, genders, and backgrounds are at the heart of the Make the Connection campaign. The resource was founded to encourage veterans and their families to seek mental health services (if necessary), educate veterans and their families about the signs and symptoms of mental health issues, and promote help-seeking behavior in veterans and the general public.

With more than 593,000 visits to more than 180,000 veterans in fiscal year 2018, VA is a national leader in providing telemental health services —defined as the use of video teleconferencing or telecommunications technology to provide mental health services. This is a critical strategy to ensure all veterans, especially rural veterans, can access mental health care when and where they need it. VA offers evidence-based telemental health care to rural and underserved areas through 11 regional hubs, expert consultation for patients through the National Telemental Health Center, and telemental health services between any U.S. location—into clinics, homes, mobile devices, and non-VA sites through VA Video Connect, an application (app) that promotes 'Anywhere to Anywhere' care.

VA also offers tablets for veterans without the necessary technology to promote engagement in care. VA's goal is that all VA outpatient mental health providers will be capable of delivering telemental health care to veterans in their homes or other preferred non-VA locations by the end of fiscal year 2020.

VA has deployed a suite of 16 award-winning mobile apps supporting veterans and their families by providing tools to help them manage emotional and behavioral concerns. These apps are divided into two primary categories—those for use by veterans to support personal work on issues (such as coping with PTSD symptoms or smoking cessation) and those used with a mental health provider to support veterans' use of skills learned in psychotherapy. Enabling veterans to engage in on-demand, self-help before their problems reach a level of needing professional assistance can be empowering to veterans and their families. It also supports VA's commitment to be there whenever veterans need us. In fiscal year 2018, VA's apps were downloaded 700,000 times.

VA is also working with Federal partners, as well as State and local governments, to implement the National Strategy. In March 2018, VA, in collaboration with the Department of Health and Human Services, introduced the Mayor's Challenge with a community-level focus, and earlier this year, debuted the Governor's Challenge to take those efforts to the State level. The Mayor's and Governor's Challenges allow VA to work with 7 governors (from Arizona, Colorado, Kansas, Montana, New Hampshire, Texas, and Virginia) and 24 local governments, chosen based on veteran population data, suicide prevalence rates, and capacity of the city or state to develop plans to prevent veteran suicide, again with a focus on all veterans at risk of suicide, not just those who engage with VA.

On March 5, 2019, EO 13861, *National Roadmap to Empower Veterans and End Suicide,* was signed to improve the quality of life of our Nation's veterans and develop a national public health roadmap to lower the veteran suicide rate. EO 13861 mandated the establishment of the Veterans Wellness, Empowerment, and Suicide Prevention Task Force to develop the President's Roadmap to Empower Veterans

and End a National Tragedy of Suicide (PREVENTS) and the development of a legislative proposal to establish a program for making grants to local communities to enable them to increase their capacity to collaborate with each other to integrate service delivery to veterans and to coordinate resources for veterans. The focus of these efforts is to provide veterans at risk of suicide support services, such as employment, health, housing, education, social connection, and to develop a national research strategy for the prevention of veteran suicide.

This EO implementation will further VA's efforts to collaborate with partners and communities Nation-wide to use the best available information and practices to support all veterans, whether or not they are engaging with VA. This EO, in addition to VA's National Strategy, further advances the public health approach to suicide prevention by leveraging synergies and clearly identifying best practices across the Federal Government that can be used to save veterans' lives.

The National Strategy is a call to action to every community, organization, and system interested in preventing veteran suicide to help do this work where we cannot. For this reason, VA is leveraging a network of more than 60 partners in the public, private, and non-profit sectors to help us reach veterans where they live, work, and thrive, and our network is growing weekly. For example, VA and PsychArmor Institute have a non-monetary partnership focused on creating online educational content that advances health initiatives to better serve veterans. Our partnership with PsychArmor Institute resulted in the development of the free, online S.A.V.E. (Signs, Ask, Validate, and Encourage and Expedite) training course that enables those who interact with veterans to identify signs that might indicate a veteran is in crisis and how to safely respond to and support a veteran to facilitate care and intervention. Since its launch in May 2018, the S.A.V.E. training has been viewed more than 18,000 times through PsychArmor's internal and social media system and 385 times on PsychArmor's YouTube channel. S.A.V.E. training is also mandatory for VA clinical and non-clinical employees. Ninety-three (93) percent of VA staff are compliant with their assigned S.A.V.E. or refresher S.A.V.E. trainings since December 2018. This training continues to be used by VA's suicide prevention coordinators at VA facilities Nation-wide, as well as by many of our VSOs [veteran service organizations].

CONCLUSION

VA's goal is to meet veterans where they live, work, and thrive and walk with them to ensure they can achieve their goals, teaching them skills, connecting them to resources, and providing the care needed along the way. Through open access scheduling, community-based and mobile Vet Centers, app-based care, telemental health, more than 400 suicide prevention coordinators Nation-wide, and more, VA is providing care to veterans when and how they need it. We want to empower and energize communities to do the same for veterans who do not use VA services. We are committed to advancing our outreach, prevention, empowerment, and treatment efforts, to further restore the trust of our veterans every day and continue to improve access to care. Our objective is to give our Nation's veterans the top-quality experience and care they have earned and deserve. We appreciate this Committee's continued support and encouragement as we identify challenges and find new ways to care for veterans.

This concludes my testimony. I am prepared to answer any questions you may have.

Senator TILLIS. Thank you.

Dr. McKeon.

STATEMENT OF RICHARD MCKEON, PH.D., SUICIDE PREVENTION BRANCH CHIEF, CENTER FOR MENTAL HEALTH SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. MCKEON. Chairman Tillis, Ranking Member Gillibrand, Members of the Subcommittee, thank you for inviting SAMHSA to participate in this important hearing on suicide prevention.

An American dies by suicide every 11 minutes. Suicide is the tenth leading cause of death in the United States and the second leading cause of death between ages 10 and 34. We've lost over

47,000 Americans to suicide in 2017, almost the same number we lost to opioid overdoses. For each of these tragic deaths, there are grief-stricken families and friends, impacted workplaces and schools, and a diminishment of our communities. The National Survey on Drug Use and Health has also shown that approximately 1.4 million American adults reported attempting suicide each year, and over 10 million adults report seriously considering suicide.

Our concern is intensified by the CDC's report that suicide has been increasing in 49 of the 50 States, with 25 of the States experiencing increases of more than 30 percent. These increases have been taking place among both men and women and across the life span. While Federal efforts to prevent suicide have been steadily increasing over time, thus far they have been insufficient to halt this tragic rise. We know that our efforts must engage multiple sectors, including healthcare, schools, workplaces, faith communities, and many others.

We have seen that concerted coordinated efforts can save lives. Evaluation of SAMHSA's Youth Suicide Prevention Grants has shown that counties with grant-supported youth suicide prevention activities had fewer youth suicides than matched counties that were not. The greatest impact was in counties that had the longest period of sustained funding for their suicide prevention efforts.

This underscores the need to embed suicide prevention in the infrastructure of States, local government, and tribal communities. In the White Mountain Apache Tribe in Arizona, youth suicide was reduced by almost 40 percent. In that community, youth who are experiencing suicidal thoughts, wherever they may be on the reservation, will be seen rapidly by a trained Apache community worker.

SAMHSA also provides grants to support the Zero Suicide Initiative. Zero Suicide is a package of interventions that uses the most recent evidence-based science on screening, risk assessment, collaborative safety planning, care protocols, treatments, and care transitions. It's inspired by the success of the Henry Ford Health Care System and reducing suicide by more than 60 percent. Centerstone, in Tennessee, has shown similar results. The State of Missouri achieved a 32-percent decrease in suicide deaths among clients served in community behavioral health centers.

SAMHSA has also been working to improve follow-up after discharge from inpatient psychiatric units and emergency rooms. In a study of youth on Medicaid in 33 States who had been admitted to a psychiatric hospital, the odds of death by suicide was 76 percent lower for youth who had a mental health visit within 30 days of discharge.

NIMH's [National Institute for Mental Health] ED–SAFE study demonstrated that rapid telephonic follow-up after emergency department discharge reduced the number of suicide attempts. Similarly, the VA's SAFE VET study showed that a combination of collaborative safety planning in the emergency department and rapid telephonic follow-up reduced suicide attempts and increased linkage to VA care.

The ED–SAFE study showed that universal screening for suicide risk in emergency rooms led to a doubling of the identification of people experiencing suicidal thoughts. And those that were identi-

fied were at equivalent risk to those being seen in the emergency room because of known suicide risk.

The SAMHSA Suicide Prevention Program that touches the greatest number of people is the National Suicide Prevention Lifeline, a network of over 165 crisis centers across the country that answers calls to the 800–273–TALK number through which the Veterans Crisis Line and the Military Crisis Line can be accessed by pressing "1." Last year, more than 2.2 million calls were answered. Evaluation studies have shown that callers to the Lifeline experience decreased suicidal thoughts and hopelessness by the end of the call. SAMHSA, the VA, and the FCC [Federal Communications Commission] have worked together to implement the National Suicide Hotline Improvement Act, and the FCC has recommended that the number 988 be assigned as a new National Suicide Prevention Hotline number.

SAMHSA and VA have worked together to fund a series of mayors' and Governors' challenges to prevent suicide among all veterans, servicemembers, and their families. SAMHSA and VA have convened cities and States for policy academies to promote comprehensive suicide prevention.

We believe that this type of strong interdepartmental effort that incorporates States and communities as partners is necessary to reduce veteran suicide. SAMHSA, VA, and DOD also work together through the Federal Working Group on Suicide Prevention as well as through the National Action Alliance on Suicide Prevention.

SAMHSA and the entire Federal Government is engaged in an unprecedented number of suicide prevention activities, but we know we all need to do more if we are to halt the tragic rise in suicide. We need to implement a comprehensive public health approach that incorporates everything we now know about preventing suicide. We must constantly be looking to improve our efforts and to learn from both our successes and our failures. We owe it to those who have served this Nation and to all the people we have lost to suicide, as well as to those who have loved them, to strive to improve until suicide among veterans, servicemembers, and among all Americans is dramatically reduced.

Thank you. This concludes my testimony. I'll be happy to answer any questions.

[The prepared statement of Dr. McKeon follows:]

PREPARED STATEMENT BY RICHARD T. MCKEON, PH.D., M.P.H.

Chairman Tillis, Ranking Member Gillibrand, and Members of the committee—thank you for inviting the Substance Abuse and Mental Health Services Administration (SAMHSA) to participate in this extremely important hearing on suicide prevention. I am Richard McKeon, Chief of the Suicide Prevention Branch in the Center for Mental Health Services, SAMHSA. I also serve as Chair of the Federal Working Group on Suicide, and I co-lead the State and Local Line of Effort for the PREVENTS Task Force established under the President's Executive Order to Reduce Veteran Suicide. Previously, I was privileged to be able to serve on the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces.

An American dies by suicide every 11 minutes. In 2018, the Centers for Disease Control and Prevention (CDC) issued a major analysis of deaths by suicide during the time period between 1999 and 2016. The CDC Vital Signs analysis showed that the tragic toll of suicide has been increasing all across the country. Suicide is the tenth leading cause of death in the United States; the second leading cause of death between ages 10 and 34. We lost over 47,000 Americans to suicide in 2017, almost

the same number we lost to opioid overdoses. For each of these tragic deaths, there are grief-stricken families and friends, impacted workplaces and schools, and a diminishment of our communities. When one of these deaths involves an American who has served his country in the military, as happens on average 17 times each day, we as a Nation suffer additionally. SAMHSA's National Survey on Drug Use and Health has also shown that approximately 1.4 million American adults report attempting suicide each year, and over 10 million adults report seriously considering suicide. This leads to huge direct medical costs, and more importantly, tremendous human misery.

As painful as these numbers are, our concern is intensified by the CDC's report that suicide has been increasing in 49 of the 50 states, with 25 of the states experiencing increases of more than 30 percent. These increases have been taking place among both men and women, and across the lifespan. While Federal efforts to prevent suicide have been steadily increasing over time, thus far, they have been insufficient to halt this tragic rise. While we do not know all we need to know about what is driving these increases in suicide, there is much we do know about what puts people at risk for suicide, what protects them from suicide, and about what needs to be done to strengthen our national efforts. We know from CDC's National Violent Death Reporting System that mental health issues play a critical role, but only about 50 percent of those who die by suicide have had a mental health issue identified and only 25–30 percent are receiving any mental health treatment. Additionally, problematic substance use is involved with approximately 28 percent of suicide deaths.

We also know that there are many distressing events and circumstances that can precipitate suicidal ideation or attempts, particularly among those with pre-existing vulnerabilities. These vulnerabilities may include homelessness, unemployment, medical illness, or interpersonal losses. We know that a suicide attempt is the single strongest predictor of death by suicide, and for those individuals we must provide proactive outreach and coordinated care and treatment. However, we also need to intervene even earlier as the majority of people who die by suicide have never made a suicide attempt, illustrating that we need to intervene earlier, before people act on suicidal thoughts, or ideally, to prevent the onset of suicidal thoughts. We know that our efforts must engage multiple sectors and must include multiple levels. We need a greater scientific foundation for efforts that can prevent individuals from experiencing the onset of suicidal thoughts. We need stronger efforts to apply what we already know to identify people who are thinking about suicide and then to get them the treatment and support they need. In addition, we need to improve both the quality and continuity of care to those who have attempted suicide. We need to make suicide prevention stronger in health care, but also need to engage schools, workplaces, faith communities, and many others. We need to have an infrastructure to support this work in States, tribes, and communities, and need to bring what we already know to scale nationally.

While we have not been able yet to halt the tragic rise in suicide, we have seen that concerted, coordinated, and sustained efforts can save lives. We have made a concerted national effort in youth suicide prevention which has produced evidence that lives have been saved. Cross-site evaluation of our Garrett Lee Smith State/tribal youth suicide prevention grants has shown that counties that were implementing grant-supported suicide prevention activities had fewer youth suicides deaths and suicide attempts than matched counties that were not. However, this life-saving impact fades 2 years after the activities have ended as it has been shown that there is no longer a difference in suicide rates between counties who implemented youth suicide prevention activities and counties that did not. The greatest impact was seen in counties that have had the longest period of sustained funding for their suicide prevention effort. This underscores the need to embed suicide prevention in the infrastructure of States, local government, and tribal communities. While all 50 states have received a Garrett Lee Smith (GLS) state grant at some point in the lifetime of the grant series, too often the suicide prevention activities cannot be sustained when the grant ends.

An example of the successful implementation of a GLS grant is the White Mountain Apache tribe in Arizona, which received three consecutive GLS grants and has shown a reduction of almost 40 percent in youth suicide deaths. In that community, youth who experience suicidal thoughts, wherever they may be on the reservation, will be seen by a trained Apache community worker rapidly after their suicide risk has been identified and the individual will be linked to needed treatment and supports. This example demonstrates the value of timely access to effective suicide prevention and intervention services and the demonstrated success of these grants at the county level show the potential for a comprehensive, coordinated county based effort to prevent suicide across the lifespan.

In fiscal years 2017 and 2018, Congress provided SAMHSA, $11 million dollars to implement the National Strategy for Suicide Prevention, with a focus on adult suicide prevention, including $9 million appropriated to the Zero Suicide initiative specifically. Zero Suicide is an effort to promote a systematic evidence-based approach to suicide prevention in healthcare systems using the most recent findings from controlled research studies as part of a package of interventions that moves suicide prevention from being a highly variable and inconsistently implemented individual clinical activity to a systematized and prioritized effort across the whole healthcare system. The Zero Suicide initiative uses the most recent evidence-based science on screening, risk assessment, collaborative safety planning, care protocols, treatments and care transitions (providing rapid follow up after discharge from inpatients units and Emergency rooms), as well as ongoing continuous quality improvement. The Zero Suicide initiative was inspired by the success of the Henry Ford Healthcare system in reducing suicide by more than 60 percent among those receiving care, and other early adopters such as Centerstone in Tennessee, one of the Nation's largest community mental health systems, have shown similar results.

More recently, the state of Missouri has shown that it is possible to reduce suicide among those receiving care in the State's community mental health system, achieving a 32 percent decrease in suicide deaths among clients served in community behavioral health centers. As an example of this approach, Centerstone's protocol for treating those identified at high risk requires that an outreach phone call be made promptly if the person at risk misses a scheduled appointment. In one instance, a person on the Centerstone high-risk protocol missed his appointment and when the follow up phone call was made, the person was on a bridge contemplating suicide. Instead, he came to Centerstone and agreed to participate in treatment. SAMHSA has funded 19 States, tribes, and health care systems to incorporate Zero Suicide and technical assistance in implementing this approach, has been provided too many more through the Suicide Prevention Resource Center and through SAMHSA's Mental Health Technology Transfer Centers. Improving the training in suicide prevention for all healthcare providers is a key component of the Zero Suicide approach.

SAMHSA has also been working through all of its suicide prevention grant programs to improve post discharge follow up since multiple studies have shown that rapid contact after discharge from Inpatient Psychiatric Units and from Emergency Rooms and prompt link to outpatient services can prevent suicide attempts. While we would all wish that discharge from an Inpatient Unit or from an Emergency Room meant that all risk for suicide had been eliminated, in reality suicide risk persists or re-emerges and there is a demonstrated benefit in maintaining contact with people during this very vulnerable time at least until they can be successfully linked to outpatient care. In a study of over 1 million U.S. veterans treated for depression, the period immediately after inpatient discharge was found to be the time of highest risk. In a study of youth on Medicaid in 33 states who had been admitted to a psychiatric hospital, the odds of death by suicide was 76 percent lower for youth who had a mental health visit within 30 days of discharge.

The National Institute of Mental Health's Emergency Department Safety Assessment and Follow Up Evaluation, which studied universal screening, safety planning, and follow up phone calls showed that rapid telephonic follow up after discharge reduced the number of suicide attempts. Similarly, the Veterans Administration's Suicide Assessment and Follow Up Engagement Veteran Emergency Treatment (SAFE VET) study showed that a combination of collaborative safety planning and rapid telephonic follow up reduced suicide attempts and increased linkage to VA care. In a study by the Mental Health Research Network on variations in patterns of health care before suicide, emergency rooms were identified as of particular importance because they combine high utilization with substantial relative risk. The ED–SAFE study showed that universal screening for suicide risk in emergency rooms lead to a doubling of the identification of people experiencing suicidal thoughts and that those identified were at equivalent risk to those being seen in the emergency department because of known suicide risk.

The SAMHSA suicide prevention program that touches the greatest number of people thinking about suicide is the National Suicide Prevention Lifeline (the Lifeline). The Lifeline is a network of over 165 crisis centers across the country that answer calls to the toll-free number 800–273–TALK (8255). The National Suicide Prevention Lifeline includes a special link to the Veterans Crisis Line, which is accessed by pressing "one." The Veterans Crisis Line also serves as the Military Crisis Line. The Lifeline is available 24 hours a day, 7 days a week, and in many communities in America, it is the only immediately available option for a person thinking about suicide to reach out for help. Last year, more than 2.2 million calls were answered through the Lifeline, and that number has been growing at a rate of about

15 percent per year. About 25 percent of Lifeline callers are actively suicidal at the time of the call and some of them need emergency rescue services.

The Lifeline also provides a chat service through the website, and the percentage of those using the crisis chat service who are actively suicidal is even higher. We believe this is reflective of the rising rates of suicide in youth, who may be more likely to use a chat service. Evaluation studies have shown that callers to the Lifeline experience decreased suicidal thoughts and hopelessness by the end of the call. Both the initial calls to the Lifeline as well as follow-up calls from Lifeline centers are frequently experienced as lifesaving. In this way, the calls themselves are actual interventions not simply a triage to another service, although referral for emergency rescue using police or ambulance is utilized when necessary when risk is both acute and imminent. SAMHSA, VA, and the Federal Communications Commission (FCC) have worked together to implement the National Suicide Hotline Improvement Act and this past August the FCC recommended that the number "988" be assigned as a new, national suicide prevention hotline number.

Community crisis centers are responsible for responding to calls and chats. While many of them receive a very small amount of funding from the Federal Government through SAMSHA, these crisis centers are not directly operated by SAMHSA. Lifeline community crisis centers largely depend on local, private, or State funding. When local crisis centers are unable to answer Lifeline calls, the calls must be answered by designated regional back up centers. When calls go to regional back up centers, the amount of time it may take to answer the call can increase, highlighting the importance of local crisis center capacity.

SAMHSA and VA have been working together to prevent suicide since 2007, when the Veterans Crisis Line was first established and the "press one option" was introduced into the National Suicide Prevention Lifeline message. More recently, SAMHSA and VA have worked together to fund a series of Mayor's Challenges and Governor's Challenges to prevent suicide among all veterans, servicemembers, and their families, regardless of whether they are receiving care though VA. Supported through an interagency agreement with VA, SAMHSA's Service Members, Veterans and their Families Technical Assistance Center has convened cities and states for policy academies and implementation academies to promote comprehensive suicide prevention for veterans. Multiple public and private partners are engaged in this coordinated effort for which onsite technical assistance is also provided. We believe that this type of strong, continuing, interdepartmental effort that incorporates states and communities as partners is necessary to reduce veteran suicide.

SAMHSA, VA, and DOD also work together through the Federal Working Group on Suicide Prevention, which includes Department of Justice, Department of Homeland Security, CDC, National Institute of Mental Health (NIMH), Indian Health Service, Administration for Community Living, and the Health Resources and Services Administration. SAMHSA, VA, DOD, NIMH, CDC and other Federal agencies and Departments also work with other public and private organizations through the National Action Alliance for Suicide Prevention (Action Alliance), which was stood up with SAMHSA funding in 2010 and has engaged over 250 organizations since its inception. The Action Alliance worked with the Office of the Surgeon General, SAMHSA, and others to revise the National Strategy for Suicide Prevention and continues to engage partners from multiple sectors to promote comprehensive suicide prevention efforts.

In summary, SAMHSA, and the entire Federal Government is engaged in an unprecedented number of suicide prevention activities, but we know we all need to do more if we are to halt the tragic rise in loss of life we are experiencing across the country. In particular, we know we need to be engaged in a strong continuing, collaborative effort across the Federal Government along with States, tribes, communities, and private partners across America to implement a comprehensive public health approach that incorporates everything we now know about preventing suicide. We know we must constantly be looking to improve our efforts and to learn from both our successes and our failures. We owe it to those who have served this Nation and to all the people we have lost to suicide, as well as to those that loved them, to continually strive to improve until suicide among veterans, servicemembers, and all Americans is dramatically reduced.

Senator TILLIS. Thank you.

Dr. Kessler.

STATEMENT OF RONALD C. KESSLER, PH.D., MCNEIL FAMILY PROFESSOR OF HEALTH CARE POLICY, DEPARTMENT OF HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL

Dr. KESSLER. Thank you. Chairman Tillis, Ranking Member Gillibrand, and Members of the subcommittee, thank you for the opportunity to talk to you today.

As Matt mentioned, suicide is a national problem, it's not a military or VA problem. The suicide rate in the United States has been going up for the last 15 years. It's one of the few countries in the world that that's the case. In most countries, it's flatter, going down.

Suicide is also fundamentally a mental health problem. The vast, vast majority of people who die by suicide, psychological autopsies show, had mental health problems. Most people with a mental health problem have an onset in childhood or adolescence. In the United States, the best estimates suggest that the median age of onset, so 50 percent of the people who will ever in their life have a mental disorder, it starts at the age of 13, and military is no exception. When we, in the Army STARRS [Study to Assess Risk and Resilience in Servicemembers] study, which is a big prospective study that I'm involved in with the Uniformed Services University of the Health Sciences, assessed a representative sample of people in the Army. The vast majority of the people who had a mental health problem told us that it started when they were a kid, before they came into the military. Now, those early problems are, typically, relatively mild, they're not the kind of thing that would get somebody excluded from being in the service. They're also not the kind of thing that people get treatment for. It's only a number of years later when the problem gets more recurrent and persistent and severe, and the suicidality starts. That's when people get into treatment, and it's tougher to treat it at that point. If they were nipped in the bud, it would be a much easier thing to do.

So, what we need to do, one thing that would be of enormous value, would be to develop more focus at the early end of the spectrum rather than late into the spectrum. Let's not wait till they're jumping off the bridge and Matt Miller's guys try to grab them back. If we could find people who have relatively mild problems and get them into treatment early enough, that could be of enormous value.

As Senator Gillibrand said, though, it's a challenge because there's a—there's reluctance to report these kind of things, and how to figure out how to get people to admit relatively mild problems is tough. As we all know, everybody wants to stop smoking after they get cancer, not before they get cancer. You know, so, I mean, it's sort of—it's a tough thing. But, working on that problem could have enormous payoff.

It's important to realize that these early treatments of relatively mild mental disorders compare very favorably to the treatment of cancer, heart disease, diabetes, and so forth. So, we know now to treat these people. It's tougher when they get to the point of having suicidality, where there are some things we know, but it just is tough. But, for the relatively mild things, cost-effectively, they can be treated.

The big difference is that, when we have physical disorders, there's usually only a small number of things that happen. If we break our arm, you know what to do. You go to the emergency room, and they set it. If you get depressed, you can go to your minister, priest, rabbi, go to a social worker, you go to a family doctor, who gives you a pill, you go to—I mean, which one of these things—the National Center for PTSD [post-traumatic stress disorder], which is a VA center, it's the leading PTS data research center in the world. They list, on their website, ten different kinds of psychotherapy for PTSD, seven different kinds of pills that have been shown to work. Each one of them works with 30 or 40 percent of people. There's nothing that works for everybody, and there's no one that's best. As a result of that, most treatments for mental disorders is trial and error. You get the first treatment, which the doctor you see is the one who has most experience dealing with that. Whether that's the best one for you or not is a different matter, and so, trial and error is the way these things go. Because people who are depressed are depressed, they give up early, they don't stick through the whole trial-and-error process. Very often, they quit, and often with tragic consequences.

There are ways of doing a better job than trial and error, and they're called, as you probably know, precision medicine. Precision medicine in cancer and cardiovascular disease is really a developed area. We could do a heck of a lot better than that than we are right now in the mental health domain. VA and DOD are both making beginning efforts in that. We really need to do more to get the right treatment to the right people right away.

There are some other things we could do much more concretely, and I'll just mention a few of them. I have them in my testimony. One is, there's been an idea around for a long time to do an inception survey. When people join DOD, have everybody do a survey about their history of mental disorders and problems so that we can find people quickly, nip it in the bud. That's something we should explore in a serious way. There are some challenges in doing it, to get people to admit things, and so forth, but it's something that could be doable.

It would also be great to figure out a principled way of evaluating, when we do those early interventions: How do you know which one works? So, we need a commitment to a strong evaluation process, where you have a—you decide whether it works or not. The people who develop it don't do the evaluations, some independent people do, so you kind of stick with the good things and cut your losses on the bad things.

We need to integrate the many systems that DOD has.

I'm running out of time, so I'll stop now, but there are several things along those lines that we could do. They're very concrete, very doable.

VA and DOD are extraordinary organizations that have the wherewithal to do these kind of things because they're the biggest integrated healthcare systems in the country. Because of their organization and their high level of expertise, they really could do this in a way that other places in the country can't. I would urge you to help them do that.

So, Mr. Chairman, thank you again for the opportunity to share these thoughts with you and your subcommittee, and I look forward to answering your questions.

[The prepared statement of Dr. Kessler follows:]

PREPARED STATEMENT BY RONALD C. KESSLER, PH.D.

Chairman Tillis, Ranking Member Gillibrand, and Members of the subcommittee, thank you for the opportunity to talk to you today about risk reduction and resilience-building to prevent suicide and suicide-related behaviors in DOD and among veterans.

As you know, the rising suicide rate in DOD and VA is a national problem, not just a problem of the military, and it is fundamentally a problem of unresolved or unidentified mental illness. Psychological autopsy studies show clearly that the vast majority of people who die by suicide in the U.S. suffered from some type of mental illness, most commonly a mood disorder, but often a complex combination of comorbid mood, anxiety, and substance use disorders. If these mental disorders had been resolved, many of the suicides would not have occurred.

Epidemiologic surveys of the U.S. general population show that people with complex mental disorder profiles typically have first onsets of disorders in childhood or adolescence, with a median age-of-onset of 13 years in the U.S. That is, half the people who will ever in their life have a mental disorder have a first onset by age 13. Military personnel are no exception. The Army STARRS study found that the majority of soldiers identified to have mental disorders reported that their first problems started well before they joined the Army.

These initial problems typically are not severe, but rather manifest as childhood phobias, social anxiety disorders, or mild depressions, sometimes coupled with secondary alcohol or drug abuse in adolescence as a form of self-medication. The vast majority of these early disorders go untreated even though they are eminently treatable. They come to clinical attention only later, sometimes many years later, when they have evolved into more complex comorbid syndromes that are more difficult to treat. We have to do a better job of early detection and intervention. Importantly, these early disorders are very common and are not severe enough at the time of military enlistment to be exclusionary. Instead, early intervention is needed to ameliorate these problems before they progress.

It is also important to note that the success of treating mental disorders among patients who have not gotten to the point of becoming suicidal compares favorably with the treatments of most physical disorders. However, there is one big difference: that the range of treatments available for mental disorders is much greater than for most physical disorders. For example, the web site of the VA National Center for PTSD, the leading clinical research center for PTSD in the world, lists no fewer than 10 types of evidence-based psychotherapy and 7 types of evidence-based medication, not to mention the 10 x 7 combinations of psychotherapy and medication that are sometimes used to treat patients with PTSD.

Not all of these treatments work for all patients, although at least one works for the vast majority of patients. And some treatments also work for patients who have gotten to the point of being suicidal. But very little is known about how to pick the right treatment for the right patient. Trial and error is consequently the norm. However, this leads to many treatment failures. After one or more treatment failures, many patients give up and drop out of treatment, often with tragic consequences, even though they would have been helped if they had continued with subsequent treatment trials. We need a better way to pick the right treatment for the right patient right away.

The investigation of that issue is known as "precision medicine." Great progress has been made along these lines in other areas of medicine, but progress in precision psychiatry has been slow because the known biological markers of mental disorders that have been the focus of work to select the best medications for treating mental disorders are too weakly related to treatment response to provide much guidance in picking optimal pharmacologic treatments and tell us virtually nothing about the likely success of psychological treatments. However, a growing body of evidence based on small trials carried out by psychologists shows that psychosocial factors hold out great promise in precision treatment planning for people with mental disorders. We need to invest in the development of precision treatment tools based on these factors to advance the agenda of getting the right treatments to the right patients right away.

In carrying out this work, which will involve both evaluating new interventions and determining which of them work for which patients, it will be important to es-

tablish a rigorous and consistent evaluation process. Both DOD and VA have taken important steps in this direction by initiating measurement-based treatment systems to assess behavioral health functioning and suicidality in multiple clinical settings. The DOD in particular has amassed the Nation's largest repository of patient-reported clinical outcome data, which includes over 4 million instances where military beneficiaries have rated how effectively their treatment is working. But more could and should be done. Some examples:

- The idea has been discussed for many years of implementing an inception survey for all DOD personnel beginning service in order to assess pre-enlistment mental disorders, childhood adversities, and other risk and resilience factors for suicidality that might profit from early intervention. Army STARRS carried out such a survey and the results continue to be very important as we follow soldiers over nearly a decade. An ongoing inception survey of this sort for all new recruits coordinated across all DOD branches might be of considerable value in pinpointing new personnel for early intervention as well as for obtaining information that could be used to help guide precision treatment planning. But experimentation and rigorous cost-benefit analysis would be needed to find the best way to present such a survey so as to encourage honest reporting and to determine if the survey has value either in finding new recruits who benefit from early interventions and/or in providing unique background information needed to support precision treatment planning.
- But how would we know if these interventions worked and for whom? As noted above, rigorous evaluation is needed that builds on the existing measurement-based care programs already implemented in DOD and VA. But the current system would have to be expanded and staff added with expertise in advanced statistical methods (e.g., artificial intelligence, other types of machine learning methods) to make that happen.
- It would also be of great value to integrate the many DOD administrative data systems into a consolidated data warehouse that could be used to target, evaluate, and refine clinical interventions for personnel throughout their military careers. Work along these lines is already underway, but needs to be strengthened and sustained.
- Increased coordination is also needed between DOD and VA. Although progress is being made, the DOD and VA electronic medical records are still not compatible. And the enormous richness that exists in the many other DOD administrative data systems is not available to VA. This needs to change.
- One place in which this need is especially acute is in the transition between Active Duty and veteran status. The suicide rate increases substantially after separation, especially in the first 2 years. The VA Benefits Delivery at Discharge (BDD) Program was developed to help address this problem through improved transition planning. Other pilot initiatives are also currently underway to strengthen these activities. And the STARRS team is using machine learning methods to pinpoint the subset of soon-to-separate personnel who are at greatest risk of post-discharge suicidality for more intensive and prolonged case management, but ongoing implementation of such a system would require greater integration than currently exists across DOD data systems.
- The Veterans Crisis Line (VCL) and other components of the VHA system could also profit from access to integrated DOD data to help with evidence-based targeting and expansion of interventions, including such things as determining when to "break the glass" on confidentiality if callers are interested in looping in a provider and when VCL personnel should become involved in outbound case management calls.
- And VHA could also profit from an expansion of currently preliminary efforts to develop precision medicine guidelines for choosing among alternative interventions. I am being a bit self-serving in saying this in that I am involved in several initiatives of this sort with the VA Center of Excellence for Suicide Prevention in Canandaigua, New York. But it is clear that these kinds of initiatives have enormous potential value and should be the focus of more effort than they are currently.

Mr. Chairman, thank you again for the opportunity to share these thoughts with you and your subcommittee. I know my list of potential actions is a long one, but there is much to be done to address the problem of military and veteran suicide. DOD and VA are leaders in tackling the national suicide problem, but numerous opportunities exist to build on their unique strengths. I look forward to answering your questions.

Senator TILLIS. Thank you all for your opening statements.

I've decided I'm going to miss the next vote, because I don't want to miss any of the testimony. I think my staff have instructed the floor to call it.

Senator Sullivan is not on this subcommittee, but he's very much concerned with a trend up in Alaska, so I've offered to have Senator Sullivan speak in my turn. I'll speak at the end, after the other members, and then——

Senator SULLIVAN. Thank you——

Senator TILLIS.—we will move to Senator Gillibrand.

Senator SULLIVAN.—Mr. Chairman. I appreciate you and Senator Gillibrand holding this very important hearing.

Let me just ask a couple of, basic questions, and I will get to the question that's going on in my State. But, Dr. Kessler, what do you think's driving the increased rates in America? It's very troubling. Does anyone know?

Dr. KESSLER. Yeah, I wish I knew. The common mental disorders—depression and anxiety disorders—seem to be illnesses of affluence. People in developing countries that are worrying about starving to death don't get depressed. They're just happy to be alive, and so, there's something of that going on.

But, why it is—you know, there's all kinds of things you can say. It's the social media, it's the destruction of the family. We just don't know. It's clear that there are biological factors that are involved. We know that stresses are involved. There's a combination between individual vulnerability and things that happen in the environment that come together in a synergistic way. But, as everybody said here today, if there was one magic bullet, we wouldn't be in the pickle we are today. So, there's a lot of things going on.

Senator SULLIVAN. Thank you.

Dr. Orvis, Captain Colston, the Chairman referenced, you know, we have a—I was actually just up there last weekend, Fort Wainwright, in Fairbanks, Alaska. That's an Army base. It's not a huge Army base. It's got a—the 1st Stryker Brigade, which is now over in Iraq, is headquartered there. In the last 18 months, they've had 10 suicides and one attempted suicide, which is an astounding number for a unit that's not that big. I understand you were informed about the EPICON [epidemiological consultation] that the Army conducted at Fort Wainwright this summer. Are there any recommendations you'd like to highlight, either positive or negative, from that report? Not just that would make a difference at this base that's struggling—and it is a remote base, and, you know, very cold in winters and—but, maybe more broadly for the military.

Dr. ORVIS. Thank you for the question.

Certainly, what's happening in Fort Wainwright is very concerning. And yes, we are aware of the EPICON that the Army undertook to understand why is there such a high concentration in a small period of time within that installation.

What I would say, first, broadly, in terms of the Services and whether it's the Army, and Fort Wainwright in particular, or other Services, is, all the Services have processes in place to look at, Are they seeing higher concentrations, and what might be occurring? And, commend the Army for doing the EPICON to really look into what might be factors unique to that installation.

We also have a body, General Officer Steering Committee for Suicide Prevention, that's enterprise wide, where we discuss these issues. So, the Army briefed on the EPICON to share those lessons learned and best practices with all the other services and with my office in Health Affairs so that we could promulgate those lessons learned more broadly than Wainwright itself.

In terms of specific lessons learned, some of the takeways that I saw are, first of all, some of our common challenges that we see as risk factors for suicide were present at that installation—relationship issues, financial issues—but there were unique factors that were coupled with that for the Arctic conditions, the more isolated and remote areas, and understanding ways that the Army could implement specific policies and programs to get after some of those specific challenges, too, are underway.

Senator SULLIVAN. Thank you.

Captain Colston.

Dr. COLSTON. I'd just add a couple of things. I mean, obviously, way up there—and I've been up there on deployments—it's really dark in the winter. And, that's associated with mood disorders. And mood disorders are a common precipitant.

The other thing I'd say is, science really isn't there. Suicides are anisotropic, and what I mean by that is, if you have, say, a Stryker brigade of 4,000 folks—and our suicide rate is one in 4,000—you might get three or four suicides. But ten? That's a huge, a huge number, and one that, I think we need to run through all the biopsychosocial stressors.

It is very hard to look back and say what, exactly, it was, and that's one of the frustrating things about suicide. We are taking prospective measures to—in regard to the treatment of mood disorders, anxiety disorders, substance-use disorders, things along those lines.

Another thing that, just culturally, that I've known, and, going to college up in Upstate New York, is—there's a lot more drinking in the winter than there was in the summer. That's always a concern, especially with young folks, vis-á-vis impulsivity and the propensity to be impulsive, and the effect on mood, and the effect on sleep that alcohol has.

Senator SULLIVAN. Thank you.

Thank you, Mr. Chairman.

Senator TILLIS. Thank you, Senator Sullivan.

Senator Gillibrand.

Senator GILLIBRAND. Thank you, Mr. Chairman.

I want to share a story of someone whose parents shared that story with me. One thing that stands out in this year's report is the acknowledgment that suicide is not caused by a single condition, but that it is linked to a number of contributing factors. I believe that we need to do more to listen to our servicemembers when it comes to these stress factors. I'm concerned that lost in the research reports are the stories of those who are no longer able to tell us about the crippling factors that led them to feel so hopeless that they take their own lives. So, I want to share Brandon Caserta's story.

Brandon joined the Navy to become a SEAL, but a broken leg during the qualification course ended that dream. According to his

family and other members of the unit, in the midst of these professional setbacks, once arriving at his new unit, Brandon's supervisor verbally abused, degraded, and demeaned him and others on a daily basis. Even though his immediate supervisor was found by a command investigation to have had a history of abusive behavior towards his subordinates, and had been previously relieved for his behavior, Brandon's command did nothing to protect those in his charge. Brandon attempted to transfer by multiple means, but a broken collarbone meant that he would be forced to remain in this environment for at least another year. On June 25th, 2018, Brandon Caserta was so unhappy and felt so hopeless that he walked out on the flight line, approached an MH–60 helicopter, apologized to a nearby sailor for what she was about to see, and ended his life by jumping into the aircraft's spinning tail rotor.

Dr. Kessler, Brandon faced personal setbacks combined with daily abuse from his superiors, and had little hope that anything would change. What would be the effect on Brandon's mental state, given these circumstances? What risk factors would he be experiencing?

Dr. KESSLER. Well, the mental state of hopelessness is, in fact, a mental state, and why it is that some people become hopeless in the face of adversity, and others not, is a tricky thing. Now, as an actuarial matter, stresses in people's lives, and stresses that seem to not just be stresses that are manageable, but things that get you in a box and there's just no way out—a lot of people who commit suicide, when you—if they end up not dying by mistake and you say, "What were you doing? Why did you do it?"—they say, "There wasn't anything else I could do, that it was—I tried everything else. It's—it was the last resort." So, the kind of thing where you get into life situations where there's no way out is this sense of hopelessness. And that sense of hopelessness, we know, as I said, actuarially, the two biggies are financial problems and your love life. We don't—you know, having the bad—bad leaders is not a good thing, but that's not one of the top three or four or five. When we've done these big surveys of 100,000 people, "What's going on in your life? What relates this to suicidality?"—it's maybe 10 in the list, something like that.

The trick in a lot of therapy with people who are suicidal is to say to them, "You know what? It's not the only way out. I could tell you some other ways. You don't like that, you want to prove to her that you really loved her, so you're going to kill yourself? How about you prove to her that you really loved her by going off and having a nice life and saying"—in other words, you try to show people that there are other ways out and scaffold them forward. But, it seems to me that's what we've got to do.

Senator GILLIBRAND. Captain Colston, would you agree that leaders ignoring a toxic environment would dissuade military members like Brandon from seeking mental health treatment and, in fact, fearing retribution from supervisors, and that the possibility of a mental health care provider contacting his command may have dissuaded Brandon from seeking help?

Dr. COLSTON. I think that's a great point, ma'am. I was actually—just when I came here, in 2011, my office promulgated the stigma instruction that we sent over a couple days ago.

It's a hard question, and one that we don't always have answers for, other than we do have a zero-tolerance policy, vis-á-vis hazing, vis-á-vis bullying, and these aren't—I've been a naval officer for 34 years—these aren't things that are culturally acceptable. These aren't things that are okay, and, to the extent that they happen, they're leadership failures. I think, whenever we get into the investigation phase of these types of things, that's what we see.

I did want to take one point off of Ron. I remember, in an earlier—in an earlier STARRS meeting, he mentioned that people with sergeants who were a little older, a little more mature, seemed to do better vis-á-vis suicidality than folks——

Senator GILLIBRAND. Yeah.

Dr. COLSTON.—who might have hard-charging young sergeants who are less socially astute.

Senator GILLIBRAND. Yeah.

Dr. COLSTON. So, those are important. Those are important things.

My view, as a child psychiatrist is, the military—the best way to raise children is to parent them gently, catch them being good. You know, that's——

Senator GILLIBRAND. Could I——

Dr. COLSTON. Oh, go ahead, ma'am.

Senator GILLIBRAND. Just to address your thing. So, I think there's—this is one of the barriers to mental health treatment. The DOD's current rules for mental health providers identifies nine conditions under which a mental health provider must report treatment to a patient's chain of command. These rules include vague requirements, such as harm to mission, and present a significant challenge to providers.

So, Captain, one of the requirements for reporting is in the case of harm to mission. Are mental health providers generally briefed on specific missions? Is it reasonable to think that a mental health provider would understand a patient's role in that mission?

Dr. COLSTON. So, we have a split—as you know, ma'am, we have a split fiduciary role, as psychiatrists, and, in that role, I don't remember ever telling a commander that someone wasn't fit for duty, vis-á-vis the mission. We have changed our culture, and I've mentioned that in this room before. A lot of times, when folks would struggle, especially early in this century, we would administratively separate them, which also had a chilling effect on accessing care. We don't do that anymore.

We do have, obviously, some mission imperatives around insider threat. I think that, in the Devin Kelly case, some of those concerns were heralded. But, we need to strike a balance, and as a provider, that balance usually goes to the patient. I think that we get it, and that's the way we train our residents right now at Walter Reed and Fort Belvoir. But, I'm not surprised to hear that we've fallen short of the mark at times, and I'm sorry about that.

Senator GILLIBRAND. Thank you.

Senator TILLIS. Senator McSally.

Senator MCSALLY. Just want to say thanks to the Chairman and the Ranking Member for having this really important hearing today, and for everybody's testimony.

I served 26 years in uniform. This issue, as I think back, first touched me personally when a cadet in my squadron at the Air Force Academy took his own life. This is something, as we see the trends going on in our society, all of us know someone or love someone who has either been in mental health crisis and suicide risk or taken their own lives. Someone close to me said, after having gone through this, that, suicide doesn't transfer the pain that you're feeling—sorry—it doesn't end the pain you're feeling, it just transfers it to those who survive, and the deep wounds for children and other loved ones when somebody feels like they have no other hope.

Twenty veterans every day are taking their own lives right now. Twenty. I just—you know, they deploy, they survive combat, and come back, and come to this place where the enemy hasn't taken their lives, but they've taken their own lives. And so, this is so important that we take all the efforts that are happening, both across the Federal Government, throughout society, and, I think, at the State and local level, our best efforts to try and address this issue. But, our veterans come from society, and we're seeing the trends that are going up. We are, a part of what's going on in our society, as well. It's not all combat related. It's these other factors that are happening.

There's a couple of examples in Arizona, which ASU [Arizona State University] has done a study. Veterans are two times more likely, overall, to commit suicide than the regular population, and, for the female veterans, it's three times more likely in Arizona. These rates are just way too high, and they're unacceptable.

And so, with a sense of urgency, I think we all really need to not just throw more money at the issue, but really have to think outside the box. What is not working? What is working? What else can we do?

In just a couple of examples of Arizonans, 2015, 53-year-old Army veteran Thomas Murphy drove to the Phoenix VA on a Sunday night with a suicide note and a gun, and shot himself. In the note, he described his physical pain and the difficulty he was having getting treatment that he felt he needed from the VA. There's countless stories like that. But, the vast majority of our veterans are not even in the VA system.

But, I want to highlight, a good-news example in Arizona. We have this Be Connected Program. In 2017, it started, and it's really working to connect veterans, servicemembers, families to whatever support they have that goes back to not in the immediate crisis, but what are the—earlier-on in the chain of events that happens.

There's one example of a—in rural Arizona, a disabled veteran called Be Connected, and the question was, Can someone help come clean up after his pets? In reality, once a volunteer showed up, they realized the pet and caring for the pet was actually a barrier for him to get treatment for substance abuse, but he wanted to make sure he wasn't going to lose his dog. And so, they were able to meet him where he was and show that they had someone who's going to take care of his dog while he actually went in and got the treatment that he needed through a 28-day program. And so, this is a great example. I've got many more. I know I don't want to spend all the time of where, at the local level, with local volunteers,

with Federal support, we really could be empowering local communities in order to be the neighbor, be the friend, remove those barriers, and get people the care they need.

You know, what else can we do, Dr. Miller, for these types of programs, to incentivize them, especially for those vast majority veterans that are taking their lives but you don't even have them in the VA system?

Dr. MILLER. I was in Arizona 2 weeks ago, and I was working with the Be Connected individuals, and am very impressed by what's occurring——

Senator MCSALLY. Yeah.

Dr. MILLER.—there. I was trying to count, when you were talking, how many times you said "local" and "Federal," and the importance of the relationship between them. That's what I think that we can work on together, is combining the power and the resources at the Federal level with the local level, realizing that, at the Federal level, in the VA, we can't do it on our own. There are local-specific data and resources that we can't cover, but they can be covered in other ways, and partnered with that which we can do, and do so well. That's where taking a look at suicide prevention, not just from a clinically-based perspective, but from a community-based perspective, is so important, and your example is a great one.

Senator MCSALLY. Well, there's another example, too. The Veteran Treatment Courts and—introduced bipartisan legislation last week to expand these. But, there have been lives saved in Arizona, where, instead of a veteran spiraling down to be behind bars or taking their own life, they're given a chance to spiral up, with accountability and treatment and support. So, we need these types of programs, I think, in every community, fit for that community.

The other concern I have is, if somebody is in crisis and they're a suicide risk—again, I've seen this firsthand recently with a friend—not a veteran, but—there's not a lot of choices. They go to the emergency room, they get locked down because they're a risk, or then they get put into an inpatient mental health ward, where they are high-functioning, but they need some help, and they don't fit in with the other population there. It can put them into a worse crisis. There's not a lot of great options in that moment for somebody who's high-functioning but really needs help.

Dr. McKeon, Dr. Kessler, I know I'm late, here, but any other comments on that? I just really think there's a gap for what people need who are crying out for help, but they're high-functioning, and they just need a path forward.

Dr. MCKEON. Yeah. I think that is a great question. Let me mention a couple of things.

So, one option that doesn't require bringing someone to the emergency room but can—but where that will be done, but only if needed—is by contacting the National Suicide Prevention Lifeline so that somebody can be spoken to or a family member who's concerned about a loved one can be spoken to, where risk can be assessed, and a determination made about what kind of help is needed without going to the emergency room.

But, there are other forms of crisis services when there's a comprehensive crisis continuum that has things like mobile outreach so

that, rather than somebody being transported to an emergency room to receive an evaluation, that same evaluation can be done where the person is. There are also crisis stabilization units. There are some excellent ones in Arizona, in Phoenix and Tucson, that provide 72 hours of crisis stabilization, not in a—where police officers can drop somebody off if the police need to be involved. So, I think that improving crisis services is one very important component—not the only component, but one very important component of improving our national suicide efforts.

Senator MCSALLY. Great. Thanks.

I'm way over my time, here, but thank you so much. I know Dr. Kessler was going to say something, but I'm going to have to wait for the record.

Thank you.

Senator TILLIS. [Inaudible.]

Senator MCSALLY. Is that okay? Thank you.

Go ahead.

Dr. KESSLER. Well, Matt mentioned the coordination between local and national, and here's a great example where it's the case. Because there are an enormous number of really creative programs that are local, that exist one place and nobody else knows they exist.

Senator MCSALLY. Right.

Dr. KESSLER. So, to have the national perspective to sort of mix and match the right things is one thing.

The other thing, the big challenge of getting the right treatment to the right person, which is one of the things I mentioned, is that veterans are much more rural than the rest of Americans. The reason is, you know, the States with the highest proportion of veterans in America, in Kentucky, West Virginia, Tennessee, because they all came from there, they joined the military, then they moved back. And it's hard to get the specialized—if you live in Los Angeles, they have, you know, these little ultra, ultra specialized things. So, how to figure out——

Senator MCSALLY. Yeah, but they don't join the military.

Dr. KESSLER. That's right. That's right, yeah.

So, the kind of thing that Richard's saying, get things that you can have that could be remote things, you could put in place, get the right thing to the right person, even if it means moving them a little bit. But, there's a lot of coordination of figuring out how to get a system to work in a coordinated way, to take advantage of the really good ideas that exist right now, many of which we don't really know about.

Senator MCSALLY. Right.

Dr. KESSLER. But, I think we could.

Senator MCSALLY. Thank you. Appreciate it.

Dr. KESSLER. There's a lot more.

Senator TILLIS. Thank you, Senator McSally.

The—I want to go back, just in terms of a level set on data. I think I have read that the incidents of suicide, adjusted for age and sex, in the whole of the military, is roughly equivalent to civil—civilian society, but for the National Guard. Is that right?

Dr. KESSLER. Yes, sir.

Senator TILLIS. Within the VA, Dr. Miller, is that roughly the same?

Dr. MILLER. No, sir. It's higher.

Senator TILLIS. It's much higher?

Dr. MILLER. Yes.

Senator TILLIS. The—I guess, the question—the first question that I have—you all have talked about programs. We've heard State, we've heard local, we've heard Federal, we've heard nonprofit, we've heard community. What effort has there been, you know, as a national effort, to try and identify best-practices programs with demonstrable efficacy and in a way to start leading these well-intentioned efforts that may not be achieving the same level of efficacy into programs that work? You don't want to completely stifle innovation, because the next-best idea may come out. But, what sort of national effort, Dr. McKeon, either at—in your department—I know that we're looking at programs within the DOD and VA to determine where we should invest our resources, but, at a national level, what concerted effort, if any, exists today to try and identify a consistent approach to what are the consistent causes of suicide?

Dr. MCKEON. Well, I would mention a couple of things, Senator.

So, I mean, I think that you've identified, and VA is utilizing in the Zero Suicide Initiative—have used a number of evidence-based approaches that can be used in healthcare systems. So, improving suicide prevention in healthcare is one piece. But, it's only one piece.

We know, from the National Violent Death Reporting System, that only between 25 and 30 percent of those who've died by suicide have received current or recent mental health treatment. So, we need broader community efforts. There's not nearly as much evidence around community evidence and what's effective. So, that's a really important area.

It's incorporated in the U.S. National Strategy for Suicide Prevention. The National Action Alliance for Suicide Prevention has made it a priority to try to help. As part of a recent meeting in—at SAMHSA, as part of the International Initiative for Mental Health Leadership, we met with mental health leaders from nine different countries to look at what we were doing in our different nations to prevent suicide, and how we can approach it comprehensively—What were the different components that were working in different places?—so that we can all learn from each other. So, it's a critical—but, we definitely need a comprehensive public health approach, but we also need more information about what can be most effective to help in the community.

For our youth suicide efforts, we try to use both strengthening healthcare for youth suicide prevention, but also strengthening work in the communities. We show some evidence of success for that in our evaluations. But, there's a lot more work to be done.

Senator TILLIS. Dr. Miller, Captain Colston, and Dr. Orvis, one of the—I'm not an expert in this field. I'm trying to learn so that we can be instructive with public policy choices. But, one thing that just strikes me is, if we have a disproportionately high number of men and women in the National Guard. They have a unique circumstance, particularly now, with the operations tempo being what

it is. Many are going—I don't know if we have data about how many of them were actually in deployments or away from home and then coming back away from the structure of the military. But, in some ways, you would almost—I could—the layperson could draw the conclusion that if that seems to be a disproportionally high number of suicides in that population, and, Dr. Miller, we know that the suicides among veterans is much higher among those who have no connection to the VA or VHA, what does that tell us about what more we need to be doing? You mentioned there's a Mobile Vet Center when they're on deployment. The problem is, oftentimes their suicides happen when they're not on deployment. So, what are we doing to better connect and provide access to our servicemembers and veterans who are—what initiatives are going on right now that can give us some hope?

Dr. MILLER. Historically, I think that—historically, I believe that we have been speaking from a perspective of accountability. Clinically, we've been over-reliant on a pure clinical perspective and addressing the situation within the walls, both metaphorically and literally, of a medical center sort of setting. I think that what we need to continue to do is find ways to engage, as Ron has said, the right care at the right time for the right person, from a clinical perspective, but then, in addition, as Richard has said, heavily investing, engaging, and measuring the effectiveness of community-based interventions that address broader issues that we know are related to suicide and suicide prevention.

Dr. ORVIS. I'll add, as well. Certainly, we know the National Guard has unique challenges, and locality and whether more geographically dispersed is a key factor there. We have a number of—in addition to the VA Mobile Vet Centers, which I think is an exciting new initiative, and it's also on drill weekends, which is a—more opportunity to have that regular care—we've been partnering very closely with the National Guard Bureau with the approach of providing as many different doors or avenues as we can. So, partnering with local resources in the community. There is Military OneSource that is available, getting—to prevention if you're having financial challenges, relationship issues, parenting challenges, the whole host of everyday life challenges. Military OneSource is available to everyone and all family members in the military.

We have our Military Family Life Counselors, both directly specific for youth and also more broadly for our military community family, and they are embedded within communities, as well, and can be called upon for surge opportunities if there's a need in a particular community to have additional support.

I will pass this to my colleague in a moment, but we have a number of avenues, in terms of mental care access, whether it's within the DOD or partnering with local organizations. "Give an Hour" is a great example of free mental health care that's available for all of our military members, including the National Guard and their family.

Dr. COLSTON. I'd just add, sir, financial security and healthcare security are big issues for this cohort. I have seen patients from the National Guard who were on Medicaid shortly before, patients who didn't have access to healthcare recently. When I've—was deployed, I once saw a young man who had an opiate addiction, who was on

buprenorphine, which is a great treatment. That's exactly what he needed to be on, but he didn't need to be in the desert on that particular therapy. So, we need to standardize and optimize care for our Guard cohort, just as we do for the Active Duty forces.

Senator TILLIS. Thank you.

Senator Gillibrand.

Senator GILLIBRAND. Thank you.

Dr. Miller, servicemembers who are transitioning or experiencing a move seem to be particularly vulnerable. My understanding from the Department's own statistics is that 37.8 percent of servicemembers who died by suicide had either entered, exited service, or had experienced a geographical move in the last 90 days, or would be in the coming 90 days. Servicemembers who are exiting the service are dealing with a number of very stressful factors, as well as the culture shock of transitioning to civilian life. Both unemployment and suicide rates among veterans must be directly impacted—by the lack of adequate coordination between the DOD and VA as military members are exiting service.

In a recent survey, Iraq and Afghanistan Veterans of America found that 65 percent of its members knew a fellow post-9/11 veteran who attempted suicide, and 59 percent knew one that succeeded. Does your office reach out to these veterans for insight and advice how you can better serve younger veterans?

Dr. MILLER. Yes. The—you are 100 percent correct that the time of transition is—represents a higher risk period for individuals, veterans, servicemembers, with regard to suicide. That time of transition can be embodied by exactly what you're talking about with that which occurs from servicemember to veteran. I am optimistic regarding that which we have spent the last year working carefully on with regard to wraparound services, 365 days before separation to 365 days post. I'm optimistic about what started on Monday of this week, which was initiation of Executive Order 13822, step 1.1, which was the VA callbacks. Within the first month of separation, we are contacting every veteran that we receive on the list of those separating. We're introducing them to the VA, we're introducing them to services with the VA, and we're offering them connection and resources within that conversation. We offer them a follow-up letter to reiterate the sources, and we offer them connection to mental health services.

Again, that began on Monday. We'll be monitoring the progress of that within our agency broad goals. I look forward to positive results, ma'am.

Senator GILLIBRAND. Have you also looked into this issue? We passed some legislation in early 2019 on overmedication of veterans, that sometimes veterans are given four or five medications, and there's some correlation between increase in suicide susceptibility because of overmedication. Have you begun to look at that? Have you had any findings up until now?

Dr. MILLER. Yes, ma'am. I feel that we've been looking at this for a few years, at the—at least, particularly with opioids, and then opioid combinations, such as with benzodiazepines.

Senator GILLIBRAND. Right.

Dr. MILLER. We have been carefully monitoring, as a whole system, opioid prescribing rates, opioid and benzodiazepine combina-

tions, and we've been working on addressing and tracking down on that. However, within that there are—and Mike knows this better than the rest of us, but there are important clinical practice guidelines to attend to. You could exacerbate issues if you taper too quickly or in a way that's not advised. So, making sure that we're doing this in a way that is consistent with clinical practice guidelines is also important. We've had a significant emphasis on that within our system, as well.

Senator GILLIBRAND. Okay.

Dr. Kessler, part of your testimony, you said that you thought it would be interesting to have an inception survey, since a lot of the data shows that many of our servicemembers come in with mental health challenges. But, as I said in my opening remarks, a lot of servicemembers don't want their commanders to know that they have a history of mental illness or that there might be some impediment to exemplary service. So, have you any thoughts about, if we did create an inception survey, how to allow it to be confidential? I'm thinking about the fact that our chaplains are able to provide guidance, spiritual counseling on a confidential basis that never goes to the commander. Is there an argument to be made to allow mental health guidance, mental health services to be given in a confidential setting, included with the inception survey, and then continue that throughout a servicemember's career, and then again upon separation, so that you have an entire continuum of care for mental health that is outside of the chain of command so it—so that there's not that barrier, the fear of being degraded or devalued or being sidelined?

Dr. KESSLER. You know, in the work that we've been doing with new soldiers, where we have, 50,000 new soldiers we survey right in the—in reception week, you know, within 48 hours of them getting into the service, we tell them that this is all confidential, that some university guy's doing it, their commanders will never know about it. We find 1 percent of people who told us they tried to kill themselves in the past. Well, that's a—if you admit that in your thing, you're not in the Army. So, all those people didn't say that. That's about half of the people who will ever make a suicide attempt while they're in the Army, they made it before they joined, and they, on purpose, didn't talk about it. So, it's clear that there's stuff going on of that sort. The—as I mentioned before, most of these problems are relatively mild, but there are some that are pretty severe.

What do you do about that? It's a challenge. There are several things we've been working on in other populations, like with college students, the same kind of age group, saying, "You know, you want to be all you can be, you want to be a master of the stresses, and so we're going to teach you some ways of being more resilient." So, it's a—"You're a winner, you're not a loser, for going in and getting help." So, I think there's some rebranding that can be done and probably do some good.

It's tough to rebrand that you tried to kill yourself. You know what I mean? It's just sort of—and so, the idea of doing something that's more confidential, that sort of goes beyond Military OneSource—and a lot of people do know that they can go to the chaplains. And chaplains are feeling beleaguered now, because

they're getting a lot of this stuff. It makes a lot of sense. But, it's really—I mean, as an outsider, it makes a lot of sense, but you really have to turn to the folks here who are the DOD people. But, as an outsider, I certainly think that is a—has a lot of common sense to it.

Dr. MILLER. Ma'am, I have a 20-second follow-up to that——

Senator GILLIBRAND. Yeah, anyone can——

Dr. MILLER.—if I may.

Senator GILLIBRAND.—speak on this issue.

Dr. MILLER. The most trouble I was in in the military when I was an officer and a clinical psychologist was when I did not report that the spouse of an F–16 driver was experiencing substance-use-disorder issues. When there was an on-installation event involving this situation, the commanding officer was livid at me for not telling him about this. I said, "Why would I tell you?" And he said, "Because I wouldn't have assigned this person to be a 16 driver if I knew that." And I said, "How fair is that?" What was really underlying his emotion was the fact that he was afraid that he was going to get in trouble and that fingers were going to get pointed.

So, at all levels, I think we also need to take a look at the culture in which we blame and point fingers, and we allow people to take a chance, in some cases, and use clinical discretion and use interpersonal discretion instead of blaming when something bad happens, as a first resort.

Senator GILLIBRAND. Related, so we've been working for a long time on trying to deal with the scourge of military sexual violence, and that more than half of the survivors are men, in terms of raw numbers. But, the number of men who are willing to report is very low, because they don't want to be devalued or made fun of or just appear that they're not strong enough or tough enough for the job, and so, they don't report. Then we've seen some evidence that untreated sexual trauma, particularly among men, is one of the leading reasons for suicide amongst that cohort.

So, one of the reforms we've put in place a long time ago is that we let people report if they've been sexually assaulted, confidentially, so they can get access to the services. It does not—it is not really working, because the men still have very low reporting. But, at least we've put that into place.

I'm thinking that, to the extent any of you have any thoughts on this issue, making a recommendation to the committee about how to create a safe space for mental health reporting, similar to the allowance we make for military sexual trauma reporting, to just get services in to these people so they don't lose hope, and don't decide—or don't fall prey to suicide.

Dr. COLSTON. I think one thing—Matt was—by the way, was absolutely right when he spoke about nondisclosing. Policywise, he was totally fine on that nondisclosure, and I think something along those lines, codified in law, might not be a bad idea. Because right now it really is, it's just a—it's a training issue. It's more——

Senator GILLIBRAND. Right.

Dr. COLSTON.—a cultural issue of how we practice, as psychologists and psychiatrists.

Senator GILLIBRAND. Well, I'd be grateful if you'd each do a recommendation to the committee by letter after you've had some time

to think about this, because I do believe having a requirement by the chain of command to report any mental health issue is a significant barrier to seeking treatment. And we've seen it in the military sexual traumas context. So, I'd love your recommendations about ways you could implement something like this that you think would be productive, based on your years of experience and expertise.

[The information referred to follows:]

Dr. KESSLER. That is an exceedingly difficulty problem. DOD personnel know that mental health problems can damage career chances. In civilian industry, this problem is managed in two ways that could be used in DOD: (i) by having laws put in place that make it illegal to discriminate based on health problems, although we know that these are often honored in the breach in the civilian world; and (ii) by putting in place external EAPs [employee assistance programs] that allow workers confidentially to seek help without their employers knowing. I see no reason the latter cannot be done in DOD. The argument that military personnel need to have their commanders know of their emotional problems should be equally true among civilian first-responders, like police, firefighters, and other emergency services workers. Yet police and firefighters typically have unions and external EAPs that protect their rights while making sure these personnel are able to do their jobs. There will continue to be some difficulties, as we would not want an actively suicidal soldier to deploy to a combat theatre in a combat arms MOS [military occupational specialty], yet we know that career advancement in the Army is enhanced by having combat deployments. Some cases will exist when confidentiality has to be broken, much as in the case where the confidentiality of a priest has to be broken in some cases of extreme danger. But these cases would be much fewer if an external EAP existed in DOD than under the current system. Military One Source and the confidentiality of chaplains are examples of work arounds that already exist in DOD, so there should be no fundamental problem creating a more general external EAP function.

Dr. ORVIS. The issue of disclosure of mental health issues to the chain of command is a complex one. While the intent of DOD policy is to effectively meet the dual requirements of caring for our servicemembers and accomplishing DOD's mission, we understand it is our responsibility to ensure our policies and procedures do not have unintended consequences. Matters related training for medical providers on when disclosures are required or not required, fall under Health Affairs. Whether barriers to seeking care are perceived or actual, we must continue to identify and address them so as to provide our servicemembers with the resources and support they deserve. This issue is one of the calendar year 2020 focus areas for the enterprise-wide Department of Defense (DOD) Suicide Prevention General Officer Steering Committee (SPGOSC).

Dr. COLSTON. In the event a DOD mental health professional determines that command should be informed, it must be done in a manner that prioritizes the servicemember's privacy and confidentiality. DOD Instruction 6490.08 requires that mental health professionals inform commanders in very specific, limited circumstances and then provide only the minimal required information to allow the commander to make decisions about risk management and unit operations. Commanders are also expected to protect the privacy of the information provided to them and restrict access to a servicemember's health information to only those with a need to know.

Dr. ORVIS. I appreciate that, and I just wanted to share one additional new thing that we're doing to—I think the panel has all spoken to the importance of—that we're trying to change the culture around help-seeking, around how we view mental health, around how we view suicide. Certainly, we need to do that, not only within the military community, but nationally.

Senator GILLIBRAND. Yep.

Dr. ORVIS. But, one of the new pilot initiatives that we're working on is a training program focused on trying to talk about a lot of those concerns that servicemembers may have of what are those perceived barriers they're having, the concerns they have that it

may have them, the impact it may have on their security clearance or the confidentially concern or their privacy concern, and talking through, What are the different resources that they can use? They could use chaplains, you know, the variety of different options, in addition to mental health professionals, to seek help. So, I think that's an important initiative that we're beginning, to help break that concern of, "I can't reach out," or maybe, "I'm not aware of the various portals of where I could reach out for support and resources."

Senator GILLIBRAND. Thank you.

Senator TILLIS. Dr. Orvis, I wanted to come back—in your opening statement, you were talking about identifying at-risk persons. I think you may have referred to it as a red flag. It brings up something else that I want to talk about. If the existence of a program like that is known, then could it have the unintended consequence of having other people try to do everything they can not to be flagged? Which actually relates to one thing that I think is a fundamental problem that I haven't seen anybody fix. I always use the example of, anytime you talk about mental health and removing—I've sat on a panel talking about removing the stigma of mental health. And then I get off the panel and somebody comes up to me, and they whisper about a family member or a friend who has mental health, which, by itself, is stigmatizing the—just, basically, perpetuating the stigma. So——

And then, Dr. Kessler, in your opening statement, you were talking about how a lot of the at-risk signs are in adolescence, when you probably have parents who may observe something, and they would write it off as the child going through puberty or teenage years if it's—I think you referred to about 13 years old. So, how do we work on that, or what work is being done to where, very early in someone's life, we're identifying it?

And then, Dr. Orvis, how are we making sure that these things that are well-intentioned to identify people that may need to seek help do not have the opposite effect of making them feel like they're about to get flagged and, therefore, perpetuating the stigma?

Dr. ORVIS. That's a really important question.

Share a little bit about the initiative, first, and the intent is for peers to help each other. We know our young servicemembers, and our young individuals across the Nation, are using social media on a regular frequency. I think there was a recent statistic that over 75 percent of our young individuals across the Nation regularly use social media. We have also done research in the DOD that has shown that individuals do disclose, when they're having suicide ideations or troubles, in social media. So, this is a tool to help—if you're seeing your buddy or your peer saying these things in their social media, and maybe nobody else is seeing it, what can you do? What should you do? How can you reach out? What can you say? What resources are available? We are evaluating it right now, so the training video is complete, but we're currently doing evaluations with our servicemembers to understand the effectiveness and efficacy before we roll it out broadly.

I think what I would also add, too, is—and we were talking about this earlier—is, many times—suicide is so complex, and it's

caused by so many different factors. And there are, frankly, simple things that we can all do. Being connected with one another, having those conversations makes a difference. And that's part of what this particular training is trying to do, is just open up an avenue to have that conversation, to not be afraid of saying, "Are you thinking about harming yourself?" We know that's a misconception, "If I say something, I could be at risk of putting a thought in someone's head, and they hadn't thought about it before." In fact, we know it's helpful. It allows that release in someone to share what they might be going through and get that connectedness and support.

Senator TILLIS. Dr. Kessler or Dr. McKeon.

Go ahead.

Dr. KESSLER. It's the $64,000 question, you know, that the challenge is, Do we want to, as I said earlier, repackage it to say, when things are mild enough that you're building strength, "You're going to be a—you're going to have a great resilience"? When it's bad enough that you can't do that anymore, there's got to be a thing where people say, "You know, I've been depressed before. I've had PTS." A general comes up and talks about this, or a famous person. But, as Dr. Orvis said, it can backfire. You know, for many years, the week with the highest suicide rate in America was the week after Marilyn Monroe killed herself, and that's been supplanted now recently. The week after Robin Williams killed himself is now the highest week of suicide. So, "If they—if he thinks life is worth living, you know, what hope is there for me?" So, it's a tricky thing.

But, to have stories of resilience, say, "Look, I've been through tough times, and I came out the other end." You might recall Rich Carmona, who was a Surgeon General at one point. He was a trauma surgeon, and he was really into, "Real men can get depressed. You know, I've been through hell, and anybody who has blood running through their veins would be depressed at a situation like that. Of course I was feeling depressed, just like people—real men get scared. You know, I was scared. Of course I was scared. If you say you're not, you're lying. So, the real people who are strong enough are the ones who admit they have it and confront it." We're going to have to go there eventually with this. How to do it in an intelligent way, how to get from here to there and not have potholes along the way, I don't know, but it's got to be something we've got to confront in a direct way eventually.

Dr. MCKEON. One thing that I would add is that recent research has indicated that stories of hope and recovery of people who are encountering difficult times, including suicidal crises, but get through it and can still thrive, are particularly important in having positive impacts. It's—for a long time within the suicide prevention field, there's been a lot of concern about depictions of suicide leading to an increase. And that—and safe messaging is important. But, this recent research about stories of hope and recovery, I think, is important.

I also would want to mention that—to reiterate something that Matt had mentioned, that it's so important that, to the extent we can, things occur within a just culture and not one of blame. It's very important within healthcare systems to—you know, every—if someone dies by suicide, they're under care, it's really important to

take a look at that. But, we won't learn from those tragic events if everyone's—if the psychiatrists, the psychologists, the physician, the social worker are afraid that they're going to be blamed. So, we need to look at these situations in a situation for the just culture, a culture that is not blaming, that's not looking to find the fault that caused the suicide, but that's hoping to understand it better and to learn from each death, to find ways that we can improve.

Dr. MILLER. Sir, if I may add, there's an article coming out of—I believe it's the Albany News, out of Senator Gillibrand's State, today, where they're talking about State leadership investing significantly in mental health counselors in the schools—elementary, middle schools—and then not just counselors, an increasing availability of clinical-type care, but also increasing education about mental health and mental health issues, and normalizing aspects of it at a very young age. I think that that's extremely powerful. I think that it's a great example of where we need to go, and I think it's an example of the power of the PREVENTS Task Force, and what we can do through PREVENTS by combining the VA, the DOD with the Department of Education, and taking a look at how to extend this beyond the State of New York.

Senator TILLIS. Thank you.

Senator Gillibrand.

Senator GILLIBRAND. No, thank you, Mr. Chairman.

Senator TILLIS. Well, I could—as you can see, we've gone through a few rounds ourselves up here, and I could go on forever. We're going to need to, because there's not going to be any one solution, and it's a—it's an effort that will continue for many Congresses.

But, one thing I am interested in, in your feedback—and I do have questions for the record that we will submit and, hopefully, get your responses back—but, the—any even meager steps or minor steps that we could be looking at as we prepare—we go into next year, and we look at the next NDA [National Defense Authorization]. I thought the point that Senator Gillibrand brought up—in your case, Dr. Miller, where perhaps we need to codify what you were doing, which was proper practice—is one little thing that we can do to make sure the command understands how they should be behave. But, any suggestions that you may have for our consideration as we begin to work on the next mark for the National Defense Authorization, and anything independent of that, we'd be very interested in your ongoing dialogue and feedback.

Again, I apologize for the hearing starting a little bit late, but I think you see the Members who came here have expressed an interest. We're very, very interested and committed to doing everything we can.

So, thank you all for being here. We'll keep the record open for one week. And we look forward to your continued feedback.

Committee is adjourned.

[Whereupon, at 4:42 p.m., the Committee adjourned.]

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR ELIZABETH WARREN

MILITARY SEXUAL TRAUMA AND MENTAL HEALTH

1. Senator WARREN. Dr. Orvis, Captain Colston, and Dr. Miller, some former members of the Armed Forces who are survivors of military sexual trauma (MST) may not meet the definition of veteran as defined in section 101 (2) in Title 38. Do you believe that expanding MST counseling at Vet Centers (i.e., centers for readjustment counseling and related mental health services for veterans under section 1712A of title 38, United States Code) to all former members of the Armed Forces, regardless of time in service or where they served—assuming no Dishonorable Discharge or a discharge by court-martial—would help reduce gaps in access to mental health services for reservists and members of the National Guard in relation to their Active Duty counterparts?

Dr. ORVIS. Expanding access to resources across geographic locations and populations served may have a positive impact on help-seeking and reduce gaps in access to mental health services. However, mental health treatment for survivors of military sexual trauma (MST) falls under a clinical purview and Health Affairs.

Captain COLSTON. Yes, I believe that expanding MST counseling at Vet Centers to all former members of the Armed Forces would help reduce gaps in access to mental health services for reservists and members of the National Guard in relation to their Active Duty counterparts. Military sexual trauma can have a variety of short-and long-term effects on a victim's mental health and may include flashbacks of assault, and feelings of shame, isolation, shock, confusion, and guilt. Victims of rape or sexual assault may be at an increased risk for developing depression, posttraumatic stress disorder, substance use disorder, eating disorder, and anxiety. It is important that services and support, wherever provided, consider and address the trauma that many individuals have experienced, including but not limited to confidential hotline availability, mental health screening, counseling, and therapy.

Dr. MILLER. Yes, Readjustment Counseling Service (RCS) believes that expanding counseling for MST, through Vet Centers, to all former members of the Armed Forces, regardless of time in service or where they served, would help reduce some gaps for reservists and members of the National Guard. It is important to note that Vet Center services include individual, group, and marriage and family counseling. This could represent only a portion of what that individual requires to accomplish their goals.

2. Senator WARREN. Dr. Miller, according to a recent report by the House Veterans Affairs Committee, "During the last 7 years, Readjustment Counseling Service (RCS) has provided 15 retreats to approximately 400 recently returning women veterans. Pre-retreat assessments and post-retreat evaluations have shown significant decrease in posttraumatic stress symptomology, and excerpts from feedback forms illustrate the positive experiences of participants." This is a women-only pilot program. Given its apparent success, do you believe it could benefit women veterans' mental health to make this program permanent?

Dr. MILLER. Yes, RCS agrees that participant feedback and outcome data illustrate the success of these retreats and recommends that permanent permissive authority be granted to continue them. Pre- and post-retreat evaluations have shown decreases in posttraumatic stress symptomology and excerpts from feedback forms illustrate the positive experiences of the participants of Women Veterans Retreats.

3. Senator WARREN. Dr. Miller, do you believe it could be beneficial to expand the RCS program in retreat settings beyond women veterans to include other veterans enrolled in the VA health care system, former members of the Armed Forces, and eligible survivors and dependents of veterans?

Dr. MILLER. Yes, RCS believes that other cohorts, in additional to women veterans, could benefit from counseling and instruction in retreat settings. Other cohorts could include those who have experienced military sexual trauma, veterans and their families, era specific veterans and servicemembers, and families that experience the death of a loved one while on Active Duty.

VA CAPACITY TO CARE FOR AT-RISK VETERANS

4. Senator WARREN. Dr. Miller, there are approximately 40,000 health care personnel vacancies within the VA. These vacancies undermine the VA's capacity to deliver mental health care services in a timely manner. Is the VA currently taking every reasonable step to fill vacancies in mental health professionals?

Dr. MILLER. The VA has taken significant efforts to increase mental health providers and capacity and ensure timely delivery of excellent mental health care to

veterans. VA is currently engaged in an ongoing Mental Health Hiring Sustainment Initiative to ensure that the gains achieved in the most recent Mental Health Hiring Initiative are sustained. Since June 2017, VHA has hired a total of 6,513 mental health providers, resulting in a net increase of 1,723 providers through January 2020. Demand for mental health care continues to grow so the sustainment initiative also involves continued engagement with facilities where staffing is below the minimum recommended staff to patient ratio. It should be noted that the vast majority of vacancies in the VA system do not reflect actual shortages or gaps in service, but rather are the result of the natural churn of an average annual 9.5 percent turnover rate in staffing due to losses and an average annual growth rate of 2 to 5 percent. Year over year, VA continues to achieve substantial growth in the clinical provider workforce to meet the needs of veterans.

5. Senator WARREN. Dr. Miller, do you need additional authorities from Congress to adequately address vacancies in mental health professionals at the VA?

Dr. MILLER. Additional congressional authorities are not needed. VA remains focused on hiring mental health professionals.

6. Senator WARREN. Dr. Miller, in your written testimony, you acknowledge the introduction of proposed legislation, The Improve Well-Being for Veterans Act (S. 1906/H.R. 3495), which "would require VA to provide financial assistance to eligible entities [. . .] through the award of grants to provide and coordinate the provision of services to veterans and veteran families to reduce the risk of suicide." In order to maintain veterans' continuity of care and ensure accountability for that care, would you agree that it is important for any outside mental health services organization receiving a grant or a contract from the VA to keep veterans connected to the VA's mental health services and programs and protect these programs?

Dr. MILLER. Strong care coordination between VA and community providers ensures veterans receive timely, integrated, high-quality care. VA believes care collaboration is important across both mental health and medical services for veterans receiving care in the community and in the VA. VA endorses a public health approach that incorporates both community prevention strategies and clinical interventions to end veteran suicide. Related to clinical interventions, appropriate mental health staffing is required for delivery of evidence-based care.

7. Senator WARREN. Dr. Miller, in your written testimony, you acknowledge the introduction of proposed legislation, The Improve Well-Being for Veterans Act (S. 1906/H.R. 3495), which "would require VA to provide financial assistance to eligible entities [. . .] through the award of grants to provide and coordinate the provision of services to veterans and veteran families to reduce the risk of suicide." Please describe the criteria that the VA should use to ensure that only reputable organizations and other entities receive grants to provide mental health care services to veterans.

Dr. MILLER. H.R. 3495/S. 1906 provides specified criteria to ensure that organizations selected meet standards of care befitting our veterans. VA would follow all requirements outlined in final legislation. Paragraph (1) of H.R. 3495 states eligible entities must provide:

1. A description of the suicide prevention services proposed to be provided by the eligible entity and the identified need(s) for those services;
2. A detailed plan describing how the eligible entity proposes to deliver the suicide prevention services, including the community partners with which the eligible entity proposes to work in delivering such services, the arrangements currently in place between the eligible entity and such partners, and how long such arrangements have been in place;
3. A description of the types of veterans at risk for suicide and veteran families proposed to be provided such services;
4. An estimate of the number of the veterans at risk for suicide and veteran families proposed to be provided such services and the basis for such an estimate;
5. Evidence of the experience of the eligible entity (and the proposed partners of such entities) in providing suicide prevention services to individuals at risk for suicide, and particularly to veterans at risk for suicide and veteran families;
6. A description of the managerial capacity of the eligible entity—
   A. to coordinate the provision of suicide prevention services with the provision of other services by the eligible entity and/or its proposed partners;
   B. to assess continuously the needs of veterans at risk for suicide and veteran families for suicide prevention services;
   C. to coordinate the provision of suicide prevention services with the services of the Department for which the beneficiaries are eligible;

D. to tailor suicide prevention services to the needs of veterans at risk for suicide and veteran families; and
E. to seek continuously new sources of assistance to ensure the continuity of suicide prevention services for veterans at risk of suicide and veteran families as long as the veteran is determined to be at risk for suicide.

8. Senator WARREN. Dr. Miller, in your written testimony, you acknowledge the introduction of proposed legislation, The Improve Well-Being for Veterans Act (S. 1906/H.R. 3495), which "would require VA to provide financial assistance to eligible entities [...] through the award of grants to provide and coordinate the provision of services to veterans and veteran families to reduce the risk of suicide." What is the VA's measure of success in such a program?

Dr. MILLER. As noted in H.R. 3495/S.1906 selected entities will be required to provide annual reports related to the services they provide and outcomes. Currently, suicide prevention programs can be measured through several supported avenues:
1) Multiple year suicide death and behavior rate surveillance;
2) Community partnerships;
3) Qualitative data to examine gaps between community programs;
4) Access to crisis care;
5) Mental health supports;
6) Outreach and awareness campaigns; and other components as determined by the suicide prevention program.

SOCIAL MEDIA

9. Senator WARREN. Dr. Orvis and Captain Colston, in your written testimony, you observed, "We will also teach young servicemembers how to recognize and respond to suicide 'red flags' on social media—to help servicemembers recognize how they can reach out to help others who might show warning signs." Is this effort integrated with any ongoing DOD efforts to educate servicemembers regarding attempts by foreign adversaries (e.g., governments and their proxies and agents) to influence servicemembers as part of their malign influence campaigns?

Dr. ORVIS. To reach the online community, specifically young servicemembers that may see different aspects of an individual's life, the Department has recently developed a brief online training video about social media indications that may precede suicide ideation and behavior. The training video will educate individuals about the emergence of warning signs of suicide on social media, as well as the constructive steps to take to intervene in a crisis and refer to appropriate care, including an understanding of why individuals should or should not take specific actions. Educating servicemembers regarding attempts by foreign adversaries to influence servicemembers as part of their malign influence campaigns is out of scope for this current brief training video.

Captain COLSTON. As stated by the Defense Suicide Prevention Office, educating servicemembers regarding attempts by foreign adversaries to influence servicemembers as part of their malign influence campaigns is out of scope of the current brief training video.

MENTAL HEALTH CHALLENGES OF NATIONAL GUARD MEMBERS

10. Senator WARREN. Dr. Orvis and Captain Colston, in your written testimony, you observed that "National Guard members face unique challenges in comparison to their Active Component counterparts[.]" One of the ways you noted that the Defense Department is working to expand their access to mental health care services is "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." Please describe your office's work with the Massachusetts National Guard to reduce suicides among members of the Guard in the Commonwealth, including any notable achievements or milestones.

Dr. ORVIS. DSPO works closely with the National Guard Bureau (NGB) and supports their suicide prevention efforts with each State and Territory. The Warrior Resilience and Fitness Innovation Incubator (WRFII), overseen by the NGB, is a joint effort by the Army National Guard (ARNG) and the Air National Guard (ANG). WRFII aims to identify, select, evaluate, and disseminate evidence-informed practices to promote resiliency and prevent suicide and related harmful behaviors. WRFII operated 11 pilot programs in fiscal year 2019. In fiscal year 2020, WRFII is adding 12 new pilots to the program, with a focus on five areas: barriers to care and resource utilization; integrated approaches to destructive behavior; promoting

connectedness; management of lethal means; and support during transitions. Massachusetts ARNG and ANG were selected for two pilots:

- Alcohol and Drug Abuse Prevention Training (ADAPT): Quarterly educational services to restore back to duty substance-impaired servicemembers who have the potential for continued military service. The program made updates to the ADAPT curriculum, completed one training in January, and scheduled two trainings in April and September 2020.
- Warrior Functional, Intensive Training (F.I.T): Expands the existing Warrior F.I.T. program by providing personnel with tools and training to meet physical readiness standards, optimize performance, and live a healthy lifestyle. Includes in-person training, assessments with personalized feedback, and an online learning portal.

Captain COLSTON. Health Affairs and the National Guard have a relationship at the strategic level. Specific work being done by the states directly is coordinated within the National Guard and shared with Health Affairs as well as Personnel and Readiness for visibility when indicated.

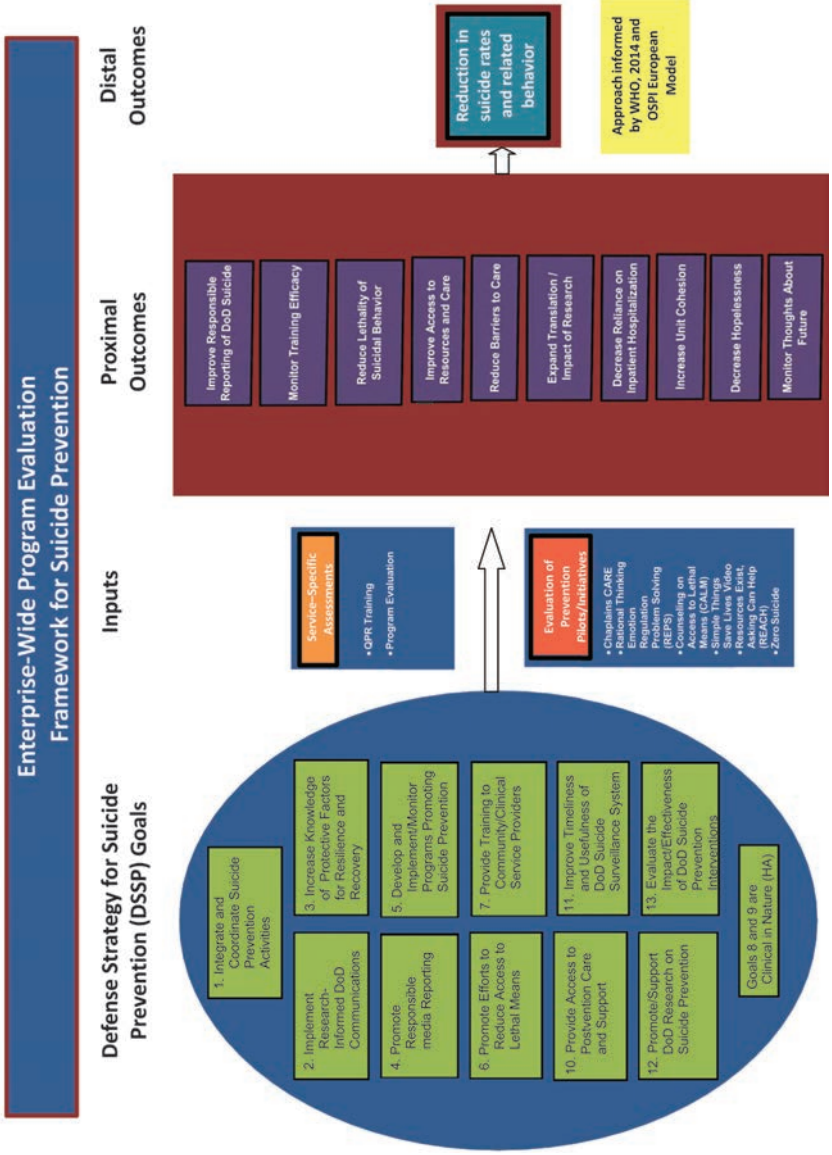
MEASURING EFFECTIVENESS OF SUICIDE PREVENTION PROGRAMS

11. Senator WARREN. Dr. Orvis and Captain Colston, in your written testimony, you observed that the Defense 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." Would you be willing to share a copy of this framework, when complete, with members of the Committee?

Dr. ORVIS. A copy of the framework is included as Attachment A.

Captain COLSTON. Dr. Orvis has provided a copy of the framework in her response to this question—please see her response.

ATTACHMENT A



12. Senator WARREN. Dr. Orvis and Captain Colston, in his written testimony, Dr. Kessler observed, "The idea has been discussed for many years of implementing an inception survey for all DOD personnel beginning service in order to assess pre-enlistment mental disorders, childhood adversities, and other risk and resilience factors for suicidality that might profit from early intervention. Army STARRS carried out such a survey and the results continue to be very important as we follow soldiers over nearly a decade." Dr. Kessler continued, "An ongoing inception survey of this sort for all new recruits coordinated across all DOD branches might be of considerable value in pinpointing new personnel for early intervention as well as for obtaining information that could be used to help guide precision treatment planning." Do you agree?

Dr. ORVIS. Accessions policy within the Office of Military Personnel Policy is responsible for the Military Entrance Processing (MEPS) process and screening. It is standard to screen all recruits for mental health issues. Assessments are conducted upon accession, at periodic points throughout a servicemember's career, and as part of the transition from military to civilian life (in close coordination with the Department of Veterans Affairs). Matters related to screening for mental health issues closely align to efforts that fall under Health Affairs.

Captain COLSTON. Additional research will help determine the value of an inception survey to identify early intervention, including comparisons to the civilian sector. Precision treatment planning may improve outcomes; however, pre-enlistment survey questions may inadvertently disqualify a recruit that may never present with mental illness throughout their service.

13. Senator WARREN. Dr. Kessler, based on your experience, what is your assessment of the effectiveness of suicide prevention and related mental health care programs implemented by the DOD and the VA for servicemembers and veterans in Massachusetts?

Dr. KESSLER. I'm not familiar with any special programs of this sort in Massachusetts. Furthermore, as an epidemiologist, my work focuses on the magnitude of the problem, predictors of the problem, and consequences of the problem, but not treatment effectiveness. The clinical researchers on the panel would be in a better position to address this question than me.

14. Senator WARREN. Dr. Kessler, what is your assessment of the partnerships between academic institutions in Massachusetts and the DOD and the VA with regard to suicide prevention and related mental health care programs assisting servicemembers and veterans? In your response, please include ways, if any, that these partnerships could be improved.

Dr. KESSLER. I'm more familiar with national partnerships than with partnerships in Massachusetts specifically. There are big differences between VA and DOD due to the fact that VA has a policy of encouraging joint appointments between academic institutions and VA, whereas this does not exist in DOD. In Boston, for example, faculty from Boston University (BU) Medical School and Harvard Medical School (HMS) both have joint VA appointments and work at the Boston-area VAs. The different VA locations in the Boston area are either BU-affiliated or HMS-affiliated. The same is true in many other communities across the country. This is less feasible in DOD because of the smaller size of DOD than VA, but this could be done in DC and San Antonio and Texas and other places with major DOD Medical Centers. But another thing that would make an enormous difference would be to have an extramural research program at VA. NIH has both a relatively small intramural research program (i.e., full-time NIH scientists working on research) and a large intermural research program (i.e., NIH giving grants to academics). But VA has only an intramural research program in which the only eligible applicants are those with 5/8th or more FTE [full time employees] in VA. I think the robustness of VA research would be increased dramatically if VA had an intermural research program that held the bulk of VA research dollars. As in NIH, where full-time NIH scientists can be collaborators in intermural research, this could be done in VA as well. That would dramatically increase the intellectual vitality of the VA research portfolio. Implicit in what I'm saying here is that a good deal of VA research is carried out by researchers who are more interested in protecting their turf than bringing in fresh ideas. That situation would change, probably radically, if an intermural research program came into existence.

COMBATING STIGMA IN SEEKING MENTAL HEALTH CARE

15. Senator WARREN. Dr. Orvis and Captain Colston, in your written testimony, you noted that "the Department is piloting a barrier reduction training designed to

address the most prevalent help-seeking concerns of servicemembers (e.g., career and security clearance loss concerns, loss of privacy and confidentiality), and encourage servicemembers to seek help early on, before life challenges become overwhelming." Please describe the stakeholders (e.g., servicemembers, clinicians, etc.) that the Department has consulted in developing this training.

Dr. ORVIS. The Office of Military Community and Family Policy is leading this effort, along with the Office of People Analytics, the Defense Suicide Prevention Office, and each of the Military Departments. All of these stakeholders were involved in developing the barrier reduction intervention called REACH (Resources Exist, Asking Can Help). Thus far, REACH has been piloted with servicemembers and leaders at select Navy, Air Force, and Army installations.

Captain COLSTON. The Office of Military Community and Family Policy is leading this effort, along with the Office of People Analytics, the Defense Suicide Prevention Office, and each of the Military Departments. All of these stakeholders were involved in developing the barrier reduction intervention called REACH (Resources Exist, Asking Can Help). Thus far, REACH has been piloted with servicemembers and leaders at select Navy, Air Force, and Army installations.

MANDATORY SEPARATION HEALTH ASSESSMENT

16. Senator WARREN. Dr. Orvis and Captain Colston, as you assess trends in mental health care and suicide prevention, are there any improvements that you would recommend at this time to the mandatory separation health assessment?

Dr. ORVIS. The Department of Defense (DOD), the Department of Veterans Affairs (VA), and Department of Homeland Security are working together to ensure seamless access to mental health care and suicide prevention resources for transitioning servicemembers and recent veterans during the critical first year after leaving the military. The separation health assessment is a key tool in understanding the needs of our transitioning members. While I have no modifications as of now, we are always in close partnership to ensure as we learn more about the experiences of our transitioning members, we can adjust the assessments accordingly.

Captain COLSTON. The DOD and VA continue to work together to complete a single, common Separation Health Assessment to streamline the transition of health care from DOD to VA; improve clinical documentation of health status at the time of separation; and improve the VA claims process for those separating servicemembers who apply for benefits delivery at discharge.

OPIOIDS

17. Senator WARREN. Dr. Orvis and Captain Colston, in your written testimony, you noted that medication is a commonly used method for attempting suicide and that "DOD has an opiate overdose death rate that is one-fourth of the civilian rate" due, in part, to efforts such as "pharmacy controls for all opiate medications." Do these pharmacy controls include declining to fill an opioid prescription under certain circumstances or partially filling opioid prescriptions?

Dr. ORVIS. Based on the 2017 Department of Defense Suicide Event Report Annual Report, approximately 2.9 percent of suicide deaths across all Military Services involved the use of opioids at time of death; 3 percent of suicide attempts involved the use of opioids at the time of their attempt. Specifics on pharmacy controls fall under Health Affairs.

Captain COLSTON. Yes, pharmacy controls can assist/support a pharmacist's decision in declining to fill a prescription.

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