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[H.A.S.C. No. 114–56]

UPDATE ON MILITARY SUICIDE PREVENTION PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

HEARING HELD
OCTOBER 8, 2015

U.S. GOVERNMENT PUBLISHING OFFICE
97–192 WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
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UPDATE ON MILITARY SUICIDE PREVENTION PROGRAMS

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Thursday, October 8, 2015.

The subcommittee met, pursuant to call, at 2:00 p.m., in room 2212, Rayburn House Office Building, Hon. Joseph J. Heck (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. JOSEPH J. HECK, A REPRESENTATIVE FROM NEVADA, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL

Dr. HECK. I will go ahead and call the hearing to order. I just want to give notice that votes are expected at sometime between 2:05 and 2:20. And so, when that happens, we will recess, go vote, and then come on back and finish.

Good afternoon, everyone.

Today, the subcommittee meets to hear testimony on the efforts by the Department of Defense [DOD] and the military services to prevent suicide by service members, family members, and civilian employees.

I want to preface my statement by recognizing the tremendous work that both the Department of Defense and the service leadership have done to respond to the disturbing trend of suicide in our Armed Forces. As a military commander who has had to deal with suicide within the ranks, I know firsthand that this has not been an easy task, and I thank you all for your hard work.

However, I do remain concerned that the recent Department of Defense inspector general assessment of the Department's suicide prevention program identified a lack of clear policy guidance and synchronization of organizations responsible for executing the program.

I am also troubled that DOD has not completed the work necessary to beginning reporting more comprehensive and inclusive statistics on military-related suicides, as mandated by Congress last year.

So I look forward to hearing from our witnesses how the Department is addressing these concerns.

Suicide is a difficult topic to discuss. But last year, 442 Active and Reserve service members took their own lives. Every one of them is a tragedy, every one of them has its own story, and every one of them demands that we not rest until we have taken action to change this extremely troubling statistic.

We know that suicide is a multifaceted phenomenon that is not unique to the military. Unfortunately, in addition to the unique hardships of military service, our service members are subjected to the same pressures that plague the rest of society: troubled relationships, substance abuse, and financial difficulties.

Each of the military services and the Department of Defense has adopted strategies to reduce suicide within our troops, so I would like to hear from our witnesses whether those strategies are working. I will tell you that I know that at least in the Army Reserve, we are at 47 suicides through September 30, 2015, which is more than we had in all of the last calendar year.

How do you determine whether the programs incorporate the latest research and information on suicide prevention? I am also interested to know how Congress can further help and support your efforts.

With that, I want to welcome our witnesses. I look forward to their testimony.

And before I introduce the panel, let me offer the ranking member, the gentlelady from California, Mrs. Davis, an opportunity to make her opening remarks.

[The prepared statement of Dr. Heck can be found in the Appendix on page 37.]

STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL

Mrs. DAVIS. Thank you, Mr. Chairman.

And I appreciate all of you being with us today.

I am very pleased that the subcommittee is continuing to work to help prevent suicides in the military.

Since our last hearing, the Department of Defense and the services, with continued support from this committee and from the Congress, have worked hard to establish, to improve, and to enhance their suicide prevention programs with the goal, of course, of decreasing suicides in the military community and, I think we would all say, not only decreasing but someday looking towards a time when it is very rare.

Sadly, even with these increased efforts, this issue continues to be a difficult one to grasp, and the number of suicides continues to grow.

I am interested to hear from the Defense Suicide Prevention Office and certainly from each of the services on the changes that have been made to the programs over the past 2 years. What have we learned? What have we changed?

In particular, I am interested in hearing more about the identification of potential indicators which may lead an individual to suicide, as well as the improvements which have been made to intervention programs providing help to those in need.

In the past, we know that the services have struggled, we have all struggled, with how best to appeal to the friends and family of service members to encourage them to step forward before it is too late. I believe this is still a critical link to prevention. These are the people that are around the service member the most, and we

must provide them the tools necessary to identify and to intervene when possible.

I certainly welcome all of you, our witnesses, and look forward to hearing from you on what has been done, what is currently being done, and where we go from here.

Thank you, Mr. Chairman.

Dr. HECK. Thank you, Mrs. Davis.

We are joined today by an outstanding panel, and, given the size of our panel and our desire to give each witness the opportunity to present his or her testimony and each member an opportunity to ask questions, I respectfully remind the witnesses to summarize, to the greatest extent possible, the high points of your written testimony in 5 minutes.

I know most of you have been here before. The lighting system will be green. At 1 minute left, it will go yellow. And when your time is up, it is at red, and I would ask you at that point to please finish up quickly. I assure you that your written comments and statements will be made part of the hearing record.

So let me welcome our panel. Dr. Franklin, Director of the Suicide Prevention Office, Office of the Secretary of Defense. Welcome. I know this is the first time in your position now before the committee. Welcome.

Lieutenant General James McConville, Deputy Chief of Staff, G1, for the U.S. Army; Lieutenant General Mark Ediger, Surgeon General of the Air Force; Major General Burke Whitman, Director of Marine and Family Programs for the U.S. Marine Corps; and Rear Admiral Ann Burkhardt, Director of the 21st Century Sailor Office for the U.S. Navy.

Dr. Franklin, the floor is yours.

STATEMENT OF DR. KEITA FRANKLIN, DIRECTOR, SUICIDE PREVENTION OFFICE, OFFICE OF THE SECRETARY OF DEFENSE

Dr. FRANKLIN. Chairman Heck, Ranking Member Davis, distinguished members of the subcommittee, thank you for the opportunity to appear before you today to discuss the current state of the Department's suicide prevention efforts.

Suicide prevention is an issue near and dear to my heart. I am a daughter of a 22-year career Navy enlisted sailor, I married an Air Force officer, and I have spent the last 20 years of my career working at various levels as a social worker with military families around the world. I have seen firsthand the trauma and devastating effects suicide has on families, friends, units, communities across the military.

Previously, as a headquarters-level policy lead in the area of suicide prevention in the Marine Corps, I worked diligently with commanders, chaplains, medical, and nonmedical helping professionals to reduce the number of suicides in the Corps.

During this experience, I realized three important things: First, suicide is absolutely preventable. Second, suicide is such a complex issue that the reduction of suicide across the services is possible only through active and at times intensive collaboration with a wide variety of stakeholders. And, third, the risk and protective

factors are common across many of the challenges that service members face.

When I train my staff as a licensed social worker, I always share how clients don't typically present to us with just one problem. They come to us and other helping professionals with a wide variety of problems, including financial, legal, relationship concerns. Some are contemplating suicide, and we have to know the signs and how to get them to help.

Therefore, I stress that it is imperative that we approach the problems of our clients in an integrated, vice stovepipe, fashion, engaging across interdisciplinary approaches as needed.

It is with this view and background that I eagerly accepted the job as the Director of the Defense Suicide Prevention Office [DSPO] in February 2015. When I accepted this challenging assignment, the Department had just adopted the 2012 National Strategy for Suicide Prevention and was developing a defense strategy consistent with this national approach. This was encouraging, as these strategy documents are central to providing service delivery that is integrated in the fashion that I previously alluded to.

Once on board, I conducted an internal assessment of the office responsibilities, mission, vision, functions. Parallel to that effort, I conducted a series of listening sessions with the services and other key stakeholders and partners, to include the Department of Veterans Affairs [VA].

And my immediate takeaway was that, despite the adoption of this national strategy, the DOD suicide prevention paradigm and DSPO's functions were still largely organized around that 2010 task force report. I realized the DOD strategic paradigm and DSPO's organizational structure had to shift in order to execute the office's responsibilities to support this new strategy and facilitate collaboration with so many stakeholders.

With this understanding of necessary changes, my immediate actions were to order a closeout of the task force report recommendations, which is near completion; also, to adopt an underlying theory base drawn from the Institute of Medicine's Prevention Continuum; and to move the Department's strategy staffing forward, thanks to the constructive input from the services and the components; and to begin the development of a Department of Defense instruction that clearly spells out the policy, the responsibilities, the procedures; and, lastly, to develop an office approach and organizational structure that could more efficiently implement this new strategy.

In my oversight responsibility, one of the main efforts of the office is to identify and leverage best practices across the services, thus ensuring rigorous science in all that we do.

To best implement the Department's strategy, I have leveraged a public health framework in organizing DSPO along five lines of effort, including data and surveillance, assessment, advocacy, policy, outreach and education. While each of these are explained in detail in my written testimony, the data and surveillance efforts will be critically important to inform the other lines of effort.

During the year 2013, according to our quarterly data reports, we know that across the Department, including Reserve and Guard Components, we, sadly, experienced 474 deaths to suicide. During 2014, we experienced 442 deaths to suicide. You will hear more

about the trends associated with these tragic losses from my service counterparts today.

In closing, I want to inform you that the Department has recently strengthened our longstanding relationship with the VA. We have already collaborated on awareness of the Military Crisis Line, as well as a database for advanced data and analytics across both departments, and, finally, an innovative campaign strategy, driven by the research, called "The Power of 1" that focuses on service members, families, civilians, offering one small gesture or one act of kindness for anyone at risk.

Beyond the VA and the services, I recognize the Department will not prevent suicide alone. I continue to work diligently with the academic sector, with the private sector, with the National Action Alliance and key agencies, such as the American Association of Suicidology, to forge the necessary long-term relationships to prevent suicide.

And I thank you so much for inviting me, and I look forward to your questions today.

[The prepared statement of Dr. Franklin can be found in the Appendix on page 38.]

Dr. HECK. Thank you.

General McConville.

STATEMENT OF LTG JAMES C. McCONVILLE, USA, DEPUTY CHIEF OF STAFF, G1, U.S. ARMY

General MCCONVILLE. Chairman Heck, Ranking Member Davis, and distinguished members of the committee, thank you for giving us the opportunity to speak before you on this very important topic.

I am going to go ahead and highlight a couple of points from my testimony.

When I was the commanding general of the 101st Airborne Division, a Gold Star mother who had lost one son in combat and one son to suicide came to the division and spoke to the spouses about suicides. And the one point that she wanted us to take away was that people don't commit suicide, they die of suicide.

And when you think about that, people don't commit heart disease, they die of heart disease. There is no stigma attached to going to see a doctor for heart disease. There are also risk factors associated with heart disease, like high cholesterol, smoking, not exercising, and eating unhealthy food. And for our soldiers, identifying and managing these risks can help reduce the possibility of dying of heart disease.

We think the same thing needs to be done with suicide. There are certain risk factors that we know, and we will talk a little bit about them, that put soldiers at high risk, and it is very important we identify these. And this is why I am a very big proponent of one of our best practices that we have put into the Army, which is embedded behavioral health at every single brigade level, so that when they identify the issues, they can get soldiers to the help they need.

The Army had a reduction in suicides in 2014, and that was mainly due to the Reserve and the Guards. And, as the chairman said, this year we are about the same level for the Active but we have seen a rise in both our Guard and Reserve, and we are very

concerned about that. And we are presently doing that analysis. But we are making progress in combating suicide, and it is really a multidisciplinary, holistic approach.

You talked about getting to soldiers. To us, it is absolutely key that we get the soldier's family, their buddy, and the junior leaders involved in getting after suicides. We bring 100,000 soldiers into the Army every single year. They come from outside, and where we are going to identify the issues, it is the soldier's family members who will be the first ones to notice when they have behavioral health issues, alcohol and drug abuse issues, financial problems, relationship problems, all those risk factors for suicide.

And the key leader is that squad leader, that junior leader who is down there with these new soldiers, who can help identify the risk factors and get these soldiers to the behavioral health at the appropriate level early on before they spiral out of control.

We are training our total force, not just soldiers but also civilians and family members, and all the Army's components to get after not only suicide prevention but resilient skills that will make them strong in the face of adversity. We have increased our access to behavioral healthcare services.

We are also fighting suicides through research. I know many of you are very familiar with the Army STARRS [Study to Assess Risk and Resilience in Servicemembers] program, and that is helping us get the best and brightest individuals after this problem. Historically, Army Medicine has found answers to some of the toughest medical problems, including yellow fever, malaria, and life-threatening infections. I am confident, working with these great partners, that they will do the same here.

We have good policy, which we can improve. We have programs we can do better at. But, most importantly, we have exceptional leaders in the Army at all levels who are committed to taking care of our soldiers.

My wife and I have three children serving in the Army. One just was commissioned as a social worker. And my wife expects, as all mothers do, for us to take care of those soldiers, their sons and daughters, who are serving their country during a time of war. And we will do that.

I thank all of you for your continued support in sustaining a professional All-Volunteer Army, and I look forward to your questions.

[The prepared statement of General McConville can be found in the Appendix on page 45.]

Dr. HECK. Thank you.

General Ediger.

STATEMENT OF LT GEN MARK A. EDIGER, USAF, SURGEON GENERAL, U.S. AIR FORCE

General EDIGER. Chairman Heck, Ranking Member Davis, and distinguished members of the committee, thank you for the opportunity to appear before you on behalf of the men and women of America's Air Force.

The United States Air Force defends our Nation with a broad range of capabilities made possible by an incredible force of professional airmen, which include members of the Active Component,

Air National Guard, Air Force Reserve, and civilians in government service.

Secretary James, General Welsh, and leadership at every level of our Air Force are committed to the development of strong, resilient airmen and to coordinated, robust support as they confront problems inherent to life and mission. The Air Force strategy for suicide prevention focuses on resilience among airmen, coupled with a community-based public health approach to prevention and timely intervention with followup for those in distress.

The Air Force leadership is very concerned about the increasing rate of suicides among airmen, a trend within the Active Force. Last year, 62 Active Duty airmen took their lives, a rate of 19 per 100,000. To date in 2015, that trend has persisted. Suicide rates in the Reserve Component and among government civilians have remained relatively static, but we are committed to prevention across the total force.

The Air Force Suicide Prevention Program is an integrated network of policy, process, and education that focuses on fostering strong, resilient airmen, providing assistance through stressful circumstances and focused support for those in distress.

In 2015, the Air Force changed its format for annual suicide prevention training to live, small-group discussions. Special vignettes and discussion guides have been developed for Active Duty and Reserve Component personnel, as well as DOD civilian employees, to address their different demographics and circumstances. This training emphasizes early intervention, risk factors, and warning signs to enable airmen to respond using the "Ask, Care, Escort," or ACE, model.

The Air Force has also fielded an annual refresher course for frontline supervisors in career fields with the highest incidence of suicide. In 2014, we updated the "Airman's Guide to Assisting Personnel in Distress" to help commanders and other leaders on effective intervention for an array of challenging problems. This year, we also released the "Air Force Family Members' Guide to Suicide Prevention" and trained over 200 family members as resilience training assistants.

Since 2012, the Air Force has embedded mental health providers in operational units where performance demands and operational stress are concerns. Mental health providers have also been placed in all Air Force primary care clinics, allowing quick access for airmen and their families as well as reducing concerns about stigma. We are on schedule to complete our 25 percent increase in Active Duty mental health positions by 2016.

We know the importance of effective identification and treatment and controlling the impact of PTSD [post-traumatic stress disorder] on airmen and families. To address this, we continue to screen airmen for PTSD symptoms via pre- and post-deployment health assessments at various points through the deployment cycle. Effective treatment has enabled the majority of airmen diagnosed with PTSD to continue serving.

In addition, in 2010, the Air Force established the Deployment Transition Center at Ramstein Air Base, Germany. This center offers a 4-day reintegration program for airmen returning from de-

ployment that involved activities associated with post-traumatic stress.

Our mental health providers are trained and current in evidence-based treatments. The Air Force is also committed to reducing suicides within the clinical setting by incorporating the latest research and innovative initiatives in our mental health clinics to better manage our highest-risk patients.

Improvement rarely happens in a silo, so we are actively engaged with the Defense Suicide Prevention Office in helping to shape suicide prevention efforts across DOD through multiple committees and working groups.

In April 2015, General Welsh initiated a comprehensive review of Air Force suicide prevention, to include an Air Force Suicide Prevention Summit, which occurred last month. Our aim is to verify factors underlying Air Force suicides, review the latest evidence regarding effective prevention, gain insight into the experience of other organizations, and refresh the Air Force strategy on identifying new actions to effectively prevent suicide. Recommendations from the review and summit are now being used to refresh the strategy and build action plans.

The Air Force is committed at every level to develop and support total force airmen as resilient, mutually supportive professionals. We need every airman across the total force, including those in uniform and our government civilians. We will continue to work closely with our colleagues in the services, DOD, and other governmental agencies and in academia in this essential effort.

Thank you for your attention to this important matter and your continued support.

[The prepared statement of General Ediger can be found in the Appendix on page 55.]

Dr. HECK. Okay, so that was the bell. My intention is to complete testimony, and then we will recess and come back for questions.

So, General Whitman.

STATEMENT OF MAJGEN BURKE W. WHITMAN, USMC, DIRECTOR, MARINE AND FAMILY PROGRAMS, U.S. MARINE CORPS

General WHITMAN. Thank you, Chairman Heck, Ranking Member Davis, and distinguished members. I am grateful for the opportunity on behalf of the United States Marine Corps to update you on our suicide prevention efforts.

This is an institutional priority. It is also a personal priority for me. I had a friend, colleague, and fellow officer in the Marines who took his own life in 2012.

Whenever a Marine chooses to end his or her own life, we are all devastated, and we ask ourselves, why? Is there something we could have done? Are there actions we can take to prevent the next suicide? And we believe the answer is "yes." We can take some actions in three different areas. We can identify the risk earlier, we can intervene earlier, and we can provide robust, ongoing support.

Together, the Department of Defense and the Marine Corps have developed programs to help us do just that, to identify early, intervene early, and provide robust support more effectively than we could in the past and with initiatives even in the last couple years since the most recent hearing here on this topic with you.

The key to leveraging these programs is human engagement by leaders, by peers, and by families. Leaders at every level are trained, prepared, and engaged with our Marines. This includes each Marine's immediate leader, whose sacred responsibility is to know that Marine. Peers who already know each other are also trained to identify and intervene early. Marines are a close-knit family. They tend to understand they have an inherent responsibility to look after each other. Equally important are family members, who may witness concerns before we do. Leaders, peers, and family members can leverage the programs and the training that your Department of Defense and Marine Corps developed as tools to help prevent the next suicide.

Let me offer just a small sampling of some of the more recent program initiatives that help us identify early and intervene early and provide that support, and then I will tell you a brief recent story in which Marines leveraged those programs to save a life.

Identifying a Marine at risk for suicide can be challenging because no single indicator can predict if someone is at risk. So we have taken a holistic approach to this, and we use all of our behavioral health skills to address the challenge.

We know that Marines contemplating suicide often find themselves in a place of hopelessness, involving a mix of stress factors ranging from relationship problems to financial distress. So we train all our Marines to respond to stress in peers. To help identify the risk, family members and Marines are trained to help identify Marines and to seek help.

To assess the risk, once we have identified some indication, we have introduced the evidence-based Columbia Suicide Severity Rating Scale across the entire Marine Corps, to include our behavioral health providers, chaplains, legal assistants, financial counselors, and others.

To intervene early and provide that ongoing support, among the things we have done, we have added a community counseling program that enhances access to care by assisting Marines and families in navigating the many resources available for behavioral health issues. They can receive immediate support regardless of which door they have entered to get help.

In addition, our Marine Intercept Program, MIP, interrupts the potential path to suicide by providing timely intervention and ongoing support, enhancing our ability to conduct ongoing risk assessment, evolve the safety plans for the at-risk Marine, and coordinate his or her care.

These are but a few, and maybe we will have a chance to talk about some others.

Let me quickly tell you about the story about one Marine from just a month ago. His trained leaders and peers had correctly identified him as being at risk for suicide due to several factors. Typically, we have 10 to 20 involved, and he was one of those.

He entered the Marine Intercept Program, and the Marines continued to be watchful. One day, when he was not at his expected place of duty on time, his noncommissioned officer leader immediately launched a search in the right places because they knew him. They found him hanging from a rope, but they found him in time. He was still alive, so they revived him, they rushed him to

the hospital, and that Marine is alive today. We are taking care of him. He is receiving support, but he is alive.

So we have some successes; we are making some progress. But, Mr. Chairman, as you said, this is difficult work. We must remain vigilant. We must continue with the Department to analyze the data regarding suicides, seek effective new approaches based on evidence-based research and empirical tools, continuously enhance our training and resources that we make available to our leaders, Marines, and the families toward what works.

I thank the subcommittee for supporting this work, and I will be happy to answer questions later. Thank you.

[The prepared statement of General Whitman can be found in the Appendix on page 67.]

Dr. HECK. Admiral Burkhardt.

STATEMENT OF RDML ANN M. BURKHARDT, USN, DIRECTOR, 21ST CENTURY SAILOR OFFICE, U.S. NAVY

Admiral BURKHARDT. Chairman Heck, Ranking Member Davis, and distinguished members of the subcommittee, thank you for the opportunity to present you information on the Navy's suicide prevention programs.

Every suicide is a tragedy, and a single life lost is definitely one too many. Sadly, in 2013, the Navy experienced a loss of 46 shipmates through suicide. Although this was a decrease of 20 suicide deaths from the previous year, in 2014 we saw an increase in our suicide total, with 68 deaths. For 2015 thus far, we have lost 44 shipmates to suicide.

Suicide is complex, and, as such, it is difficult to draw conclusions from numbers alone. We continue to monitor the health of the force and investigate every suicide and suicide attempt. The Suicide Prevention Team examines each case for pertinent information that might inform our prevention program. Results from these reviews consistently reveal that demographic distribution of suicide largely mirrors the Navy demographics, and suicides typically occur when sailors are experiencing some combination of multiple recent stressors, including intimate relationship problems, loss, recent career transitions, disciplinary or legal issues, work problems, and financial strain.

The 21st Century Sailor Office stood up shortly after the 2013 hearing, facilitating an integrated approach to total sailor fitness and resilience. The office encompasses diverse elements that impact sailors' physical and psychological health.

Promoting comprehensive wellness is one of our core strategies to proactively prevent destructive behaviors that can ultimately increase suicide risk. Our efforts are focused on education and awareness, prevention and intervention, sailor care, and crisis response.

To that end, since 2013, we have launched several key initiatives. We have expanded our Operational Stress Control Mobile Training Teams, providing training to enable deckplate and senior leaders to better assess and mitigate stress in their units. In 2014, we mandated this training for all units 6 months prior to their scheduled deployment.

We have also assigned deployed resilience counselors to our aircraft carriers and large-deck amphibious assault ships, working

alongside chaplains, behavorial psychologists, and medical professionals who proactively assist our sailors on a daily basis.

We have also implemented several key evidence-based suicide prevention and intervention measures, including training on the use of the Columbia Suicide Severity Rating Scale and the Veterans Affairs Safety Plan to enhance risk assessment and intervention at the deck plate.

We have also released guidance for commanders and health professionals to reduce access to commonly used lethal means of suicide through the voluntary storage of privately owned firearms.

In 2014, we launched our "Every Sailor, Every Day" campaign to promote ongoing and active engagement, peer support, and bystander intervention so that no sailor feels alone. This campaign places strong emphasis on daily interaction to not only build trust and foster hope but enable that early recognition of warning signs and get sailors the help they need.

During the 2015 Suicide Prevention Month, we introduced a new message to this campaign, "1 Small ACT." This message encouraged simple actions to make a difference and perhaps save a life. It is based on the Navy's "Ask, Care, Treat" bystander intervention model and the Navy's supporting the DOD and Veterans Affairs "Power of 1" concept.

We have also released an improved suicide prevention general military training which is interactive, scenario-based, and designed to generate dialogue about stress navigation, suicide prevention, intervention, and also crisis response.

Suicide prevention is about taking care of people. Navy's commitment is to provide sailors and their families the tools they need to thrive during and beyond their Navy careers.

Thank you, and I look forward to answering any questions you may have.

[The prepared statement of Admiral Burkhardt can be found in the Appendix on page 78.]

Dr. HECK. Again, I thank the panelists for keeping their testimony within 5 minutes. I think that is a record for everyone doing so.

We will recess and return right after votes. I ask the members to return as quickly as possible.

[Recess.]

Dr. HECK. Okay. We will the reconvene the hearing.

And, again, I thank the panelists for their testimony.

We will now begin questions from the members of the committee. Reminding committee members that we will adhere to the 5-minute rule, and if there is time remaining after the first round, we will go with a second round of questions.

So, Dr. Franklin, in your testimony, you talk about the rate of suicide among the Active and Reserve Components. And the question is, how does the DOD actually calculate the rate of suicide, and how do the current military suicide rates compare with the civilian rates?

We hear a lot of emphasis, and rightfully so, on the number of suicides within the military, and perhaps it is because it is a much more closed, basically, society with a lot of oversight and oppor-

tunity to intervene. But do the rates within the military differ all that significantly from what we see in the general population?

Dr. FRANKLIN. Thank you so much for that question. I will go ahead and start with the latter part.

Typically, I try to sway folks away from comparing the military rates to the civilian rates for a number of reasons, some of which you just mentioned. But the military as a whole, largely a healthy population, largely covered by health care. When you compare demographically across the civilian population, we are looking at folks that have no health care, perhaps they are homeless, unemployment rates. There are all sorts of factors that make the two populations drastically different.

On the other hand, also, the military has additional stressors in some cases. I am actually looking at this a little bit further to see if I can find a demographically similar characteristic or population. What I want to make sure we don't do is just compare a CDC [Centers for Disease Control and Prevention] data set across gender and age and think that we have a one-for-one comparison with the military, because we don't.

Dr. HECK. Right.

Dr. FRANKLIN. So that is a sticky wicket, but certainly I can understand why folks want to ask the question, looking at whether or not we should look at comparisons across the university sectors perhaps or other types of demographics like perhaps first responders and trying to dig deeper so that I can find a good comparison group.

But the other question that you asked me was about the rate calculation. The rate calculation recently changed, and we are looking at the total force. We work within the Defense Suicide—I am sorry, the Defense Manpower Data Center to get the denominator. And then, from there, we will take the total number of suicides, and it is just a math equation where we will divide the two. And that is how we calculate the rate.

Dr. HECK. So you say the rate recently changed. How was it calculated previously?

Dr. FRANKLIN. Before, we would separate it out. And so now we are looking at more of the total force.

Dr. HECK. Okay. All right. Thank you.

And, General McConville, I appreciated your analogy and the fact that you used the phrase "die from suicide" not "commit suicide," and the analogy you made with heart disease. And you mentioned one of the issues that we find is the stigma associated with seeking behavioral health assistance and folks concerned that somehow if their chain of command learns about it, you know, it is going to impact their eval [evaluation], may impact their future promotions.

So I would ask one of the panelists, what is being done within your service to try to remove the stigma of reaching out for help so that we can get ahead of this problem as opposed to being reactive?

General MCCONVILLE. Well, sir, thank you for that question, because, as a former commander, that is why we started to think about it in a different way. We have to change the culture of how we look at suicides, because it is just like heart disease.

And so what I found very helpful and what, really, the Army as an institution is propagating is, if you have problems with mental health, it is the same thing as having some type of heart disease, and you need to go to the right doctor.

So you identify those type of issues and, again, I talked to you about being a proponent for the embedded behavioral health. Having that as close to the point of need that we can get behavioral health is really very, very important. And the way that works in a division, that brigade combat team has a multidisciplinary team that actually sits there that does physical fitness with the unit that is there. So if a soldier starts to have problems, we can get them in early on.

I use the analogy even with heart disease, if you wait and I am not a doctor, so, the doctors here, you know, don't—I make it up anyways. But, you know, if you wait till you are 95 percent, you know, clogged and you go to the doctor, they may not be able to help you. But if you get them early on when you are starting to have high cholesterol and you are starting with these risk factors and you get them to see the doctor, they get you on the appropriate diet, they can get you to stop smoking, you can do those type things. We need to do the same thing with suicide if someone is starting to have a problem.

And the ranking brought that up, about the family members is absolutely key. They are the ones that know. I have looked at a lot of suicides over the years, and people go, "No one knew." Well, someone did know. And, usually, when you peel it back and you take a look at it, there was a buddy that knew or a family member knew. And if we got it early on, we could have got the help they needed, and we might have saved a life.

Dr. HECK. All right. My time is about to expire, so I will come back on the second round and follow up.

Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

And I actually was going to ask all of you about perhaps one incident or story that you go back to, you know, every day when you come to work, thinking about either a success story or one that was tragic. And I think, you know, several of you mentioned that, but I guess I would wonder what that is.

It is always helpful to have a family member at a hearing like this or someone who has sort of really been there. And I have a feeling that you have lived through that through the folks, but I wondered if you wanted to share that and what it has done in terms of your own drive to make sure that we are able to address this.

General MCCONVILLE. I will go ahead and start.

I guess, you know, I have many examples, having commanded a very large organization in combat over the last couple years. But one of the things that we did at Fort Campbell is we used to do a Mother's Day brunch for all the Gold Star Mothers and family members the week before Mother's Day, and we invite all the Gold Star family members. And it was interesting who used to come as part of our survivors outreach. And we had people come that had lost their sons and daughters to suicide.

And one man, in particular, came. And it is amazing, the pain that that father was going through, the fact that he had lost his son to suicide. And he came to Fort Campbell because there was a good program there. His son wasn't even in the division, but we had this great survivor outreach person, Suzy Yates, that took incredible care of these families, and he came to that brunch.

And you could see the pain. And it is a very, very different pain, what parents go through with a suicide, than, you know, soldiers, I have lost soldiers in combat, I have lost soldiers to accidents, I have lost them—but that suicide, it has an—first of all, it is the end of the world for the parents. And it is a gaping hole to units when you see what happens when you have a suicide in the unit, because everybody wants to wonder what we could have done.

Mrs. DAVIS. Uh-huh.

General MCCONVILLE. And so you can feel my passion about this stuff. And, you know, I have thought through this stuff, and it is getting after what we do to take care of soldiers. So, every day I wake up, we have a sacred obligation to take care of the sons and daughters that parents sent us, and the last thing we want to do is to have a son or daughter die of suicide. And that is a sacred obligation for us.

Mrs. DAVIS. Uh-huh.

General EDIGER. The story I always think back to is, early in my career, when I was a squadron flight surgeon for a fighter squadron in the Air Force, we lost a lieutenant young fighter pilot to suicide, married, with a child on the way. And the thing that struck me about that was that it was really a somewhat impulsive act, in that case, in that he was confronted with an acute situation, a problem that was really, when you looked at it, completely solvable.

And then I saw the rippling effect of that tragedy as it went out to the family, and a child that was born without a father. And that really struck me, that we really have a responsibility to help particularly our youngest members in the military arrive at a more functional approach to problems and how they approach problems, solve problems, and that we need to do a better job of connecting them with sources of help in terms of just their basic life skills so that their approach to problems like that don't turn into a tragedy.

Mrs. DAVIS. Uh-huh.

General WHITMAN. Mr. Chairman, you know, the Marine Corps tracks and studies every one of the suicides and attempts and ideations that we have. And we study them and pull from them what we can.

Each of us, I am sure, has our own personal most devastating story. Mine would be the friend I lost in 2012. There is no question he was a very close friend.

But we look at all these. We looked at them in 8-day reports. And the entire institution does. The assistant commandant of the Marine Corps gets those reports; we review them together. If someone has survived, if it is an attempt or an ideation, the commanders get involved through our Marine Intercept Program and evaluate what the problem is. We pull data out of that, as well.

And then, finally, we have a regular institutional effort, an Executive Force Preservation Board that is led by our assistant com-

mandant, that looks at all the cases in aggregate and tries to pull the lessons that we can from those to prevent the next one.

Mrs. DAVIS. Uh-huh.

Admiral BURKHARDT. For me, I am passionate about people, and I strongly believe that every life is worth living. And it is really sad when I see the SITREPs [situation reports] that come in and I think about those lives that we have lost and the family members and the units impacted.

And the Navy is committed to helping our young people and all our service men and women and their families understand how to better identify those risks and refer people to help and make sure that everyone has a chance to live life fully and really thrive in our environment.

Mrs. DAVIS. Okay. Thank you.

Dr. HECK. Ms. Tsongas.

Ms. TSONGAS. Thank you, Mr. Heck.

Thank you all for being here. I can tell you that this is an issue that really strikes home with my constituents, as they read the alarming statistics and stories or if they have been personally impacted by a family member or friend who served in the military. So I appreciate all the work that each of the services has done and that the DOD has done, as well.

But I really want to ask a question about, and you have all certainly given great testimony to the efforts that the services are doing, investing in. But I really want to address the issue of how you all are working together with each other and with the DOD.

So, on September 30, 2015, the DOD Office of the Inspector General issued a report that states that, quote, "DOD lacked a clearly defined governance structure and alignment of responsibilities for the Defense Suicide Prevention Program," unquote. And that report also states that the DOD, quote, "did not standardize best practices across the Department, and the services did not take advantage of each other's knowledge and experience," unquote.

And I know that this is often not unique to suicide prevention. We hear that often in other contexts, as well, that you work within your own service and not always across services.

So I would like first Dr. Franklin to address what changes are being made to address these issues. And, also, if each of you could comment upon how you share best practices and work across the services.

So let's start with you, Dr. Franklin.

Dr. FRANKLIN. Sure. Certainly. Thank you so much for the question.

Make no mistake, the DOD IG [Inspector General] absolutely cited a number of the things that you spoke about. The policy, the evidence-based practices, the research—all of it needs to be coordinated, and we absolutely needed a strategic approach.

I will tell you, I think the Department was largely operating in a reactive mode early on in the suicide arena as a result of the Department of Defense task force. And so, by "reactive," I mean they were chasing down those task force recommendations, 76 of them, and they were trying to get current.

Upon completion of that, like many programs, it was an opportunity to take a pause and look at the program and look at the na-

tional landscape in the area of suicide prevention and then determine our own strategy, moving away from task force recommendation mode to a science-based approach based on our current needs and the state of the program.

So when I arrived in the office and I did a series of listening sessions with the services, we right away changed our practices. I couldn't be more pleased to tell you that the services meet on a quarterly basis. Their suicide prevention program managers are—we have had two of those meetings so far. They are 2-day meetings. They share a number of best practices. I could give you examples. And you heard in some of their testimony where some of them are implementing similar tools like the Columbia Suicide Severity Scale or the VA safety planning. They learned that from each other. And those are exciting opportunities, and I absolutely see that as the future of the office.

I am a social scientist by trade, and I think that we need to leverage the research and we need to work together. And I am eager to see the future of this team when we can have more time and place to execute many of these evidence-based approaches.

Ms. TSONGAS. Can each of you give an example of where you learned a best practice from perhaps the DOD or from each other?

General MCCONVILLE. Well, I know there is coordination with—from where I sit, I know that we meet at the program manager level.

What I am surprised to see as you listen to the testimony is how the concepts, especially when I look at my Marine colleague here, you know, we are pretty much moving towards getting after the problem the same way. We understand in combat-type units that these new soldiers coming in that are most susceptible, getting the leadership, getting the families—we have shared the STARRS studies that we have worked with that show, which we have all spent a lot of money on, what type of indicators. And as I listen to testimony, I see many of our colleagues using that same type information. And as we pass the information back and forth, for me, it kind of gives an idea that, hey, we are all getting after the same thing.

I did an exchange with the Japanese, which is kind of interesting. We talked about sharing suicide information. Their concept is very similar to what we are trying to do. They have a one company, one floor concept. And it gets around to this whole relationship, which my Marine Corps colleague talked about, is how we make sure people are taking care of each other and identifying those risk factors so—I see the risk factors the same across each and every one of us.

Thank you.

Ms. TSONGAS. General.

General EDIGER. A couple of examples I will add is, we are sharing the data from our research. And I know we have learned a lot from watching and studying the Army STARRS data in terms of resilience and the ability to measure that and predict certain outcomes.

I mentioned our Suicide Prevention Summit in the Air Force that occurred 3 weeks ago. And Dr. Franklin was a prominent participant in that, but, also, the Marines were there and gave some ex-

cellent presentations in terms of their programs and actually, we are borrowing significantly from what the Marines are doing and what we are implementing now.

Ms. TSONGAS. I have run out of time, but thank you.

Dr. HECK. Mr. MacArthur.

Mr. MACARTHUR. Thank you, Mr. Chairman.

I am sorry I missed your opening remarks. I was at another hearing. But I read the memo, the advance memo, and I just had a few things that maybe you have covered already, I don't know.

First, there is nothing more tragic than young people—often, these are the people we want to be the next greatest generation. And we see so much that they have to live for, and, obviously, sometimes they don't.

You mentioned, Dr. Franklin, that it is a closed system, the military. I think that was your word, or maybe that was the chairman's words. But you suggested you can't really compare military suicide rates with civilian rates. I think the chairman called it a closed system, but same idea.

So I am interested in comparisons within that system. And the years of numbers that I see here cover 4 years. And I just wondered, if you apply this new methodology of calculating the rate and I gathered it is currently done against total force. I am not sure what you looked at previously; you could tell me that.

But if you applied this current methodology going back 10 or 15 years—have you done that? And what does it show about the trending of suicide within the military? Is it going up? Down? Staying the same? Give me some sense of the magnitude of direction.

Dr. FRANKLIN. Sure. Certainly. Thank you so much for the question.

I would need to get back to you on whether or not we took the current methodology and traced it back 10 or 15 years. The difference between the two methodologies are that one looks at the total force and the others sort of separate it out. But that is certainly something that we could do and get back to you.

[The information referred to can be found in the Appendix on page 93.]

Dr. FRANKLIN. Overall, when I look at the numbers, I see a lot of fluctuation. There are times where you will see that it will spike, and you will try to study it and understand it. It is a 1-year spike or a 2-year spike. And then you will see where it has dipped slightly or it has gone up in a way that it is not statistically significant yet. And so it is just this up-and-down fluctuation over time.

Either way, it is too many. We say one is too many and continue to study the data, not only in the context of the quantitative numbers, but, also, some of my colleagues today talked about the qualitative stories. Studying the full review of each and every one of these cases is critically important. They are not just a number. We must know the names, the faces, and the stories, the risks, the protective factors, what was behind each and every one of them.

Mr. MACARTHUR. I would appreciate it if you could back get back to us. I think it could be helpful to look at trends over time, because perhaps there are some factors that are at play, with conflicts that they are in or different things, where you see elevated or depressed rates of suicide.

Dr. FRANKLIN. Yes, yes, certainly. Over time, we talk a lot about relationship issues being at the heart of a lot of this, but financial struggles, legal struggles, and also just this notion of, particularly within the military environment, sort of a falling from glory or no longer feeling a sense of belongingness with the unit or with the military. But, certainly, continuing to study those risk factors.

And I would also turn it over to—my Army colleague may have more to say here about the identified trends specific to the Army.

General MCCONVILLE. Yes, sir. I could talk a little—and, again, I can't break down the numbers. I just have the statistics really for the Army as we look at different types of mortality, whether it is accidents, natural, suicide, or homicide.

But, basically, what we see is, in the Army, compared to the civilian population, is in 2005 we were below the numbers. We were basically at a rate of about 13, and the U.S. was running about 18. And then, as we went from 2005 to 2012, it began to grow. And during that period of time, the Army actually crossed the civilian average. Now it has come back down to where we are a little higher, but, again, I am not a statistician, but they would say that is within the normal.

So when we look at the death rate within the Army, what we find is, as far as accidents, it is much lower than our civilian counterparts. We talk about natural, much lower than our civilian counterparts. Suicides, a little higher, but, you know, again, the statisticians say that is about the same. It was statistically higher in 2012. And then, for homicides, it is much lower than the rate.

So that is kind of how it breaks out. And I am not smart enough on the analysis of how they got all those numbers.

Mr. MACARTHUR. I yield back.

Dr. HECK. Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman.

I wanted to follow up on some questions asked by my colleagues Ms. Tsongas and Mr. MacArthur.

One of the conclusions of the inspector general's report is that we don't have good or consistent measures for success. And so I would love to get your advice, Dr. Franklin, for this oversight committee on how we can best gauge the job that you are doing and that the different branches are doing in preventing suicide.

Dr. FRANKLIN. Thank you. Thank you so much for the question.

And measuring suicide is difficult, but it is not impossible. And we absolutely owe you that, and we need to do that.

When I arrived in the office, we started a refreshed effort in the context of our measures-of-effectiveness work. Early on, I think we were trying to bite off more than we could chew and attach measures of effectiveness to every single program out there. And now we have streamlined our approach, and we are looking at key indicators that we can collect from the chaplains, from the medical community, and then directly from the services that get after it.

It is a much more streamlined, simple approach. We have developed a series of logic models to study the outcomes of the Suicide Prevention Program as a whole vice the individual parts and pieces that make it up. So I am certainly pleased to share those models with you.

It is definitely an important issue. Measures of effectiveness should be part of everything we do, and we shouldn't think of it as an afterthought but, rather, part of the front end of programming.

Mr. O'ROURKE. One of the things that I think is cited as a success story in the IG report—and you mentioned it, I believe, in your opening testimony—is the data that you are collecting now, and you implied data across service and then as the service member transitions out and becomes a veteran.

And you mentioned the analytics that you are doing, the advanced analytics that you are doing on that data. Can you give us an idea of what it is that you are measuring?

And I appreciate the focus on ensuring that we are sharing best practices across service branches. How are we sharing with the VA and vice versa?

Because I think all of us here are also very concerned with veteran suicides, as well. And so, you know, whether it is the risk factors that General McConville brought up earlier that are identifiable, I want to know if those are being shared with VA providers and clinicians and what kind of impact we are having there.

Dr. FRANKLIN. Yes. Yes. Two-part question.

The first, I think you are getting after this Suicide Data Repository. This is a massive database, a data set that pulls together about 22 other data sets, drawn off of the CDC and the National Death Index data.

It is a joint partnership between the Department of Defense and the VA. So we both put into it, and we can both pull out of it. And so far, we have developed a charter and had a series of meetings to discuss the art of the possible on the data and analytics, and it is very exciting. We do not have any results from it yet, but the framework is in place, and a number of discussions have been held, particularly in the context of predictive analytics.

Mr. O'ROURKE. Can you go deeper into that? And perhaps anyone else who is with you at the panel. Are you seeing correlations with combat, with specific kinds of combat, specific experiences within combat correlated to higher likelihood of suicide attempt?

Dr. FRANKLIN. Those are precisely the things that we are going to begin looking at. The database was just stood up. We have only recently put the business rules in place and put in a series of processes for folks to access the data, to begin to look at the research questions and going through proper IRB [Institutional Review Board] procedures and those sorts of things. So it is in its early stages, but there is quite a bit of excitement about the potential future of it.

So far, what we have also done is discussed opening up to academic sector and letting folks know our research needs and our gaps so that folks can tap into the database and help us study these very issues.

I wish I had more for you in the context of specifics on the analytics, and I hope to at another time, potentially even another hearing.

Mr. O'ROURKE. I look forward to that.

And, General McConville, you mentioned identifying risk factors and then acting upon those. Any that I just mentioned right now,

are those correlated? Are those risk factors that you are looking at, combat service, particular kinds of combat service?

General MCCONVILLE. We have.

And the value of the massive STARRS study was it is really not as combat-related as some would think. And, you know, as we went through this, the folks that are most likely to commit or most likely to die of suicide are those that have zero or one deployments. It is not the multiple deployers, which we were kind of—you know, that is counterintuitive to what a lot of us thought. And that was, again, you know, a very—and we are continuing to look at that. It doesn't mean that one deployment does not affect you, but it does get back to those that may have some type of behavior health issues going into the military. That is very, very important.

And as we move to a complex behavior module, it is more than one effect. The fact that someone goes through a divorce does not mean they are going to die of suicide. The fact that someone has a drinking problem does not mean—all those. But it is getting those compact factors coming together and then understanding how they affect—because they affect all very differently.

The thing we are trying to get to is really trying to measure resilience. And it is not like on the positive side. You know, when we bring soldiers in, resilience or grit is something we are trying to define in our screening process. So if when someone comes in—we know what a resilient person is. We have always focused on physically fit, but we are also focusing on mentally fit, and we are also focusing on character. Because those are the attributes that we are trying to bring into the service.

And then, once we get them in, is to give them the type training they need when they are brand-new soldiers in initial training and during that first period of time. Because what we see is, if we look at suicide attempts and what our studies have shown us, actually, it is female soldiers that are most likely, first-term soldiers, to attempt suicide. Brand-new soldiers—male soldiers are most likely to die of suicide during their first term.

So that first term is very, very important, the first couple years when a soldier comes in, because we really haven't fully brought them into the culture of the military. And this goes for a lot of things, with sexual harassment, sexual assault. All those things tend to happen at a higher percentage in that 1- or 2-, first-year soldier. And that is why we are really focusing on this "Not in My Squad" campaign that we are going after.

Mr. O'ROURKE. Thank you for your answers. I am going to have to yield back to the chairman.

I appreciate the indulgence.

Dr. HECK. Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

One, first of all, I want to commend the Army, and I don't know if the other services are doing it too, in terms of recruiting and now trying to develop methodologies to determine who is more resilient than others, who is more likely to fall victim to the stressors of training, of combat training, of deployment, of all the things in the military. And so I think that is very important, if we could mitigate problems through the intake process in terms of who comes in.

One thing I wanted to ask all of you is that, what is different, if I look at my service in the first Gulf war and my service in the Iraq war later on, in 2005–2006 in Iraq, that in the first Gulf war, you were just checked out. It was probably the last war where there wasn't the Internet, where you just—you know, it was snail mail. You checked out. You went there, you came back. You didn't have communications with your family until post-conflict, then occasionally on a land line, on a phone.

But in the Iraq war, where you have—and Afghanistan too—where you have forward operating base and you have soldiers, Marines, and sometimes airmen and sailors going outside the wire, coming back in, getting in real-time with their families, being told, you know, we are having these problems and these problems. And so, all of a sudden, they have the compounding effect of being concerned about what is going on at home in real-time and being deployed in a combat zone.

How much are those stressors factors in suicide rates? And the fact that we have fewer deployed troops today, does that bring it down? Although we have a lot of deployed troops, just not in a combat zone, but all over the world.

Who can comment on that?

General MCCONVILLE. Sir, I can comment on it.

Really, I think you bring up a great point. And as I look and try to put this in perspective with the strategy that we have, is, you know, when we were going to the Gulf war and we were doing that before, there was no contact. Now, the soldier is sitting there, he or she is Skyping with their significant other. And, I mean, I could give you some horror stories of some of the things that happened while people are Skyping and things that have been said.

So that creates a tremendous amount of stress on our soldiers. Because we look at some of the factors, we are saying, okay, so relationships is a problem, financial is a problem. Well, they have a direct access to that soldier to do that. So that is a significant concern as we go forward.

And, again, that is why we want to build the resilience, both in the soldiers but also the families. And one thing that we really haven't talked about is our resilience training for families. And right now we are training master resilience trainers. Spouses have taken that on. They are more ecstatic, and they are excited about that. That is making a difference, so much so that we are standing up a program for our teens too, because they want it. And, again, anyone that has, as you know, had military kids traveling around, and with the stress of the military—very, very important for our folks.

Mr. COFFMAN. Good.

General EDIGER. This is one of the prime factors that led us to start training family members as resilience training assistants. Because the connectivity back home, while comforting in many cases, it can also share the stress from what is happening in the operational environment. And so we recognize the importance of having Key Spouse programs and actually incorporating resilience training into the Key Spouse program, which led us to do that.

I think in terms of the members who are actually deployed, we have actually found that our suicide rates among airmen during

the time they are deployed are far lower. And we think that is because of the sense of responsibility to their fellow airmen, and they are part of a team, and they understand that they have a responsibility to be there for their team. And so, during the actual deployment, we have found that the rates of suicide attempts are far lower.

General WHITMAN. Three parts of your question, I think.

Is there a link to combat and deployment? We have not found any in the Marine Corps, similar to the Army experience and the Air Force experience. It is a factor, but it is one of many. And, typically, suicide is related to 10 to 20 of those, in any given case. Sometimes it is, but it more often than not in the past year, it wasn't, deployment or combat.

We are looking at screening very hard. Part of our Marine Corps Recruiting Command effort, a very deliberate effort to look at what screening would be the most effective up front before a Marine comes in. And we use a Marine total fitness model to look at body, mind, and spirit, and social.

And, finally, we are also training families through a new Conquering Stress with Strength program that we initiated this past year. It is fairly new, but it has been well received. And we expect to expand that across the Marine Corps.

Admiral BURKHARDT. The Navy has similar results, where we have not found that deployments has been significantly related to death by suicide.

Mr. COFFMAN. Okay.

Thank you, Mr. Chairman. I yield back.

Dr. HECK. Mr. Walz.

Mr. WALZ. Thank you, Chairman and Ranking Member.

I want to thank each of you for the work you have done. It is gratifying to me to see the commitment is here. And I know, going out and talking to folks over the years and having worn the uniform within the last 10 years, this is not a box to check, obviously, for the services. This is a commitment that is deeply engrained in the culture. And for that, I am incredibly grateful.

It is a very difficult task to take on. It is one we understand we have a moral responsibility to, but it is a readiness responsibility, as we all know. This is a force multiplier, keeping people healthy.

And I think the resiliency training—I would make the case that, once again, you are probably outstripping the private sector. And this issue of mental health parity is still a troubling thing, a stigma in the private sector. We have worked very hard to get insurance to pay for it, in some cases, until very recently.

So I understand the challenges. And I also think you know, all of us here, that it is amazing to me, and people want to fix this badly, and they want a fairly easy fix. And I remember we worked really hard in the VA earlier this year when we passed the Clay Hunt bill. And I was gratified to see that happen. But I said, if you needed a stark reminder of this, in my hometown of Mankato, Minnesota, the day we passed it, the next day on the paper, the top half of the paper said, "Clay Hunt Bill Passes Congress." The bottom half of the front page was a young man walked into the Minnesota State University, Mankato, library and died by suicide, gunshot wound, on that very same day.

And so it reminds me that this is a deep dive. We are in it for the long haul. There are many factors. The research is catching up or starting to. And I am grateful for where you are going.

And I think that leads, to me, I am not going to ask in detail. This is just my hunch on this. I think the spirit that I have seen this be taken on is real, it is happening. And so when I see the IG was talking about unsynchronized, I think that is pretty much a condemnation of our entire mental health system, if you will. And so I am not sure if there is any question to ask there, if you agree with where they are at or if there is something we can do. I read that and am—and perhaps we should be more concerned, but it strikes me as perhaps this is deeper. I don't know.

Maybe starting with you, Dr. Franklin. And, also, I am grateful for your office proactively reaching out soon after you were in your job and working with us. Because we are unsynchronized with the VA, if you will, and you are working to try and make that happen.

Dr. FRANKLIN. Yes. Thank you so much. Good question.

And the unique part of this challenge at the DOD level is putting the standards in place, making sure we have the best research and opportunities for the services to work together. And the Department really serves in a facilitator role, in some regards, bringing some synergy to the table so that the services learn from one another.

But, at the same time, I couldn't agree with you more, in the context of the services needing to have service-unique and -specific programming where relevant, provided that it meets the standard and that it is the best and the best that we know from the science.

So honoring the service uniqueness. Having worked as a social worker for the Army and the Air Force and at the headquarters level for the Marine Corps, I can tell you that they are quite similar but also quite different, as you probably well know.

Mr. WALZ. Yeah. And I hear it listening to folks talk. And I think that is important. So I think, you know, it is important for us to publicly address that. I appreciate the IG pointing this out, but I think there is more to this than what the report said.

So the next thing is part of that and I heard each of you say this, and, General McConville, you mentioned this, this peer-to-peer piece or whatever. We did best practices on Clay Hunt and showed there is a lot of success there. We are kind of looking outside the governmental things, different organizations, one I am partial to, Ride for Recovery, and some of these, of how do we use these with evidence-based programs that are making a difference? How do we synchronize across these? Because they have their own issues inside the world of the Army, the Marines, and so forth.

And I don't know if any of you want to tackle that or maybe this is to you again, Dr. Franklin of, how do we use those external resources?

Dr. FRANKLIN. External resources, in some sense, even from the VA and also from just, sort of——

Mr. WALZ. Yeah.

Dr. FRANKLIN [continuing]. What I say, outside-the-gates resources. Certainly, we have come up with a number of good ideas by looking at best practices with other population groups. Whether

we study police officers or firefighters, there are evidence-based practices that can be applied right inside the DOD.

And part of that is hearing about them, learning about them. I have taken a number of briefs myself on these practices, trying to stay current. At our quarterly council meeting, we bring in experts from outside industry. Most recently, the American Association of Suicidology came in and briefed. The Coast Guard has come in and briefed a number of best practices.

And then, from there, the relationships are in place for folks to gain more information and further discovery and determine how that particular practice might fit within their service.

Mr. WALZ. Well, I am glad to hear that. Because I think what I hope you need to know is in the VA, we talked about this—this is all of our issues, all Americans.

Dr. FRANKLIN. Yes.

Mr. WALZ. We need to pull in every resource. And you are doing all you can, but if there are things we can do, we need to make that as available as possible.

So thank you, Chairman.

Dr. HECK. Thank you.

Dr. Franklin, let me ask this. And I know you are new into the position, and I appreciate you with your office call that you had a few weeks back. We talked a little bit about metrics and the effectiveness and measures.

But the question I have for you specifically now is: Last year, Congress required DOD to develop a policy to collect data on suicide attempts involving members of the Armed Forces and deaths of military family members that are reported as suicides. It is my understanding that the policy is still being developed. So when can we expect to see that policy?

Dr. FRANKLIN. You are absolutely right; the policy is in progress, and it should be done by now. I agree with you. And if folks on the panel are frustrated, as am I. We need to move this policy along sooner rather than later. It is an important policy, and looking at the family member data piece intuitively makes sense. It is the right thing to do.

I wish I could give you an exact date, but just know that it is one of the top priorities on my list right now, and I am working it hard, as is our entire P&R [Personnel and Readiness] leadership team.

Dr. HECK. Can you ballpark it, maybe not an exact date?

Dr. FRANKLIN. I would say February 2016. And my leg [legislative] affairs person behind me is probably not appreciating me giving that date, but I am trying to get it done sooner——

Dr. HECK. All right.

Dr. FRANKLIN [continuing]. Sooner rather than later. And, definitely, like I say, I couldn't agree with you more.

The good news about this policy is that all the services have met; they have agreed upon a standardized approach. Actually, the Army led that group. I couldn't have been more pleased with them for that.

And so, methodologically, the process has been staffed and looked at and studied. And I feel confident that when you get the data there will be an increased level of fidelity, in part because of the

length of time that it has taken to put the plan together. But, again, it needs to move.

Dr. HECK. Great. I appreciate you making that a priority.

You know, all of you talked about the importance of the first-line leader, the squad leader, and being the person to identify at the lowest possible level somebody who may be at risk. And I certainly agree.

And I know it is very hard to prove the negative, to prove the thing that didn't happen, but how are you measuring whether or not the programs you have that are training the frontline leaders are actually effective in decreasing suicide attempts?

I can tell you that, again, in personal experience, I had a squad leader, had been through all the training, the ACE [Ask, Care, Escort] training, it was actually a master resilience trainer—and was out with one of his squad members on a Friday night. Two hours later, after he dropped that squad member off, the squad member died of suicide.

And so the question is, how do we know that the programs that we have are actually effective in giving the tools necessary to those first-line leaders?

And I am going to start with Admiral Burkhardt, because we have been starting this way, and you have been awfully quiet. So we will start this way and go in reverse order.

Admiral BURKHARDT. Yes. Thank you, sir.

I think one of the things we have noticed with our bystander intervention is helping sailors know that it is "Every Sailor, Every Day" and that they have responsibility to step up and step in. And that has resonated with that peer-to-peer training and the dialogue and the methodology that we have been rolling out, our training and our awareness. The sailors are engaged, and they want to make a difference.

I think the struggle is connecting the dots. So a lot of different—whether it is a family member or the unit or one of the programs that the member has been engaging, like financial counseling or if they have been going through administrative or legal separation processing or transitions from duty stations, is that we have a way to make sure that there are warm handoffs between programs and also that we are keeping in touch with that sailor to recognize the change.

Where I have seen a lot of difference between the suicide ideations and—that the sailors are sharing with their shipmates, and the shipmates are bringing it to attention and referring the sailor to the proper resource. And I see that quite often in the reports I receive, that it is happening, whether that referral is to a shipmate or to the chain of command or it is a family member that is bringing it to the attention of the chain of command or the chaplain.

And the chaplain—we are really focused on a strategy to make the confidentiality apply to the service member and making a concentrated effort to say that also applies to the family member. And it can make a difference where the family member may have a perceived or real perception that if they bring something forward to the Navy that they could be hurting the member's career.

Dr. HECK. Thank you.

Admiral BURKHARDT. Yes, sir.

Dr. HECK. General Whitman.

General WHITMAN. Yes, sir. It is hard to prove a negative, of course, but we, too, track each individual story. I mentioned one in my opening report. And we do have a number of those, where we can at least see that, in that case, at that moment, we saved a life.

We have a more robust now training, annual training program for our Marines called Marine Awareness and Prevention Integrated Training. Every Marine goes through this every year, and it includes elements of identifying risk factors, triggering events, warning signs, protective factors. I have tested this when I have gone to visit units, and Marines can read back to me what they have learned.

So, again, anecdotally, I think it is making a difference. They know. And you can trace back that training to some of these individual cases for peers and for the direct leaders with those Marines.

Dr. HECK. Great. Thank you. My time has expired.

Ms. Speier.

Ms. SPEIER. Mr. Chairman, thank you. And thank you for holding this very important hearing.

And thank all of you for being here.

I have been rattling around in my head the New York Times Magazine story just a few weeks ago. I mean, I just can't get the pictures of some of those tragic stories out of my mind. And I hope all of you, I see the Rear Admiral is nodding her head; she has read it. I don't know if all of you have read it. If you have it, I really commend you to read it. Because while it talks about the suicide rates among veterans, it raises a lot of questions.

And one of the earlier questions by one of my colleagues was about whether we are tracking combat versus stateside and the like. And I get the impression that you don't see any difference in terms of the suicide rate between those that actually serve in active combat and those who are not in a combat setting. They raise that question in that article.

And I don't know, I guess the question is, do you track that?

Dr. FRANKLIN. Absolutely. This is tracked through the DODSER [Department of Defense Suicide Event Report], Suicide Event Reporting, tool. It is tracked whether the——

Ms. SPEIER. And you see no difference, basically.

Dr. FRANKLIN. There was recently an article published in the New England Journal of Medicine. The title of the article is something to the effect of "Deployment is not a singular risk factor when it comes to suicide."

The issue is you often have to unpack that variable of deployment. Not only have they deployed, how many times? What was the length of their deployment? What was their level of combat exposure while they were on that deployment? And what was their preexisting trauma perhaps that they have experienced before they even went into the war zone? So it starts to get complicated very quickly. Also, what protective factors did they have in place if they had had preexisting trauma or not?

So I struggle when we try to narrow it down to just two simple variables: deployment, suicide. It is really not that simple. The issue around suicide that a lot of the folks on the panel——

Ms. SPEIER. So, excuse me a minute, Doctor.

Dr. FRANKLIN. Yes.

Ms. SPEIER. I have limited time.

Dr. FRANKLIN. Yes.

Ms. SPEIER. So do we think that possibly multiple deployments may have an impact on the higher incidence of suicide? You don't know that either?

Dr. FRANKLIN. It is not what the data is telling us.

Ms. SPEIER. Okay. I——

Dr. FRANKLIN. No, ma'am.

Ms. SPEIER. That is fine. Okay.

Let me ask this question. In that same article, there was a reference to one vet who went to seek help, spoke to a counselor, and the counselor said to him, "You have to think about this as a breakup, like a breakup with a woman, and you have to think of it in those terms and move on with your life." And I thought to myself, we have serious problems if we have healthcare professionals providing services to persons with mental health issues talking to them in those kinds of terms.

So it raises the question, what are the qualifications of those who are counseling persons that have mental health issues who are Active Duty military?

General EDIGER. I can speak to that.

So, across all three services, we have common standards in terms of the credentials that are required in order to gain——

Ms. SPEIER. And they are?

General EDIGER [continuing]. Privileges.

Well, for licensed clinical social workers, there is a licensure in one of the States of the Union. And they must be certified as a licensed clinical social worker.

As far as psychologists, we privilege them at the Ph.D. level, for our clinical psychologists across the three services.

And, of course, psychiatrists, residency-trained in a program approved by the ACGME [Accredited Council for Graduate Medical Education], which is the——

Ms. SPEIER. Right.

General EDIGER [continuing]. Organization in the U.S. that does that.

Ms. SPEIER. So a clinic social worker could, in fact, be counseling someone who is suicidal.

General EDIGER. Yes. Yes. And they are trained to do that.

Ms. SPEIER. Okay.

So have we, kind of, reviewed the qualifications of those who provide those services and see success versus non-success? I mean, maybe that is not something we can do, but it certainly would be interesting to see if there is a certain level of educational attainment and experience that is most effective in assisting someone who has suicidal tendencies.

General EDIGER. And so, in the Military Health System, we have a scope of practice that is specifically defined for each individual provider and that is tailored to their certification and their specialty. And so each commander of each medical unit specifically privileges the provider to provide certain elements of mental health care.

And so a licensed clinical social worker knows full well what privileges they hold and what services they are qualified and cleared to perform. And then, if they recognize that a patient needs care that goes beyond their scope of practice, then they refer them to a higher level of care, to a clinical psychologist or a psychiatrist as the case may be, or perhaps refer them for residential or inpatient care.

And so this is all monitored through a quality assurance process that is defined in a DOD instruction.

Ms. SPEIER. Mr. Chairman, could I have one more question?

Dr. HECK. We are going around for a second round, so hopefully we will get to you.

Mrs. Davis.

Mrs. DAVIS. Go ahead.

Dr. HECK. Okay. Mrs. Davis will yield.

Ms. SPEIER. Thank you. I thank you for yielding.

I have one question, one comment.

The use of psychotropic drugs with persons that have suicidal tendencies I am sure is used a great deal. Have you tracked those who have committed suicide as to whether or not they have taken their lives with drugs or by use of firearms?

And what has that told you? What have you learned from that?

General EDIGER. We do.

In regards to firearms, at the DOD level, we actually have statistics, and that is the most frequent means of committing suicide among service members across all three services. And that is true of males nationally in the U.S., as well.

In regards to mental health care, we do actually track, and we know which of the patients, which of the service members that commit suicide were under mental health care within 90 days, in our case, of the time they committed suicide. Each of those cases is individually reviewed.

And we have a lot of service members that receive mental health care month to month. I know in the Air Force we have 230,000 mental health visits a year across it. And, of course, the rate at which those mental health patients commit suicide is well below, you know, .01 percent.

But everyone that does commit suicide who was under some kind of mental health care, both Army, Navy, and Air Force, is reviewed to determine if there is something we can learn from that.

And I can tell you, in many cases, those patients had encounters with mental health, but, actually, even though at every visit we have a standard that we require a suicidal risk assessment, in many cases those patients never expressed an intent or a desire to commit suicide during their mental health visit.

Ms. SPEIER. I thank the gentlelady for yielding, and I yield back.

Mrs. DAVIS. Thank you.

You all talked about the resilience and trying to build that in with families. And I have some dear friends, and it is kind of an amazing case that has been followed by a lot of people because their son had enough going for him to write a very extensive suicide note. And one of the issues for them was whether or not there would have been the ability for someone to contact them that their son was having such difficulty.

We have many safeguards in terms of confidentiality, and I respect all of those. But are there some tools, in working with this and I was trying to go through, as well, with the IG's report. I didn't see them making any specific recommendations. Obviously, we are concerned about confidentiality on a number of different levels. But families want to be there for their loved one, and often they have no idea.

Are there some ways that you are seeing that that can perhaps be someone would have the ability to sign off on permission? And I would see this even as early as the recruitment phase, that while you are educating families and parents and the service member—I don't know. How do we do that? Because I think we would prevent more problems if families had the knowledge.

Dr. FRANKLIN. Yes. And thank you, Rep. Davis, for sending that family to me. I had a wonderful afternoon with them, and I really appreciated the opportunity that you provided in terms of hooking us up. And I appreciated the special time that I had with them to hear their unique story.

And I could see their story transferrable across multiple other stories, and so I was thankful that they highlighted it and brought it forward, because I think that could be a practice. And I gave them my commitment to look into that further, this notion of a listserv or perhaps some education and outreach to parents of young service members that would educate the parents on just military life in general.

Being a part of this culture for my entire life, there are some things we take for granted about the culture that we know because we have always known them. And that family and many others like them could greatly benefit just from some education and some awareness in a way that doesn't impact the confidentiality that you mention.

Thank you so much.

Mrs. DAVIS. Thank you.

Dr. HECK. Mr. MacArthur.

Mr. MACARTHUR. I recognize your primary focus is on prevention, as it should be, and I respect you for that. I have a question for General McConville, and it has more to do with the impact of these suicides on others and its effect on military readiness.

And you noted earlier that there is a higher suicide rate among those with fewer deployments, which is surprising, I guess, to me. And you suggested the possibility, maybe even the likelihood, that this is related to preexisting conditions when people enter service.

And I wondered, are your findings making their way to the recruitment process? Things likes resiliency, are you looking at indicators and putting that into recruitment? Or is it too unformed yet, the conclusions, for that to have happened?

General MCCONVILLE. Thank you for the question, sir.

Where we are right now is this notion of measuring resiliency, because we want to prevent suicides, but what we really want to do is we want to build these incredibly high-quality soldiers that can go out on the battlefield and do the things that we need to do for the country.

So what we use, we have the Army Research Institute that works for us. It is social scientists; that is what they do for a living.

And what we are trying to do is take terms like "resilience" and say, okay, how do you actually test someone?

We have tests that we do right now when soldiers come in. They take, other than the standard-type test, we call it TAPAS [Tailored Adaptive Personality Assessment System], where we try to get an idea of how sound they are. But we are trying to refine that science.

Mr. MACARTHUR. But does that imply, because I am inferring that you have concluded that lack of resilience is a possible precondition, something that predisposes somebody to taking their own life.

General MCCONVILLE. Well, what we have found, at least from the Army perspective, is, we were doing what I would call a lot of diving catches and my Marine colleague talked about that, is how we, all of a sudden, had a soldier in serious and we basically saved his life. We have lots of stories, Marines, all of us have.

So that is one part of it. But what you want to do is kind of move away from that. What we are trying to do is move the whole force, really, away from what the red area. I call the diving catch the red area. We move to a yellow area, where we start to manage and identify these transitions or these high-risk factors that we are training our solders to do.

And we move them even further, where they are really in a resilience phase, where we build soldiers who can handle stress, who can handle adversity. If they have behavioral-health-type issues, they are getting that early on, just like if you had knee injuries or physical-type injuries.

Mr. MACARTHUR. Yeah. And my question is take your knee injury. There is a certain degree of physical incapacity that would render someone unfit for military duty.

General MCCONVILLE. Right.

Mr. MACARTHUR. Are you taking some of these findings regarding resilience and other things that I think you are suggesting may be precursors or things that cause somebody to be more tending towards that, are they coming into the recruitment process? Are you looking at resiliency or brittleness, maybe the opposite, in personality testing to see whether someone raises a red flag at the recruitment?

Or is it, again, too unfounded yet and would actually be discriminatory? I am trying to get a sense of whether you have closed the loop on the recruitment side.

General MCCONVILLE. Yeah. What we are trying to do is we are trying to find that sweet spot. Because we don't want for folks that have sought treatment, to say, "Hey, you can't serve." You know, we are trying to find—I mean, just like some of the types of injury. We want to give everyone the opportunity to serve that can meet the standards and is mentally fit enough to do that. So we don't want to have an arbitrary, if you have had some type of behavioral health counseling, if you saw a high school counselor.

So the challenge we have right now and I have asked my, I am not a scientist. I am a helicopter pilot by trade. But what we are trying to do is get the science to help us do that, where it is a fair-type assessment where we can screen and look at that.

Part of the STARRS study was to try to find that. We are not there yet in science. And we would like to get there because we think that would be helpful for everyone involved, if we could screen to a level where we identify—like we could do with a lot of the physical-type injuries.

Mr. MACARTHUR. I would just add, in my few remaining seconds, I am not faulting you for that. I think it could be a slippery slope, but I am interested in, as we come to conclusive findings, where they make their way into our practices in the military. I think that would be helpful.

I yield back.

Dr. HECK. Mr. O'Rourke.

Mr. O'ROURKE. Mr. Chairman, I just want to thank those who testified today.

I learned a lot at today's hearing. And some of the facts that you gave us were counterintuitive to my assumptions about where we should be looking and where we see risk.

But I do think, Dr. Franklin, that we do need to see the analysis that you talked about, and we do need to better understand the measures for success and hold ourselves and you accountable for that going forward.

And I am very interested in understanding how we apply what we learned here or within the Department of Defense to taking care of veterans who may be at higher risk for death by suicide.

So thank you all for what you are doing.

Thank you, Mr. Chairman.

Dr. HECK. Mr. Walz.

Mr. WALZ. I am good.

Dr. HECK. Ms. Speier? Okay.

Again, I thank you all very much for being here today and offering your testimony. We all stand ready to assist you in whatever way possible as we try to erase this scourge of suicide within our military.

This hearing is adjourned.

[Whereupon, at 4:00 p.m., the subcommittee was adjourned.]

A P P E N D I X

October 8, 2015

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

OCTOBER 8, 2015

Opening Remarks – Chairman Heck
Military Personnel Subcommittee Hearing
Update on Military Suicide Prevention Programs
October 8, 2015

Good afternoon.

Today the Subcommittee meets to hear testimony on the efforts by the Department of Defense and the military services to prevent suicide by service members, family members and civilian employees.

I want to preface my statement by recognizing the tremendous work both the Department of Defense and the service leadership have done to respond to the disturbing trend of suicide in our armed forces. As a military commander who has had to deal with suicide within the ranks, I know firsthand that this has not been an easy task and I thank you for your hard work.

However, I am concerned that the recent Department of Defense Inspector General assessment of the Department's suicide prevention program identified a lack of clear policy guidance and synchronization of organizations responsible for executing the program. I'm also troubled that DOD has not completed the work necessary to begin reporting more comprehensive and inclusive statistics on military-related suicides as mandated by Congress last year. I look forward to hearing from our DOD witness how the Department is addressing these concerns.

Suicide is a difficult topic to discuss. But last year, 442 Active and Reserve service members took their own lives. Every one of them is a tragedy, every one of them has its own story, and every one of them demands that we not rest until we have taken action to change this extremely troubling statistic.

Suicide is a multi-faceted phenomenon that is not unique to the military. Unfortunately, in addition to the unique hardships of military service, our service members are subject to the same pressures that plague the rest of society: troubled relationships, substance abuse, financial difficulties.

Each of the military services and the Department of Defense has adopted strategies to reduce suicide within our troops. I would like to hear from our witnesses whether those strategies are working. How do you determine whether your programs incorporate the latest research and information on suicide prevention? I am also interested to know how Congress can further help and support your efforts.

With that, I want to welcome our witnesses and I look forward to their testimony.

Prepared Statement

of

Dr. Keita Franklin

Director, Defense Suicide Prevention Office

Department of Defense Suicide Prevention Update

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE

MILITARY PERSONNEL SUBCOMMITTEE

October 8, 2015

Introduction

Chairman Heck, Ranking Member Davis, distinguished Members of the Subcommittee, thank you for the opportunity to appear before you today to discuss some of the Department's suicide prevention initiatives. Every loss due to suicide is tragic. Within the Department, we recognize that one suicide is too many, as each permanently impacts families, units and the military writ large. We take suicide prevention seriously and we are working hard to address this complex problem. Research tells us that there is not one single methodology to significantly reduce suicides among Service members. Put simply, an effective suicide prevention strategy requires a comprehensive approach with many lines of effort to produce meaningful reductions. We have endorsed a public health approach to suicide prevention and have adopted the Institute of Medicine Prevention continuum for our framework, to execute a service delivery for suicide prevention that is evidence based and available to universal, selected and indicated population groups. This approach ensures a comprehensive service delivery available across all areas of risk. In addition, we recognize that suicide prevention requires an "all hands approach," and we have engaged purposefully to ensure a coordinated system of care that works together to ensure that Service members do not fall through the cracks. This requires coordinated approaches among community based counselors, mental health assets, chaplains, line leaders, law enforcement, legal communities, and a host of other aiding professionals.

Suicide Data and Trends across Department of Defense

Strong and accurate data and surveillance approaches are essential. Ensuring we understand the scale and scope of the challenge we face will inform our prevention service delivery. To this end, we have revised our suicide rate calculation in an attempt to more appropriately reflect our total force. Informing our stakeholders about our data is also essential. We have initiated wider dissemination of quarterly suicide prevalence reports in an effort to increase awareness about this important topic with key stakeholders, to include Congress.

The rate of suicide for the Active Component was 22.7 in 2012 and we saw a reduction to 18.7 in 2013. In the Reserve Component, the rate was 24.2 in 2012

and we saw an increase to 26.4 in 2013. The 2014 rates have not yet been released, but there were 273 Active Component suicides and 170 suicides in the Reserve Component. For the Reserve Component, this was a reduction from 2013, where there were 220 suicides and 2012, where there were 204 suicides. The Active Component saw a decrease in suicides from 2012 to 2013, from 321 to 254, and an increase from 2013 to 2014 from 254 to 273. Since 2010, the Department has increased surveillance among our Guard and Reserve components. During the period between 2011 and 2013 we have seen consistent increases in the total rates for these populations. These increases greatly concern us, and we are partnering closely with these communities to further examine the data and develop appropriate interventions that target risk factors and leverage protective factors to help those in the most need. We recognize that the Guard and Reserve present unique challenges regarding service delivery approaches, and we will continue to be diligent in our data and surveillance efforts to understand these challenges. Strong data and surveillance methodologies help us identify our most at-risk populations. Thus far, we have learned from our data that those struggling with relationship issues, legal concerns or significant financial problems are most at risk. Additionally, we have also learned that protective factors such as a sense of belonging, increasing coping and problem solving skills, and access to quality mental health care serve as key factors in preventing suicide.

The Department recently awarded grants to the American Association for Suicidology and Massachusetts General Hospital to conduct pilot programs in suicide prevention outreach and education for the National Guard, Reserves, their families, and caregivers. This effort will fulfill section 706 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013, which directs the Secretary of Defense to carry out a pilot program to enhance the efforts of the Department of Defense (DoD) in research, treatment, education, and outreach on mental health, substance use disorders, TBI, and suicide prevention in members of the National Guard and Reserves, their family members, and their caregivers through community partners.

The Department also recently finalized an approach for collecting family member data on suicide. This data collection process, required through the FY 2015 NDAA, Section 567, will help the Department determine the prevalence of spouses and children who die by suicide.

Suicide Prevention Program Evaluation and Research

We continue to work with the Military Services to evaluate our suicide prevention programming to ensure that we are offering evidence based practices that work. This effort involves a three-tiered approach of cataloging the Department's suicide prevention efforts toward those programs that are directly targeted toward suicide prevention, those that impact suicide prevention outcomes, and those that are indirectly targeted toward suicide prevention. We have also leveraged our relationship with the Department of Veterans Affairs (VA) to ensure a comprehensive research strategy is tied to gaps in the area of suicide prevention. We also continue to support the Joint VA and DoD Suicide Data Repository, a research tool that brings together a number of data bases for the purposes of examining suicide mortality.

Section 582 of the FY 2015 NDAA directed a report to Congress on the Prevention of Suicide among Members of United States Special Operations Forces. The report responds directly to the elements of policy, program strategies, training, and reporting regarding suicide prevention for Special Operations Forces and their dependents. The report ultimately finds there are cultural nuances and needs of the Special Operations Forces community that need to be addressed. In response, the Department is partnering with the Special Operations Command in the execution of a Peer Support Pilot program.

Leveraging Evidence Based Practices

We recognize peer-to-peer support as an evidence based strategy in the prevention of suicide. Identified as a best practice, a 2011 RAND report found that peer-to-peer support models were an effective strategy to bolster the efforts to prevent suicide. The Department continues a peer-to-peer support strategy through Military OneSource to ensure that a strong continuum of care exists for military Service members and their families. Service members seeking assistance through a peer-to-peer call center often call with a number of complex issues that require not only building rapport around common lived experiences, but also engaging other resources and conducting warm-hand offs for more intensive assistance.

We have recently re-focused our Suicide Prevention and Risk Reduction Committee, composed of Service level suicide prevention experts, toward identifying and leveraging best practices across the Department. Services and other stakeholders use this forum to share challenges, look for potential solutions, and identify best practices collectively. For example, recently, leaders within the United States Navy, United States Air Force and the United States Army have engaged in discussions with the United States Marine Corps on an intervention designed to provide increased community based care for those who have had an ideation or an attempt of suicide. This is one example where the Services have worked together to leverage best practices and learn from each other as part of our overall effort to prevent suicide.

We continue to collaborate with the Department of Veterans Affairs, academic institutions and the non-profit sector for the purposes of ensuring unity of effort and maximization of resources. For example, The "Power of 1" campaign, a joint VA/DoD campaign strategy, conveys that one small act could save the life of a Veteran or Service member in crisis. Both Departments promoted the "Power of 1" during Suicide Prevention Month. The campaign emphasizes the effect that one person, one conversation, or one act can have on the life of a Veteran or Service member by offering hope and opening the door to support. It also is designed to spread the word about VA and DoD mental health resources and suicide prevention efforts. This campaign aims to encourage Veterans, Service members and the people in their lives to educate themselves about suicide risks, identify warning signs and learn the steps to take in a time of crisis. One of those steps is to leverage the "Power of 1" and to encourage those in crisis of suicide to call the Veterans/Military Crisis Line for assistance.

As a Department, we are committed to evidence based approaches. We supported the work of the Services on the execution of key training on suicide assessment tools such as the Columbia Suicide Severity Rating Scale. This tool, endorsed by the National Action Alliance, provides an easy to understand, standardized assessment tool for helping determine if someone is at risk for suicide. Along with the VA safety plan, this tool has been widely disseminated across the United States Navy and the United States Marine Corps, with a plan for further endorsement across all Services.

Suicide Prevention Policies

The Department of Defense published the Directive, "Defense Suicide Prevention Program" in 2013. A follow on instruction is currently underway. As a Department we have shifted our efforts from the 2010 Task Force Report on Suicide in the Military to the Defense Strategy for Suicide Prevention (DSSP). The DSSP, in the final stages of staffing, aligns with the 2012 National Strategy for Suicide Prevention (NSSP). In addition, the Defense Suicide Prevention Office has worked with the Services to develop training standards for gatekeepers (A Gatekeeper is an individual who routinely interacts with individuals at risk of suicide as part of his/her daily duties. Examples of Gatekeepers include: Chaplains, Healthcare Providers, Leaders, Counselors, Military Family Life Consultants, and Recovery Care Coordinators). These standards, geared toward all gatekeepers, help various communities of professionals understand their role in the prevention of suicide.

Conclusion

In closing, suicide is a complex issue, but is preventable. The Department will not stop in our efforts to reach Service members at risk and provide them with the help they need. Our future Department-wide efforts will be focused on more effectively integrating our suicide prevention efforts into the larger portfolio of programs that target common risks and protective factors. Programs such as Family Advocacy, Sexual Assault Prevention, and Substance Abuse will work collaboratively to reduce incidents across all areas. Our Soldiers, Sailors, Airmen, Marines, and their families deserve nothing less. We look forward to continue working with Congress as we further refine our work on preventing suicide. Thank you for your support of the brave men and women who serve our Nation.

Keita Franklin, LCSW, PhD
Director, Defense Suicide Prevention Office
Office of the Under Secretary for Personnel and Readiness

CURRENT ASSIGNMENT:

Dr. Keita Franklin, a member of Senior Executive Service, is the Director for the Defense Suicide Prevention Office. She is responsible for policy and oversight for the Departments Suicide Prevention programs.

PAST EXPERIENCES:

Dr. Franklin previously served as the Behavioral Health Branch Head where she was charged with leading the integration of USMC behavioral health programs. In this capacity, she was responsible for the administration of a number of key program areas including; Research, Program Evaluation, Data Surveillance, Program Development, Functional Systems and Prevention and Clinical Services comprised of Substance Abuse, Family Advocacy, Suicide Prevention, Combat Operational Stress Control and non-medical counseling programs.

Dr. Franklin directed the policy, future planning, training, technical assistance, resource management and advocacy efforts for seventeen installations and over 200,000 Marines and families across the Corps. Her focus centered on leveraging the science to develop and execute an integrated service delivery built on a common risk and protective factors. In this capacity Dr. Franklin led a team of cross disciplinary professionals in the standing up a comprehensive system of care composed of a number of new programs while ensuring strong program evaluation processes were in place for monitoring program effectiveness. Dr. Franklin also transitioned the United States Marines Corps non-medical providers from paper based files to an IT care management documentation system. Dr. Franklin's specialty area of focus is on impact of deployment and trauma on military and family relationships, particularly spouses and children. Dr. Franklin has published on deployment and psychological well-being on family relationships and alcohol related issues. She has served as an adjunct faculty member at George Mason University and Virginia Commonwealth University and has lectured on numerous topics impacting military service members including; deployment stress, secondary trauma, women's mental health issues in the military, parenting in the military and behavioral health needs of today's service members. Prior to working for the Marine Corps, Dr. Franklin served at the installation and regional levels for both the United States Air Force and United States Army. She has worked in the areas of prevention, clinical treatment, child welfare and program administration over a variety of programs. Dr. Franklin has also worked in the non-profit sector in the area of adoptions.

Dr. Franklin is a licensed social worker with a specialization in children and families and has a PhD in social work with specialized training/certifications from the Center for the Advancement of Research Methods and Analysis. Dr. Franklin received a leadership award from Virginia Commonwealth University for leading efforts to help train and advise the social work profession on working with military families.

RECORD VERSION

STATEMENT BY

LIEUTENANT GENERAL JAMES C. MCCONVILLE
DEPUTY CHIEF OF STAFF, PERSONNEL (G-1), ARMY

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON MILITARY PERSONNEL

FIRST SESSION, 114TH CONGRESS

ON UPDATE OF MILITARY SUICIDE PREVENTION PROGRAMS

OCTOBER 8, 2015

NOT FOR PUBLICATION UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

STATEMENT BY
LTG JAMES C. MCCONVILLE
DEPUTY CHIEF OF STAFF, PERSONNEL (G-1), ARMY

Introduction

Chairman Heck, Ranking Member Davis, and Distinguished Members of this Committee - Thank you for the opportunity to appear before you on behalf of America's Army.

The most valuable asset the U.S. Army has is its people. It is our Soldiers who put their boots on the ground, and fight and win the Nation's wars. These men and women raise their right hand to defend the Constitution. Their continued dedication and commitment to the mission demonstrates what it means to be the strength of the Nation.

These Soldiers have families, squad leaders, and buddies who stand by them through all the challenges and unique demands military life places on them. It is these relationships that are the strength of our Soldiers.

Our people are invaluable. They have answered the call to serve their Nation to fight and win in a complex world. We must take care of them.

Strategic Overview

The Army's first priority is readiness. We must ensure the Army remains ready as the world's premier combat force. We are committed to making sure our Soldiers are properly trained, well equipped, and expertly led. To sustain readiness, we must take care of our troops and keep our Soldiers, Civilians, and Families in the forefront of all we do. The collective strength of our people – their mental and physical resilience – is the core of our Army.

Our Soldiers are highly trained and highly motivated. While they enter the Army with varying levels of experience and resilience, all make a commitment to live the Army Values and serve as Army Professionals. We strive to build upon their education and experience, increase their resilience, and optimize their performance.

Leaders in our Army understand that the loss of any Soldier is one too many. After 14 years of sustained combat, our leaders know first-hand how the death of a Soldier significantly impacts the readiness of their unit, tears at the cohesion of their team, and leaves an unimaginable void for the family.

Suicide Prevention Trends

The Army has had a reduction in suicides during 2014, down to 243 Soldiers, the lowest annual total since before 2010. As of 30 September 2015, the Army has had 208 Soldiers die from suicide, which marks an increase of 29 suicides from the same date in 2014. While the overall rate of suicide is down over the last five years, we are very concerned with the loss of any Soldier in our formations. When broken down by component, the Active Army has seen an increase in two suicides, the United States Army Reserve (USAR) has seen an increase of 16 suicides, and the Army National Guard has seen an increase of 11 suicides since 2014. In 2014, there were seven active component deaths from suicide while deployed. In 2015, there was one active component death from suicide while deployed. We are committed to reviewing the "how" and "why" from every case to learn from it.

Suicide is both a serious and complex challenge for our Army and our Nation. The demographically adjusted U.S. Suicide rate for 2013 was 20.5 suicide deaths per 100,000, slightly lower than the Army rate of 22.9 per 100,000 according to 2013 calendar year data. While this is a concerning statistic for the Army, we remain committed to recruiting and retaining the very best of our Nation has to offer, and once these young Americans are in our ranks, we owe nothing less than the very best to lead and care for them.

Suicide Prevention Efforts

The Army is committed to a multi-disciplinary, holistic approach to suicide prevention that emphasizes the importance of a Soldier's family, squad leader, and buddy. When I was a Division Commander, I used the term "golden triangle" to describe these relationships and the importance they play in identifying potential problems and difficult transitions early and at the lowest level. It is essential to be aware of what is going on in the lives our Soldiers. Often Family members and buddies will be the first to notice alcohol and drug use, financial problems, and relationship issues. When the lowest level leader is also aware, he or she can help the Soldier and their Family get the right kind of care. This is what makes our squad leaders so important. This past year, we've launched the "Not In My Squad" Campaign as a grassroots effort to empower squad leaders to know their Soldiers, take care of them, and get them the resources they need.

Training

All Soldiers and Army Civilians receive Ask, Care, Escort (ACE) training. This training provides the Army team the skills needed to recognize a Soldier in crisis and provides them the tools to get the Soldier help. It is also offered to family members. The Army also provides Ask, Care, Escort -- Suicide Intervention (ACE-SI) training. This higher-level training provides company level leaders the capability to recognize and effectively intervene when Soldiers exhibit signs of distress. Approximately 8,300 company level leaders have been trained. Additionally, the Army has Advanced Intervention Skills Training (ASIST) for gatekeepers. There are more than 2,300 ASIST trainers in the Army. This training teaches participants how to carry out life-saving interventions for people at immediate risk of suicide. To date, the Army has trained almost 117,500 Soldiers and Civilians.

In an effort to promote unit and individual resiliency, the Army also offers resiliency training. There are more than 23,000 Soldiers, Family members, and Civilians who serve as Master Resilience Trainers for company-size units. Our resilience training teaches skills that are designed to build competencies such as connection, mental agility, optimism and self-regulation. Resilience training is embedded across our Army, delivered through 26 Comprehensive Soldier Family Fitness (CSF2) Training Centers at installations worldwide. Soldiers receive two hours of resiliency training in Initial Military Training (IMT) when they first join the Army and up to 16 hours of installation level training when they report to their new unit. Training is reinforced annually as well as offered to family members to include a new teen resiliency effort.

Programs

At unit level, we've fielded the Commander's Risk Reduction Dashboard (CRRD) that provides Battalion and Company Commanders with reports on Soldiers with risk events and the risk event status of newly-arrived Soldiers. The information available to the Commander is limited to the Soldiers under his or her command. The CRRD is currently fielded to FORSCOM units, Fort Sill, 1st Army, and USAREUR, with fielding to MEDCOM and the remaining force in FY16.

We also continue to use the Global Assessment Tool (GAT) that allows Soldiers, Army Civilians, and adult family members to self-assess and gauge, at any time, their personal readiness and wellness in the areas of physical and psychological health, social connectivity, spiritual health, financial, and family preparedness.

Behavioral Health Initiatives

The Army Medical Department continues to employ a comprehensive and multi-faceted approach to reduce suicides among Soldiers, Army Civilians and their Families. The Army's continued emphasis on Soldiers and Family members seeking help will sustain high demand for Behavioral Health (BH) care. The Army has increased access to, and

availability of, Behavioral Health Care services. This has contributed to an overall increase in the number of Behavioral Health appointments in the Army increased from 991,655 in FY07 to 2,047,375 in FY14. The Army has been successful at meeting ongoing high demand for acute appointments as evidenced by the most recent access to care data. As of July 2015, the Army met the same-day standard for acute appointments 92% of the time. Behavioral Health clinics on all installations allow Soldiers to walk in without an appointment or a referral.

Army Medical Command initiated the Behavioral Health Service Line (BHSL) to implement a standardized system of care to identify, prevent, treat and track behavioral health issues affecting Soldiers and Family members. The BHSL enhances existing BH efforts by ensuring an enterprise-wide approach to the delivery of existing and emerging BH programs.

The Army is removing the stigma associated with seeking BH through programs, such as Embedded Behavioral Health (EBH), which was developed to increase readiness by more effectively identifying and treating Soldiers with BH conditions. The EBH model of care places multidisciplinary teams of BH professionals into direct support of brigade-size units and locates them in small clinics in close proximity to the unit's work area. EBH serves as the single point of entry into BH care for each battalion's Soldiers and leaders. EBH has been associated with improved access, quality and safety in Soldier care and improved readiness at the time of deployment. It has been consistently recognized as a DoD-wide best practice.

Army STARRS

The Army Study to Assess Risk and Resilience in Service members (Army STARRS) began in 2008 as a partnership between the Army and the National Institute of Mental Health (NIMH) to better characterize suicidal behavior among Soldiers. This is the largest study ever conducted to assess risk and protective factors for suicide and related psychological problems in military personnel.

To support this work, the Army assembled a very large historical data set containing extensive information on more than 1.6 million Soldiers who served on active duty from 2004-2009. During 2011-2012, the research team collected data directly from approximately 110,000 Soldiers who personally consented to participate in the research. These Soldiers completed extensive surveys and underwent neurocognitive testing. Approximately 52,000 Soldiers provided blood samples that were analyzed for evidence of biological markers associated with suicidal behavior. All of this information was collected and securely stored to fully protect each individual Soldier's privacy. For the past two years the emphasis has been on analyzing this huge volume of data.

Some of the key findings that have emerged from the research to date are: (1) Among Soldiers, suicides were more likely to occur after the first year of service, and to involve young, male, junior enlisted Soldiers, with relatively low educational attainment. (2) Soldiers in the traditional combat arms occupations had the highest overall suicide risk. (3) Being married is normally protective against suicide in the U.S. civilian population, but was protective for Soldiers only while they were deployed. (4) Demotion in the prior two years, and not being promoted along with one's peers in the first two years of service increases the risk of suicide. (5) Behavioral health problems, both past and present, are potent risk factors for suicide. (6) Risk for suicide increased with a Soldier's first deployment compared to those who had never deployed, but there was no additional risk of suicide with additional deployments.

The researchers also disproved a number of proposed explanations for the increasing Army suicide rate. Contrary to what some suspected, Army STARRS found that receiving an Army accession waiver, serving during stop-loss, living in a single barracks room, and the changes over time in the Regular Army demographics such as age, sex, race, and education, did not account for the increase in suicide rates during 2004-2009.

The researchers also looked closely at non-fatal suicidal behavior, which includes suicidal thoughts, plans, or attempts. About 14% of the surveyed Soldiers who were

beginning basic training reported having had suicidal thoughts before entering the Army. This information was not available to the Army during the accessions process, highlighting one of the challenges we face in deciding who to accept into military service and emphasizing for us the importance of pre-accessions screening.

Suicide attempts are one of the strongest predictors of future suicides. Suicide attempts occur approximately 10-20 times more commonly than suicides. Suicide attempts were more likely to occur during the first year of service and involve young, never married, female, junior enlisted Soldiers, with less than a high school education. Enlisted Soldiers accounted for 99 percent of the suicide attempts. The researchers identified several warning signs of near-term suicidal behavior, including escalating anger, violent outbursts, and episodes of family violence.

More than 30 manuscripts have been published in peer-reviewed scientific literature to date. The 2013 National Research Action Plan identified Army STARRS as a critical national resource. Army STARRS concluded on June 30, 2015. As a follow-up to Army STARRS, the Office of the Assistant Secretary of Defense for Health Affairs has agreed to continue research with the Study to Assess Risk and Resilience in Service members – Longitudinal Study (STARRS-LS) under a Memorandum of Agreement between the Acting Under Secretary of Defense (Personnel and Readiness), the Secretary of the Army, and the Director of the NIMH. STARRS-LS began on July 1, 2015. This allows us to closely follow approximately 72,000 Soldiers over the next five years, both those who remain in service and those who have returned to civilian life, the latter to be accomplished in partnership with the Veterans Affairs.

Conclusion

We have and will continue to invest significant resources in studying and combating the underlying causes of suicides as we seek to determine correlation and causality derived from complex personal and environmental factors that may influence suicides.

Any time a Soldier, Army Civilian, or Family member dies, the loss is devastating to Family and friends, fellow Soldiers, and the Army. It is our shared responsibility to ensure the personal readiness and resilience of those who serve. As we continue our mission to reduce the occurrence of suicide, I ask for your support as we work toward building and sustaining the resilience and readiness of our Soldiers, Army Civilians and Family members. I wish to thank all of you for your continued support, which has been vital in sustaining our professional all-volunteer Army and will continue to be vital to ensure the readiness and future of our Army and the Nation.

Lieutenant General James C. McConville
U.S. Army Deputy Chief of Staff, G-1

Lieutenant General James C. McConville became the U.S. Army's 47th Deputy Chief of Staff, G-1 on August 4, 2014. He is responsible for developing, managing, and executing manpower and personnel plans, programs, and policies for the total Army. Prior to this assignment, he served as the Commanding General of the 101st Airborne Division (AASLT) and Fort Campbell, KY.

Lieutenant General McConville hails from Quincy, MA and was commissioned as an Infantry officer in the U.S. Army upon graduation from the United States Military Academy in 1981. He holds a Bachelor of Science Degree from the United States Military Academy, a Master of Science Degree in Aerospace Engineering from the Georgia Institute of Technology, and was a 2002 National Security Fellow at Harvard University.

LTG McConville's command assignments include command of an Aero-Rifle Platoon in D Troop, 2-10 CAV from 1984 to 1985 and C Troop, 2-9 CAV from 1986 to 1987 in the 7th Infantry Division (Light) at Fort Ord, CA; command of 2-17 CAV from 1998 to 2000 in the 101st Airborne Division (AASLT) at Fort Campbell, KY; command of the 4th Brigade, 1st Cavalry Division at Fort Hood, TX from 2002-2005 with service in Operation IRAQI FREEDOM; and command of the 101st Airborne Division (AASLT) and Fort Campbell, KY from 2011-2014 with service in Operation ENDURING FREEDOM.

LTG McConville's key staff assignments include S-3 for Flight Concepts Division; S-3 for 5th Squadron, 9th Cavalry; S-3 for the 25th Combat Aviation Brigade; J5 Strategic Planner for the United States Special Operations Command; G-3 for the 101st Airborne Division (AASLT); Executive Officer to the Vice Chief of Staff of the Army; Deputy Commanding General (Support) for the 101st Airborne Division (AASLT) with service in Operation ENDURING FREEDOM; and Deputy Chief and Chief of the Office of Legislative Liaison.

LTG McConville is a Master Army Aviator qualified in the OH-58 Kiowa Warrior, the AH-64D Longbow Apache, the AH-6, AH-1 Cobra and other aircraft. His awards and decorations include the Distinguished Service Medal (with Oak Leaf Cluster), the Legion of Merit (with 2 Oak Leaf Clusters), the Bronze Star (with 2 Oak Leaf Clusters), the Defense Meritorious Service Medal (with Oak Leaf Cluster), the Meritorious Service Medal (with 2 Oak Leaf Clusters), Air Medal (Numeral 2), the Joint Service Commendation Medal, the Army Commendation Medal (with Oak Leaf Cluster), the Army Achievement Medal (with 3 Oak Leaf Clusters), the Combat Action Badge, the Expert Infantryman's Badge, Master Army Aviator Badge, Air Assault Badge, Parachutist Badge, and others.

Lieutenant General McConville is married. He and his wife have two sons and a daughter.

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE SUBCOMMITTEE ON MILITARY PERSONNEL

COMMITTEE ON ARMED SERVICES

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: SUICIDE PREVENTION

STATEMENT OF: LIEUTENANT GENERAL MARK A. EDIGER
SURGEON GENERAL
UNITED STATES AIR FORCE

OCTOBER 8, 2015

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

Air Force Suicide Prevention

Chairman Heck, Ranking Member Davis, and distinguished members of the committee, thank you for the opportunity to appear before you on behalf of the men and women of America's Air Force.

The United States Air Force defends our nation with a broad range of capabilities made possible by an incredible force of professional Airmen who bear great responsibility in demanding missions. Our Airmen include members in the active component, Air National Guard, Air Force Reserve, and civilians in government service. Secretary James, General Welsh and leadership at every level of our Air Force are committed to the development of strong, resilient Airmen and the coordinated, robust support to Airmen as they confront problems inherent to life and mission.

Accordingly, the Air Force strategy for suicide prevention focuses on resilience among Airmen coupled with a community-based public health approach to prevention and timely intervention with follow-up for those in distress. This strategy includes actions across a preventive spectrum that extends from primary prevention measures focused on resilience for all Airmen to mental health care focused on Airmen in distress. This consists of layers of prevention with the broadest foundational layer reaching every Airman by fostering resilience and a culture of Airmen mutually supportive as Wingmen. The second layer provides assistance to those in personal or mission circumstances imposing stress. The third layer provides focused support and care for Airmen in distress. The program is an integrated network of policy, process and education that focuses on fostering strong, resilient Airmen, provision of assistance through stressful circumstances and focused support for those in distress. Through the program, leaders serve as role models and change agents, continuously working to sustain a culture of mutually

supportive Wingmen and working to connect Airmen with sources of assistance and care. The program was designed with 11 overlapping elements grouped into three categories: 1) leadership and community, 2) education, and 3) protections for those under administrative or legal investigation.

The Air Force is experiencing a rising rate of suicide among Airmen and a comprehensive review of our prevention strategy and program has been directed by Secretary James and General Welsh. This review is in progress and we just completed a Suicide Prevention Summit. Those activities will be described in this testimony.

Progression of Prevention

Since adoption of the strategy based upon the 11 elements, the Air Force has continuously adapted and evolved tools and procedures to apply the strategy. Through a partnership with the University of Rochester, the Air Force has continuously evaluated the effectiveness of its program. Using information gathered through the evaluation, the Air Force updated its guidance by rewriting and publishing our Suicide Prevention Instruction, which established tiered training requirements, and codified DoD Suicide Event Report requirements. We created a frontline supervisor training course tailored to career fields with the highest incidence of suicide. We developed the Airman's Guide to Assisting Personnel in Distress, and the Community Action Information Board directed all units to complete an annual end-of-year self-assessment checklist to ensure full implementation of the 11 elements of the program.

Recent suicide prevention initiatives include a renewed emphasis and enhanced format for annual suicide prevention training. This annual training for the total force is now conducted in a "live" small group discussion. Specific vignettes and discussion guides have been developed for active duty and reserve component personnel as well as DoD civilian employees in

acknowledgement of their different demographics and circumstances. This training emphasizes early intervention, risk factors and warning signs to enable Airmen to respond using the ACE (Ask, Care, Escort) model. The Air Force has also fielded an annual refresher course for frontline supervisors in career fields with the highest incidence of suicide to ensure their knowledge of tools and techniques to support and assist Airmen remains current. In 2014, we updated the Airman's Guide to Assisting Personnel in Distress. This tool provides guidance to Commanders and other leaders on effective intervention for issues including domestic violence, suicide risk, sexual assault and other sensitive and challenging problems. We also revised and expanded post-intervention guidance for Commanders and other leaders. Topics addressed included memorial guidance to ensure that unit leaders manage the aftermath of a suicide with sensitivity while focusing on appropriate messaging that would not inadvertently increase risk. Moreover, this year, we released the Air Force Family Members' Guide to Suicide Prevention to ensure that we are including family members in our coordinated community response. AF Public Affairs guidance, specific to suicide and consistent with appropriate evidence-based messaging was also updated and issued in September 2015.

Since 2012, the Air Force has been conducting successful pilot projects that embed mental health providers in operational units where performance demands and operational stress are concerns. This operational outreach reduces barriers between mental health professionals and Airmen by fostering confidence through informal interaction and familiarity of mental health providers with the mission. In addition, mental health clinicians known as Behavioral Health Optimization Providers have been placed in all Air Force Family Health Clinics. This provides quick access to mental health providers in the primary care setting, reducing concerns about stigma and assuring prompt access for Airmen and families.

The Air Force remains committed to the necessary provider staffing and training to deliver highly reliable and safe mental health care. In response to the 2010 National Defense Authorization Act, Section 714, mental health active duty authorizations are increasing and will reach the target growth of 25 percent by 2016. We thank the Committee for its support to high quality, accessible mental health support to Airmen.

Our mental health providers are trained and current in evidence-based treatments, to include Prolonged Exposure and Cognitive Processing Therapy. This training is delivered in all Air Force internships and residency programs for trainees and to all providers following completion of training. The Air Force continues to collaborate with the Departments of Defense and Veterans Affairs in advancing research on prevention and treatment of combat related injuries, including Posttraumatic Stress Disorder (PTSD). Finally, the AF is committed to reducing suicides within the clinical setting by incorporating the latest research and actively seeking innovative initiatives in our mental health clinics to better manage our highest risk patients; increasing communication of safety events, disseminating lessons learned and providing enhanced risk-assessment training for primary care providers.

Recognizing the significant overlap between interpersonal violence, alcohol and substance abuse and suicide, we have also developed novel programs to assist in the prevention of child/family violence, such as Mission Dad. This effort provides on-line education and support to new fathers while we actively expand our capabilities to detect and address substance abuse by increasing the number of mental health technicians certified as Drug and Alcohol Counselors by nearly 75% in the past year.

Collaboration within DoD and National Suicide Prevention

The Air Force is actively engaged with the Defense Suicide Prevention Office (DSPO) in helping to shape suicide prevention efforts across the DoD through the Suicide Prevention and Risk Reduction Committee, the DoD General Officer Steering Committee on Suicide Prevention, along with other working groups and committees. The Air Force significantly contributes to five DSPO working groups, with significant emphasis on strategic messaging and stigma reduction. The Air Force also partners with DSPO and other services in promoting the "Military Crisis Line" component of the Veterans Crisis Line to ensure Airmen have access to immediate confidential services.

The Air Force Suicide Prevention Program continues to contribute to the body of scientific literature and to the study of suicide and suicide prevention. The 2012 National Strategy on Suicide Prevention states: "…the experience of the U.S. Air Force Suicide Prevention Program has shown that leadership, policy practices, and accountability can combine to produce very impressive successes. These findings should be shared and adapted for use in different settings." The Air Force is committed to its suicide prevention program, but also eager to embrace the way ahead as we continue to evolve our program to achieve and sustain maximum efficacy in preventing suicides.

Post-Traumatic Stress Disorder

Although PTSD has not proven to be a prevalent contributing factor to suicides in the Air Force, we recognize the importance of effective identification and treatment in controlling the impact of PTSD on Airmen and families. Air Force mental health providers are trained in evidence-based treatments for PTSD and treatment has enabled the majority of Airmen diagnosed with PTSD to continue serving.

We continue to screen Airmen for PTSD symptoms via Pre- and Post-Deployment Health Assessments and at various points through the deployment cycle. All Airmen receive education and training on how to recognize symptoms of PTSD and how to access the right resources. In 2010, the Air Force established the Deployment Transition Center at Ramstein Air Base, Germany. This center provides a four-day reintegration program for Airmen returning from deployments that involved activities associated with post-traumatic stress. Since its inception, the Deployment Transition Center has processed over 8,000 re-deployers, including service members from the Navy and Marine Corps. The design of the Center is entirely consistent with the Comprehensive Airman Fitness framework and specifically targets resiliency challenges due to family separation and the demands of combat operations. While initially focused on forces returning from the U.S. Central Command area of responsibility, the Deployment Transition Center is expanding its support to re-deploying Airmen from the Africa Command area of responsibility. Over the its five years of operation, the Deployment Transition Center has proven to diminish post-traumatic stress, relationship conflict, anger problems, depression, sleep disturbance, and alcohol use problems.

Trends in the Incidence of Suicide in the Air Force

The Air Force leadership is very concerned about the increasing rate at which suicide is occurring among Airmen, a trend that has persisted since 2007 despite a focused prevention effort and adjustments to address underlying factors. The increase has been most evident in the active force. Last year 62 active duty Airmen took their lives, a rate of 19 per 100,000. To date in calendar year 2015 the Air Force has seen 70 total force suicides, 48 of which are Air Force active duty members, and 13 civilians. The Air Reserve Component had a total of 24 suicides in 2014, consistent with the rate in 2013 and 2012. The Air National Guard trended down from

2012 to 2013 and remained virtually unchanged from 2013 to 2014, while the Air Force Reserve was generally consistent with prior annual rates. While this reflects an increase in the suicide rate in the U.S. population, we are committed to reversing this troubling trend among Airmen. Deployment has not been found to be a risk factor for suicide in the Air Force. The stressors most frequently identified among Airmen that commit suicide have remained unchanged for decades and include relationship problems, legal/administrative issues, work-related stressors or a combination of these factors. The Air National Guard and Air Force Reserve report similar underlying factors. In a 2014 analysis of our Air Force data we determined that the majority (56%) of those who died by suicide were coping with three or more significant stressors.

2015 Comprehensive Review and Suicide Prevention Summit

In April 2015, General Welsh initiated a comprehensive review of Air Force suicide prevention to include an Air Force Suicide Prevention Summit. The purpose is to identify factors underlying Air Force suicides, review the latest evidence regarding effective prevention, gain insight into the experience of other organizations, refresh the Air Force strategy and identify new actions to effectively prevent suicide.

The review is in progress under the oversight of a Senior Steering Group. Elements of the review include: 1) multidisciplinary analysis of investigations and medical information on active duty suicides in 2013 and 2014, 2) review of medical care to Airmen with suicidal ideation, 3) a National Institutes of Health (NIH) funded on-site assessment of suicide prevention and Community Action Information Board processes at 17 installations. In the on-site assessments, a research team from the University of Rochester will conduct focus groups with key stakeholders, Airmen of all rank groups and family members to more fully understand the

impact of existing prevention programs, identify barriers to effective implementation, and develop recommendations to improve community prevention.

The Air Force Suicide Prevention Summit was conducted 22-25 September 2015, with 160 diverse participants consisting of total force Airmen from multiple career fields at all levels of seniority, behavioral health experts, suicide prevention experts from DoD and the Services, researchers from academic institutions, and national experts from the NIH, the Department of Veterans Affairs and the Centers for Disease Control. The participants interacted with Air Force senior leaders, received relevant presentations, and populated ten break-out groups. The breakout groups considered factors pertaining to a new generation of Airmen, the mission, new knowledge about prevention, communications, socio-economic factors, developmental education, and others to arrive at observations and recommendations. Each group discussed their recommendations directly with the Chief of Staff of the Air Force and Vice Chief of Staff of the Air Force. The recommendations are comprehensive and provide new approaches within each layer of the spectrum of prevention. The recommendations from the review and Summit are now being used to refresh the Air Force strategy and build action plans.

Conclusion

The Air Force is committed at every level to develop and support total force Airmen as resilient mutually-supportive professionals. We are working hard to meet mission demands while keeping stress on the force to a level compatible with good health and high performance among Airmen. We need every Airman across the total force, including those in uniform and our government civilians. We will continue to work closely with our colleagues in the Army, Navy, DoD, Department of Veteran Affairs, other governmental agencies and academia in this

essential endeavor. Thank you for your attention to this important matter and your continued support.

Lieutenant General Mark A. Ediger
Surgeon General of the Air Force, Headquarters U.S. Air Force

Lieutenant General Ediger is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Ediger serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force people. General Ediger has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of a $5.9 billion, 44,000-person integrated health care delivery system serving 2.6 million beneficiaries at 75 military treatment facilities worldwide.

Prior to his current assignment, General Ediger served as Deputy Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

General Ediger is from Springfield, Missouri. He entered the Air Force in 1985 and has served as the Aerospace Medicine Consultant to the Air Force Surgeon General, commanded two medical groups and served as command surgeon for three major commands. He deployed in support of operations Iraqi Freedom, Enduring Freedom and Southern Watch.

EDUCATION
1977 Bachelor's degree in chemistry, University of Missouri, Kansas City
1978 Doctor of Medicine degree, University of Missouri, Kansas City
1981 Residency in family practice, Wake Forest University, Winston-Salem, NC
1991 Master of Public Health degree, University of Texas School of Public Health, San Antonio, TX
1992 Residency in aerospace medicine, USAF School of Aerospace Medicine, Brooks AFB, TX

ASSIGNMENTS
1986–1988 Chief, Family Practice, Air Transportable Hospital Commander, 1st Medical Group, Langley AFB, VA
1988–1990 Flight Surgeon and Chief, Flight Medicine, 94th Fighter Squadron, Langley AFB, VA
1990–1992 Resident in Aerospace Medicine, USAF School of Aerospace Medicine, Brooks AFB, TX
1992 –1994 Chief, Aeromedical Services, 325th Medical Group, Tyndall AFB, FL
1994 –1996 Chief, Aerospace Medicine Branch, and Chief, Professional Services Division, Headquarters Air Education and Training Command, Randolph AFB, TX
1996–1998 Chief, Aerospace Medicine Division, Air Force Medical Operations Agency, Bolling AFB, D.C.
1998–2000 Command Surgeon, Air Force Special Operations Command, Hurlburt Field, FL
2000–2002 Commander, 16th Medical Group, Hurlburt Field, FL
2002–2003 Commander, 363rd Expeditionary Medical Group, Southwest Asia
2003–2007 Command Surgeon, Headquarters U.S. Air Forces in Europe, Ramstein Air Base, Germany
2007–2008 Command Surgeon, Headquarters Air Education and Training Command, Randolph AFB, TX
2008–2012 Commander, Air Force Medical Operations Agency, Lackland AFB, TX
2012 –2015 Deputy Surgeon General, Headquarters U.S. Air Force, Washington, D.C.
2015–present Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION
Rating: Chief flight surgeon
Flight hours: More than 800 hours, including 90 combat support hours and 38 combat hours
Aircraft: C-130, MH-53, F-15, T-38 and KC-135

MAJOR AWARDS AND DECORATIONS
Air Force Distinguished Service Medal
Legion of Merit with two oak leaf clusters
Bronze Star Medal
Meritorious Service Medal with four oak leaf clusters
Aerial Achievement Medal

PROFESSIONAL CERTIFICATIONS
1982 American Board of Family Practice (most recent recertification in 2015)
1992 Aerospace Medicine, American Board of Preventive Medicine

EFFECTIVE DATES OF PROMOTION
Major 28 April 1986
Lieutenant Colonel 28 April 1992
Colonel 28 April 1998
Brigadier General 14 April 2008
Major General 13 July 2012
Lieutenant General 5 June 2015

(Current as of 10 Jun 15)

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HOUSE ARMED SERVICES COMMITTEE

STATEMENT OF

MAJOR GENERAL BURKE W. WHITMAN,

DIRECTOR, MARINE AND FAMILY PROGRAMS DIVISION

UNITED STATES MARINE CORPS

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE

SUBCOMMITTEE ON MILITARY PERSONNEL

CONCERNING

UPDATE ON MILITARY SUICIDE PREVENTION PROGRAMS

ON

8 OCTOBER 2015

NOT FOR PUBLICATION UNTIL
RELEASED BY THE
HOUSE ARMED SERVICES COMMITTEE

INTRODUCTION

Chairman Heck, Ranking Member Davis, and distinguished Members of the Subcommittee, on behalf of the U.S. Marine Corps, thank you for holding this hearing and the opportunity to update you on our suicide prevention efforts.

When a Marine chooses to end their own life, all of us are impacted – families, friends, and the entire Marine Corps community. We all share in the responsibility to do what we can to protect each Marine's life.

The Marine Corps embraces prevention efforts through a series of actions to foster hope and connection for those at risk for suicide. We will continue to apply the resources necessary to combat this difficult issue. Early intervention is key; it is a continuous challenge to engage Marines in help-seeking services early. We remain vigilant. This means continuing to analyze the data, seek new evidence-based research and empirical tools, and ensure training and resources are available.

UNDERSTANDING SUICIDE STATISTICS AND RISK FACTORS

For calendar year (CY) 2015, through 31 August, there have been 33 Marine Corps (Active Duty and Selected Marine Corps Reserves) suicide deaths. This is slightly higher than the number of Active Duty and Selected Marine Corps Reserve suicide deaths at the same period of time in CY 2014 (32 suicide deaths during CY2014 through 31 August 2014). The number of CY 2015 suicide deaths is lower than the number of CY2013 deaths occurring at the same period of time (38 suicide deaths through 31 August 2013).

A continuous challenge for the Marine Corps is to engage Marines in help-seeking services early, before problems worsen to the point of suicide. Suicidal ideation is a reflection of

distress that requires intervention. The Marine Corps began collecting data on suicidal ideation in late 2013. Limited data is available for comparison, but there were 907 events of suicidal ideation reported in 2014 and 587 events in 2015 through 31 August.

For CY 2015, through 31 August, there have been 197 Active Duty suicide attempts. This number is higher than the number of CY 2014 Active Duty suicide attempts (162) through 31 August 2014, and higher than the number of CY 2013 Active Duty suicide attempts (185) through 31 August 2013. We believe that the increase in attempts and the rates of suicidal ideation are reflective of better identification of at-risk Marines and more emphasis on reporting requirements that support interventions.

We consistently track Active Duty suicides through the Department of Defense Suicide Event Reporting, Armed Forces Medical Examiners Service, Department of Defense Suicide Prevention Office, and various reporting mechanisms for the Reserve component and have several suicide prevention efforts underway to continue to explore the underlying reasons for suicide.

Marines contemplating suicide may have several interactive factors that may be chronic, acute, or gradually emerging. The cumulative risk is dynamic for any group of Marines and any individual Marine over time. Examples of risk factors include financial stress, loss of relationships, substance misuse, legal problems, behavioral health conditions, history of trauma, family history of suicide, and many forms of transition that erode a critical protective factor inherent to Marine Corps culture: a sense of belonging. Transitions such as Permanent Change of Status (PCS), separation and retirement, change of occupation, or divorce can be particularly challenging when combined with other risk factors. Additionally, a Marine's significant change in status within their unit due to a legal action can result in feelings of shame, loss of face, and

perceived or real alienation from peers that is equally detrimental. Research to date has not correlated deployment experience with suicide risk. However, further research may identify specific deployment variables or deployment combined with particular risk factors that could increase risk of suicide.

SUICIDE PREVENTION EFFORTS

Due to the complex nature of suicide that often manifests as an outcome of other behavioral health issues, the Marine Corps has focused on a holistic prevention and early intervention approach. There are usually many warning signs that precede a suicide and it is imperative that everyone in our community be able to recognize the warning signs and know how to help someone connect with appropriate care.

A key component of our behavioral health efforts is to have engaged leaders at all levels. It is vital for leaders to know their Marines and know how to respond immediately and effectively to warning signs. Additionally, successful prevention efforts require a command climate of vigilance and a concerted effort to ensure that each Marine understands that seeking any form of assistance to ensure wellness is the desired course of action.

The Marine Corps, through our leadership, has worked tirelessly to ensure each Marine knows that help is literally a fingertip away—whether by pushing a button on a telephone to call our DSTRESS line, opening the door to their local Community Counseling Program (CCP), knocking at the door of their unit chaplain, or texting a team leader.

Our Marine Expeditionary Force (MEF) Prevention provides another avenue to understand and mitigate the risk factors within a command. The Marine Corps has embedded civilian behavioral health personnel in the Active Duty operating forces to assist commanders.

Prevention Directors serve as a direct link between Marine Expeditionary Force commanders and Headquarters to improve communication on prevention initiatives, data requests, and feedback to and from the operating forces.

One of the most integrated suicide prevention efforts in the Marine Corps is the implementation of the evidence-based Columbia-Suicide Severity Rating Scale (C-SSRS). All Marine Corps Community Services Behavioral Health programs use the C-SSRS; as do all those interacting with Marines at risk for suicide, including but not limited to: chaplains, Marine Corps Defense Counsel, legal aid, medical staff, substance abuse treatment personnel, Sexual Assault Prevention and Response personnel, Family Advocacy personnel, and financial counselors. This effort identifies Marines considering suicide, facilitates communication, and allows for coordination of care among the many professional roles supporting Marines as a team.

The Marine Corps has a variety of non-medical, prevention-oriented programs where Marines and their families can find solutions to life's stressors that may add to suicide risk. In 2013, the Marine Corps launched our Community Counseling Program (CCP). CCP services are located on installations worldwide to increase access to care and assist Marines and their families in navigating the many support resources available for various behavioral health issues. Whether a Marine or family member is seeking help for stress, relationship challenges, parenting struggles, or concern about substance misuse, the Marine will receive immediate support in accessing all needed resources regardless of why they first sought counseling. The concept is that there is "no wrong door" in accessing care.

CCP counselors are licensed clinicians, who provide evidence-based screenings and assessments, short-term, non-medical counseling interventions, psycho-education, clinical case management, and care coordination. These services are provided to individuals, couples, and

families coping with a wide variety of behavioral health issues. Less than two years from when CCP was first implemented, in the third quarter, our case load in fiscal year (FY) 2015 is 2,098 new cases opened; 1,599 full assessments completed; and 8,026 individual session hours provided, of which 1,758 were with spouses and 735 with children.

In conjunction with the launch of CCP, in November 2013, the Marine Corps implemented the Marine Intercept Program (MIP) to ensure that Marines who experience suicidal ideation or attempt suicide receive ongoing risk assessment, safety planning, and coordination of care. MIP, founded on suicide prevention research, is designed to interrupt the potential path to suicide by providing timely intervention. MIP partners with the Marine's leadership, CCP, and Navy medical services in a combined effort to support the Marine during a known period of high risk.

In the event a Marine or attached Sailor is identified with a suicidal ideation or suicide attempt, CCP immediately reaches out to the Marine through his or her command to offer services. MIP services include an evidence-based suicide risk assessment and a coordinated safety plan that is continuously updated through a series of caring contacts for a minimum of 90 days. CCP is responsible for contacting the command within 24 hours of receiving a new case if the command does not initiate contact with the CCP. In a preliminary review of MIP cases, Marines who receive MIP services access care 2.5 times faster than Marines who access care from military treatment facilities (an average 4.6 days vice 11.5 days), miss fewer appointments, and access specialty care more often.

Within the first full year of MIP (CY 2014), 1,196 occurrences of suicidal ideation or suicide attempts were reported and assigned to MIP. In CY 2015 (through 31 Aug 2015), 793 occurrences of suicidal ideation or attempted suicides have been reported and assigned for MIP

services. Since its implementation in November 2013, of the 2,086 Marines accepting MIP services (66.3 percent of the Marines accept services), only one Marine has died by suicide to date.

Additional prevention and early intervention services are provided by the Military Family Life Counselors (MFLCs) who are funded by Department of Defense. MFLCs are licensed mental health professionals who provide non-medical, solution-focused counseling to military personnel and their families, assisting them in exploring alternate solutions to daily life stressors. For the second quarter of FY 2015, there were 138,125 face-to-face MFLC sessions.

Since 2010, the DSTRESS Line has been available to Marines, attached Sailors, and family members, providing anonymous 24/7/365 phone, chat and Skype support. DSTRESS continues to be a critical resource in suicide prevention. Since August 2010, program staff have successfully intervened 35 times to interrupt the cycle of suicide (meaning, program staff effectively assessed, ensured safety and connected the Marine to local resources).

The Marine Corps is also continuing our efforts of suicide prevention with our Reserve Marines. The Psychological Health Outreach Program addresses post-deployment behavioral health concerns and enables crisis-related interventions through social worker contractors. These social workers provide an array of referral services in the community to include follow-up with service members. The programs have proven effective in the overall management of identifying Marines in need of behavioral health assistance and have provided an avenue to those service members who seek behavioral health assistance. This program is an essential resource for treatment referral and follow-up to ensure our Marine receive appropriate health services.

Because Marines and families often utilize social media to stay in touch with friends and family, the Marine Corps launched a suicide prevention campaign in August and September of

2015 that included Facebook, Twitter, and printed materials distributed throughout the Corps. This campaign leveraged technology to demonstrate how to notice signs of at-risk thoughts, identify resources available, and highlighted the trend of individuals expressing suicidal thoughts on social media. In addition, the campaign encouraged Marines and family members to use social media to stay connected with their loved ones, especially during Permanent Change of Station (PCS) when Marines are separated from their support networks and are most vulnerable. The posts directed users to the DSTRESS Line, and instructed users on how to use Facebook's Suicide Prevention Tool to report alarming content. To date, the four social media posts have been seen by over 55,000 people and shared more than 300 times.

TRAINING MARINES TO RECOGNIZE SUICIDE

In addition to our services and preventive efforts, educating those in leadership positions to recognize at-risk Marines is vital. Various warning signs commonly precede a suicide. Those who surround a Marine must know the warning signs of suicide—whether that is the Marine, his or her fellow Marines in the unit, the commander, or a family member. Annually, all Marines are trained to apply the acronym **R.A.C.E.**— **R**ecognize suicide warning signs, **A**sk one another about suicide, **C**are for one another through listening and support, and **E**scort fellow Marines to help.

In response to efforts by this Subcommittee, the Marine Corps has initiated a training program titled "Conquering Stress with Strength (CSWS)." CSWS is the first available family-focused training that provides Marine Corps families the skills for appropriately responding to high-stress situations. As of today, there are 22 Marine Corps Family Team Building trainers trained in CSWS across Marine Corps installations. Although CSWS is a new and growing

workshop, it has been conducted in 13 sessions thus far and prepared 120 participants to respond to suicide.

Effective 1 January 2015, we replaced our annual training "Never Leave A Marine Behind" with Unit Marine Awareness and Prevention Integrated Training (UMAPIT). UMAPIT training educates Marines and attached Sailors in evidence-based interventions to provide them with the skills to build self-resilience and provide support to and empower their peers. UMAPIT is designed to consolidate and replace required training sessions for four separate areas: the Family Advocacy Program (FAP), Substance Abuse Program (SAP), suicide prevention and response, and combat operational stress control (COSC). Topics covered include common risk and protective factors, warning signs, intervention strategies, referral and reporting, definitions, and the "big five" resources (peers, chain of command, chaplain, medical/Marine Corps Community Services counselors, and the DSTRESS hotline).

Operational Stress Control and Readiness (OSCAR) is a Marine-led training that builds teams of Marine leaders, medical providers, and chaplains in maintaining warfighting capabilities by identifying, managing, and preventing combat and operational stress issues as early as possible. As of 31 March 2015, more than 33,000 Marines are trained as OSCAR team members in units across the Marine Corps. We developed a new version of OSCAR in January 2015. The updated OSCAR is a 4-hour curriculum that teaches skills to prevent and mitigate stress injuries. OSCAR teams are key members of the Force Preservation Councils and Human Factors Boards, which provide Marine Corps leaders an opportunity to share information to promote the welfare of Marines. This knowledge allows leaders to identify crisis intervention requirements or early warning signs of mounting issues.

CONCLUSION

Suicide prevention is, and remains, a top priority for the Marine Corps. We are working tirelessly to ensure we are effectively preventing and addressing behavioral health issues, stressors, and underlying vulnerabilities that increase the risk of death by suicide. We can prevent suicide by promoting protective factors and genuine caring contacts within our units. Being part of the Marine Corps community reinforces the idea of a profession of arms and the participation in something larger than oneself. Connections save lives.

The Marine Corps will continue to provide the necessary attention and resources to prevent suicide, ensuring all Marines are fit, fortified and strengthened, and better able to withstand the tensions and stressors of life in and out of the Marine Corps.

Major General Burke W. Whitman
Director, Marine and Family Programs Division

Major General Burke W. Whitman was reared in Atlanta where he graduated with honors from Lovett High School. He played rugby and earned a BA with honors on a work scholarship from Dartmouth College, an MBA from Harvard University, and a commission as an officer of Marines after graduate school.

As a Marine, he has commanded infantry and reconnaissance units at the platoon, company, battalion, and regiment levels; served as an operations officer at the battalion, brigade, division, and geographic combatant command levels; conducted combat operations in Bosnia, Iraq, and Afghanistan; developed strategy at the Pentagon; and earned a Master of Strategic Studies degree from the Army War College.

A chronology of military assignments: Rifle Platoon Commander, 2nd Battalion, 4th Marines; Aerial Observer; Mortar Platoon Commander; Company Executive Officer; Battalion Operations Officer; Task Force Eagle, Bosnia; Light Armored Company Commander; Civil Affairs Detachment Commander; Reconnaissance Company Commander; Division Operations Officer; Commanding Officer, 4th Reconnaissance Battalion, Iraq; Operations Officer, U.S. Central Command; Deputy Chief (Middle East), Joint Chiefs of Staff; Director, Afghan Forces, 2d Marine Expeditionary Brigade, Afghanistan; Commanding Officer, 25th Marine Regiment, Africa; Member, Amphibious Capabilities Working Group & Ellis Group; Assistant Division Commander, 2d Marine Division; Deputy Commanding General (Mobilization), II Marine Expeditionary Force; and Director, Ministry of Interior Advisory Group, Afghanistan. Major General Whitman currently serves as the Director, Marine and Family Division, Manpower and Reserve Affairs.

As a civilian, he has served as CEO, CFO, and Board Member of multiple corporations, two traded on the New York Stock Exchange and listed in Fortune 500. He was named Best CEO and Best CFO in his Industry by Institutional Investor Magazine. He has served on the boards of the Federation of American Hospitals, Lovett School, Marine Corps University, and Toys for Tots Foundation; on the Founders Group of the National Museum of the Marine Corps; and on the Secretary of Defense Reserve Forces Policy Board.

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STATEMENT OF

REAR ADMIRAL ANN M. BURKHARDT, U. S. NAVY

DIRECTOR, 21ST CENTURY SAILOR OFFICE

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

HOUSE ARMED SERVICES COMMITTEE

ON

MILITARY SUICIDE PREVENTION PROGRAMS

OCTOBER 8, 2015

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
HOUSE ARMED SERVICES
COMMITTEE

Chairman Heck, Ranking Member Davis, and distinguished members of the Committee, thank you for holding this important hearing and for affording me the opportunity to offer an update on Navy's Suicide Prevention and Resilience Programs.

The loss of a single shipmate to suicide is a tragedy that affects many; it takes away a life, shatters a family, and hurts unit cohesion and morale. We work closely with the Office of the Secretary of Defense and the other Services in a collaborative effort to implement highly-effective suicide prevention programs. We remain resolute in our efforts as we focus on the risk factors that contribute to suicide-related behaviors and suicides, and how we can enable commanders to foster environments conducive to physical and psychological health. It starts with commitment toward creating a culture in which seeking help is not only viewed as a sign of strength, but which is an inherent way of life for every Sailor and Navy family member.

Sadly, in 2013, Navy experienced the loss of 46 shipmates through suicide. Although that represented a decrease of 20 from the previous year, in 2014 we saw an increase in our suicide total, with 68 deaths. We've suffered the loss of 44 shipmates thus far in 2015. Suicide is complex, and as such, it is difficult to draw conclusions from numbers alone. We continue data assessment and analysis in order to identify patterns to support and inform measures to detect suicide risk and intervention points, identify potential program gaps, and recommend improvements for Navy Suicide Prevention efforts. We continue to vigilantly monitor the health of the force and investigate every suicide and suicide attempt. The suicide prevention team examines each case for pertinent information that might inform our prevention program. Results of these reviews consistently reveal that:

- Demographic distribution of suicides largely mirrors overall Navy demographics.
- Suicides typically occur when Sailors are experiencing some combination of multiple recent stressors, including: intimate relationship problems, loss, recent career transitions, disciplinary/legal issues, work problems, sleep problems, and financial strain.

While stressors may contribute to suicide risk, resilience is strengthened through leadership, peer support, strong family bonds, support services, and a sense of purpose. Suicide prevention training requires both leader-focused and peer-driven action and responsibilities to promote resilience and overall well-being in Sailors.

In January 2013, the Vice Chief of Naval Operations established Task Force Resilient to explore factors that impact resilience. The resulting report recommended establishment of the 21st Century Sailor Office to focus on creating and maintaining more coordinated and streamlined efforts in resilience programs supporting Sailors and their families. Suicide prevention is among the programs in the 21st Century Sailor Office portfolio.

Suicide Prevention – Every Sailor, Every Day

Findings from case reviews support the continuation and expansion of Navy's "Every Sailor, Every Day" campaign. This campaign was launched in September 2014 to emphasize personal responsibility, peer-support and bystander intervention, through an array of evidence-based communication strategies. Messaging, products and resources are provided to enable tailored engagement for command-level implementation. The "Every Sailor, Every Day"

campaign is consistent with, and expands the aperture of, the previous "all hands, all the time" messaging, which engaged Sailors, family members, peers and leadership.

The Suicide Prevention Program provides comprehensive evidence-based support to the fleet through policy, training, strategic communications and analysis. Together, these efforts are designed to promote resilience by helping Sailors, commands, families and Navy civilians proactively identify and mitigate stress reactions before crises occur and to create a culture supportive of good psychological health.

The Navy Suicide Prevention Program strives to reduce the prevalence, and minimize the risk factors, of suicide by enabling Sailors—through knowledge, personal responsibility and resources—to thrive as members of a healthy, resilient and mission-ready force. It emphasizes the importance of leadership taking steps to establish a climate in which all feel comfortable using resources to stay fit and ready, while promoting the notion that seeking help is a sign of strength. Equally important are proactive engagement and bystander-intervention efforts by all members of the Navy community, which are essential to helping our people safely navigate stress and, ultimately, prevent suicide.

Navy adopted a comprehensive and tailored approach to building resilience, suicide prevention training, intervention, research, and analysis. This approach includes a solid foundation of unit-level suicide prevention coordinators, mental health providers, installation first-responders skilled in handling behavioral emergencies, and increased family awareness of suicide risk factors, warning signs, and support resources. Current efforts are focused on:

- Education and Awareness,
- Prevention and Intervention, and
- Sailor Care and Crisis Response.

Education and Awareness

Navy Suicide Prevention Program educational efforts are aimed at increasing knowledge and understanding of suicide risk and protective factors, and building skills that enable early intervention. Fleet engagements have proven effective in delivering the message to Navy leaders. Participating in Personal Readiness Summits, community-specific training, and other similar forums, focuses leaders' attention on suicide prevention and Total Sailor Fitness. During these forums, leaders are encouraged to exercise heightened vigilance during periods of increased risk among Sailors, including times of transition, loss, and relationship problems. Active communication and engagement on multiple levels—command-to-family, leader-to-Sailor, and peer-to-peer—are heavily emphasized as means to connect the dots and facilitate early intervention. Trusting and meaningful connections are protective factors against suicide, providing opportunity for those most attuned to changes in a Sailor's behavior or circumstances to share their concerns, while serving as a constant reminder that we are not alone in navigating life's challenges.

In fiscal year 2015, fleet engagements included co-developing and co-facilitating a Professional Development Training Course (PDTC) for chaplains, enhancing their pastoral care skills in suicide prevention, intervention and postvention. Additionally, these three-day training events underscored the chaplains' invaluable role in advising command triads on command-

climate issues, such as negative perceptions and attitudes related to coming forward about psychological health concerns, and how to encourage help-seeking behavior at the deck plate-level. Chaplains are consistently promoted as a resource throughout Navy Suicide Prevention educational efforts, emphasizing their unique and unbreakable confidentiality. As such, PDTCs included training in the use of evidence-based prevention and intervention tools including the Columbia Suicide Severity Rating Scale and the Veterans' Affairs Safety Plan. PDTCs were conducted in 14 key concentration areas around the fleet to equip chaplains with the knowledge and resources necessary to assist Sailors and family members in crisis.

Suicide Prevention Coordinator (SPC) training is conducted via webinar and during Personal Readiness Summits. Over 800 additional SPCs were trained in 2014, and another 500 in 2015, enhancing local suicide prevention efforts at the deck plate by having a qualified program advocate at nearly every command.

Our Operational Stress Control (OSC) Program—a key component of proactive suicide prevention—promotes an understanding of stress, awareness of support resources, and provides practical stress navigation tools to help build resilience of Sailors, families, and commands. Engaged leadership reinforces the importance of mind and body fitness to support Navy's tenets of *Warfighting First, Operate Forward and Be Ready.* OSC training promotes leader-focused actions to assess individual and unit stress levels, and to provide leaders with tools to help Sailors better navigate operational and personal stress and build resilience. On January 1, 2014, Navy implemented policy that requires all deployable units to receive OSC training within six-months prior to deployment. This dialogue-driven training is delivered in-person by OSC Mobile Training Teams (MTTs). More than 55,000 Sailors have been trained in Navy OSC for Leaders (NAVOSC-Lead, E7 and above) and Deck-plate Leader OSC (DPL-OSC, E4-E6) to

date. Efforts are currently underway to tailor courses to leaders in specific communities, for example, within the reserve component or in the medical community.

Institutionalized across the fleet and embedded in various career milestone courses, over 26 advanced OSC modules are tailored to career milestones of the Sailor, and incorporate tangible skills to strengthen resilience and mitigate stress.

After a comprehensive review, Navy overhauled Suicide Prevention General Military Training, aligning it with National Strategy for Suicide Prevention training standards. This modernized, interactive training is conducted in small group settings to facilitate active dialogue, using realistic scenarios to build Sailors' skills in early recognition and intervention. Training released early this year has garnered positive initial feedback across the fleet.

Prevention and Intervention

Engaging with Sailors on a personal level is the foundation of effective prevention and intervention. To that end, last year we released guidance for commanders and health care professionals on reducing access to commonly-used, highly-lethal, methods of suicide, by encouraging voluntary storage of privately-owned firearms.

In 2014, we started assigning Deployed Resilience Counselors (DRCs) on every aircraft carrier and large deck amphibious assault ships. DRCs are credentialed, civilian clinical counselors. This initiative essentially extends the reach of the Navy's Fleet and Family Support Center programs to deployed units, providing short-term counseling and prevention education.

DRCs provide services to the crew while deployed and enable a warm hand-off to shore installation services upon return to homeport.

While leadership engagement is critical, we place significant emphasis on peer-to-peer interaction, especially in promoting behavioral change to, ultimately, prevent suicide. We have developed a strategic communications effort aimed at engaging Sailors and family members in the fight to break down barriers, reshaping the conversation about stress and suicide in the fleet, and promoting ongoing dialogue. Our efforts are audience-driven; focusing on proactive and positive messaging that resonates with Sailors and families. We communicate these messages through an array of products, using channels that Sailors and families embrace in their everyday lives, such as social media networks. Additionally, we release a monthly newsletter for Suicide Prevention Coordinators (SPCs) and key fleet personnel, providing fresh tips and best-practices to strengthen local programs, and key policy updates. We frequently add new resources to our catalog of educational products, such as fact sheets on best practices for discussing suicide in everyday conversation and/or media reporting. These products are available online, or may be ordered in-bulk, at no cost to commands.

Following the industry-recognized *NavyTHRIVE* campaign in 2013, providing Sailors and families with tools to "thrive, not just survive," Navy Suicide Prevention adopted and expanded the Bureau of Medicine and Surgery (BUMED) *Every Sailor, Every Day* concept into a Navy-wide communications campaign. This evidence-based campaign launched during Suicide Prevention Month, in September 2014, emphasizes personal responsibility, peer support and bystander intervention. Because Suicide Prevention Month is used to catalyze engagement and introduce sustainable efforts and messaging, *Every Sailor, Every Day* continues to serve as our core Suicide Prevention and Operational Stress Control communications campaign.

This year, Navy Suicide Prevention released a new video as part of the campaign illustrating practical applications of the *Every Sailor, Every Day* concept. The video is being shipped to every command in the Navy. This year, we used Navy Suicide Prevention Month to add a new dimension to the campaign by introducing the "1 Small ACT" message. This message encourages simple, yet meaningful, interactions between peers, leaders and family members, to promote cohesion, intervene, and save lives, based on the Ask Care Treat (ACT) model. The "1 Small ACT" message ties into broader collaborative communications efforts among the armed forces, Department of Defense Suicide Prevention Office (DSPO) and the Department of Veterans Affairs (VA) to promote their "Power of 1" concept. As part of the new message's launch and to reenergize engagement across the fleet, we developed printable signs that Sailors, and all members of the Navy community, can personalize with examples of a small act that can make a difference in the lives of others and ultimately prevent suicide.

In the past two years, our partnerships have helped expand the reach of our suicide prevention efforts to broader audiences. In 2013, we significantly increased collaboration with the Navy Chaplain Corps, helping to promote chaplain confidentiality through a variety of multimedia products. We continue to collaborate on key efforts, from training to strategic communications, to ensure Sailors and families are aware that chaplains are available to talk through life's challenges without fear of being judged or experiencing adverse career impacts.

Additionally, in 2014, Navy Suicide Prevention formed a partnership with Navy and Marine Corps Public Health Center's Health Promotion and Wellness Department, advancing our public health approach to suicide prevention. Since that time, we have collaborated on over a dozen communications products and produced two webinars for "high touch point" personnel,

to educate them on current evidence-based tools and resources. We have also partnered with the award-winning *Real Warriors Campaign*, heralded by service members and families for its authenticity as a trusted resource for navigating psychological health and stress-related challenges. *Real Warriors Campaign* has helped publicize our efforts and extend reach beyond the Navy to the entire Department of Defense community, most recently promoting the "1 Small ACT" Photo Gallery and accepting submissions through their popular mobile application.

Leveraging resources at the Bureau of Medicine and Surgery, and the Office of the Chief of Navy Reserve, targeted messaging and products for the reserve component were developed to specifically address the challenges associated with our citizen-Sailors. Through the Navy Reserve Psychological Health Outreach Program (PHOP), teams of licensed mental health professionals visit reserve units on a periodic basis. During these visits, PHOPs conduct psychological health screening, Operational Stress Control training and suicide prevention briefs. PHOP teams are also available via a 24/7 information line by which unit leaders, Sailors and their families can access resources for employment, finances, psychological health, family support and child care. This program continues to facilitate successful reintegration of countless citizen-warriors mobilized in support of National Defense requirements.

Sailor Care and Crisis Response

While most Navy suicide prevention activities focus on resilience-building and early intervention, we must also be prepared to intervene at any stage of a crisis. It is not enough to know what to do. We must also know how to do it. Every Navy command is required to maintain a crisis response plan to ensure individuals understand how to quickly and effectively

get help to someone in distress, and ensure the safety of someone at acute risk, until he or she can receive professional care.

Navy's Medical Home Port Program is a team-based model focused on optimizing the relationship between patients, providers and the broader healthcare team. Mental health providers are embedded within Medical Home Ports to facilitate regular assessment and early mental health intervention. This model enables Sailors to be treated in settings in which they feel most comfortable and reduces the stigma associated with the care they receive. Additionally, improving early detection and intervention in the primary care setting reduces the demand for time-intensive intervention in mental health specialty clinics.

When a suicide occurs, timely and compassionate resources and assistance are the first steps to mitigating the effects on those impacted by the tragedy. The Navy Gold Star program, established in October 2014, provides long term support for surviving family members of Sailors who die on active duty, including combat fatalities, accidental death, and suicides. Navy Gold Star coordinators connect survivors to support groups and grief and bereavement counselors, provide benefits milestone management, request copies of documents, and offer information and referral services. Navy continues to maintain a strong partnership with the Tragedy Assistance Program for Survivors (TAPS), which offers unique support services directly to Navy families during the long grief and recovery process following a suicide. Additionally, Navy Special Psychiatric Rapid Intervention Teams (SPRINT) are on call 24 hours-a-day, seven days-a-week, for circumstances requiring a higher level of support, and local chaplains and Fleet and Family Support Centers regularly provide command consultation, assistance in arranging memorial and funeral services, and grief counseling.

Investigations into completed Navy suicides indicate that when contemplating suicide a Sailor may come in contact with key personnel, such as legal professionals, first responders, and chaplains, who have the opportunity to intervene. We implemented targeted training to ensure these individuals are prepared to identify risk factors and respond appropriately. Specialized training for officers of the Judge Advocate General Corps (JAGC) and agents of the Naval Criminal Investigative Service (NCIS) has proven critical in recognizing and intervening when suicide ideations are made. We are creating new training products specifically for installation emergency first responders, such as Emergency Medical Services (EMS), dispatchers, and security personnel, which cover safety, de-escalation, and response coordination, for behavioral health emergencies and suicide risk situations.

Conclusion

We ask an incredible amount of our Sailors and their families. In return, we are inherently responsible for providing them with the level of support and care commensurate with their personal sacrifices. On behalf of all the men and women of the United States Navy and their families, thank you for your commitment to this critical issue and for your continued support of our Sailors and their families.

Rear Admiral Ann M. Burkhardt
Director, 21st Century Sailor Office (N17)

Rear Admiral Ann Burkhardt holds a Bachelor of Science in Mathematics from Jacksonville University, Jacksonville, Florida; a Master of Science in Administration from Central Michigan University and is certified as a senior professional in Human Resources. She completed the Naval War College Fleet Seminar Program (JPME 1), the Joint and Combined Warfighting School (JPME II) and is designated as a joint qualified officer.

As a Navy Human Resources officer her assignments have been in the areas of training and education, personnel management and manpower. Burkhardt began her career as an instructor teaching math, reactor principles and physics, later becoming a master training specialist at Naval Nuclear Power School, Orlando, Florida.

Her next assignments were as division officer, Naval Computer and Telecommunications Station Jacksonville, Florida; officer-in-charge, Naval Telecommunications Center Mayport, Florida; administrative officer, Naval Station Mayport, Florida; Navy Personnel Command, Officer Post-Board Matters (PERS-833), Enlisted Personnel Progression (PERS-81) and deputy for Career Progression (PERS-8B), Millington, Tennessee; executive officer, Training Support Center, Great Lakes, Illinois; commanding officer, Enlisted Personnel/Chief, Joint Assignments & Personnel Reliability Program, J1, United States Strategic Command Offutt Air Force Base, Nebraska; chief of staff and vice commandant, Defense Equal Opportunity Management Institute, Patrick Air Force Base, Florida; commanding officer, Naval Education and Training Professional Development and Technology Center, Pensacola, Florida; and head, Office of Diversity, Inclusion and Women's Policy (OPNAV N134), Arlington, Virginia. Burkhardt most recently served as CNO Fellow on the Chief of Naval Operations Strategic Studies Group (SSG 34) at the Naval War College, Newport, Rhode Island.

Burkhardt assumed the duties of Director, 21st Century Sailor Office August 21, 2015.

Burkhardt's decorations include the Defense Superior Service Medal, Legion of Merit (two awards), Defense Meritorious Service Medal, Meritorious Service Medal (two awards), Navy and Marine Corps Commendation Medal (five awards), and the Navy and Marine Corps Achievement Medal.

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

OCTOBER 8, 2015

RESPONSE TO QUESTION SUBMITTED BY MR. MacARTHUR

Dr. FRANKLIN. Prior to our implementation of the current rate methodology in March of 2014, we used a method that was based on duty status. The previous method did not distinguish the Active Component from the Reserve Component, represented the number of Reserve and National Guard Service members in the force at 11% of the Active Duty population, and combined fiscal and calendar year data. The current methodology provides leadership with a clearer distinction between Active and Reserve Components, and we are able to determine that the Reserve Component appears to be tracking at a higher rate than the Active Component.

We have applied the current rate calculation methodology to our data going back 11 years (2003–2013) for the Active Component, and 4 years (2010–2013) for the Reserve Component. Once we applied the new method to the past years for the Active Component, we did learn that the new Active Component rates followed yearly trends similar to the previous methodology which was based on duty status. We do not have the data needed to calculate the rate retroactively prior to 2010 for the Reserve Component.

Applying the new method and examining the Active Component data from the Armed Forces Medical Examiner (2003–2013), the suicide rate increased from 2003 (10.8 per 100,000) until it peaked in 2012 (22.7 per 100,000). In 2013, the Active Component suicide rate declined to 18.7 per 100,000. We have not yet published a 2014 rate.

Applying the new rate calculation method and examining the data from the Reserve Component, there was an initial decrease from 23.5 per 100,000 in 2010 to 21.8 per 100,000 in 2011. Since 2011, the rate steadily increased to 26.4 per 100,000 in 2013. In the current methodology, Reserve Component rate includes members of the National Guard and Reserve regardless of their duty status. [See page 17.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

OCTOBER 8, 2015

QUESTIONS SUBMITTED BY MR. JONES

Mr. JONES. What is the Department of Defense and the services doing to determine what information sharing would be most helpful to help prevent suicides?

Dr. FRANKLIN. The Department of Defense has two governance structures to guide suicide prevention efforts and share best practices. The first is the Suicide Prevention Risk and Reduction Committee (SPARRC) which meets on a quarterly basis. The SPARRC serves as a collaborative forum of subject matter experts to facilitate the flow of information between the Defense Suicide Prevention Office (DPSO), Military Departments, and other stakeholders for the exchange of best practices and lessons learned. It also advises the Director, DSPO on suicide prevention issues; identifies policy and program changes required to improve suicide-related programs; submits recommendations to the Director, DSPO for approval; and facilitates and implements action items approved by the Suicide Prevention General Officer Steering Committee (SPGOSC). The SPARRC also facilitates collaboration between federal organizations such as the Department of Veterans Affairs, Department of Health and Human Services, including the Substance Abuse and Mental Health Administration, Centers for Disease Control and Prevention, and National Institute of Mental Health.

The second governance is the SPGOSC which serves as an advisory body to the Under Secretary of Defense for Personnel and Readiness (USD(P&R)). The SPGOSC facilitates the review, assessment, integration, standardization, implementation, and resourcing of suicide prevention policies and programs. It also addresses present, emerging, and future suicide prevention needs, and evidence-based practices for military and civilian personnel that have DOD-wide applicability and provide recommendations to the USD(P&R) via the DSPO.

DSPO most recently attended last month's Air Force summit on suicide prevention to share evidence-based best practices to help inform the Air Force's suicide prevention, intervention and postvention efforts. The Army, Navy, and Marine Corps also had representatives at the Summit to share best practices. It is through on-going engagement with the Services and other stakeholders that we will continue to share best practices to guide the Department's suicide prevention efforts.

Mr. JONES. As I understand it, military members and veterans all access the same call center when they call in to a DOD/VA suicide prevention hotline. The person providing the immediate counseling must have as much information as possible to help prevent a suicide and get the military member or veteran the help they need. All information is vital to include medications, number of deployments, martial status, children, etc, anything that will help the counselor connect with the caller. Is this type of information readily available to the counselor and if not why not?

Dr. FRANKLIN. Veterans/Military Crisis Line (VCL/MCL) staff has read-only access to callers' relevant information that aids in thorough suicide assessment and dispatch of emergency services, if needed. Staff can view the Department of Veterans Affairs (VA) medical records for registered Veterans and Guard or Reserve members; staff use Joint Legacy Viewer (JLV) to view the Department of Defense's medical records for Active Duty Service members and Guard or Reserve members who are not registered with VA. Except in an emergency for which VCL/MCL staff must dispatch emergency response, staff ask for a caller's permission to access medical record information, and will respect the caller's request for privacy and not access records if denied permission. There are no other limitations on information VCL/MCL staff can legally ask callers. Information that is particularly relevant to the VCL/MCL mission and routinely reviewed via access of records during calls includes:

- Past suicide attempts, recent assessments of suicidality and safety plan for suicide prevention
- Past and current lists of medications and the conditions for which they were prescribed
- Branch of service, dates of service, and combat status
- Demographic information including address, age, social security number, and race

- The Social Security Number (SSN) is a primary field used to search within both VA medical records and Joint Legacy Viewer (JLV) in order to identify the correct patient record. Both systems can be searched using only the last 4 of the SSN and, if multiple results are returned, the name or other demographic information can be used to confirm the correct record is viewed

- Next of kin information
- Recent medical or mental health care and upcoming appointments

Mr. JONES. What is the Department of Defense and the services doing to determine what information sharing would be most helpful to help prevent suicides?

General MCCONVILLE. Suicide prevention efforts between the Military Services are now more integrated compared to recent years as a result of the collaborative approach under the Defense Suicide Prevention Office (DSPO). The DSPO established the Suicide Prevention Risk Reduction Council (SPARRC) for the purpose of collaboration, communication, and documentation of suicide prevention best practices across the Department. The DSPO General Officer Steering Committee was also established with participation across the Department to provide oversight and guidance for governance and execution of the Defense Strategy for Suicide Prevention.

To further our collaboration and information sharing efforts across the four Services, the Army established a Service Suicide Prevention Program Manager (SPPM). SPPM conducts a monthly teleconference to review ways to bolster our holistic prevention efforts across multiple prevention portfolios. We frequently review and share policy guidance, data sharing, tools, and training curriculum, and have worked closely on intervening techniques with the Navy and Resilience Training with the Air Force. From the Medical perspective, the Army Director of Psychological Health conducts a weekly meeting with participation across all Services to discuss potential Office of the Secretary of Defense, Mental Health policy changes.

Mr. JONES. As I understand it, military members and veterans all access the same call center when they call in to a DOD/VA suicide prevention hotline. The person providing the immediate counseling must have as much information as possible to help prevent a suicide and get the military member or veteran the help they need. All information is vital to include medications, number of deployments, martial status, children, etc, anything that will help the counselor connect with the caller. Is this type of information readily available to the counselor and if not why not?

General MCCONVILLE. Yes, the Veterans/Military Crisis Line (VCL/MCL) staffs have access to each caller's relevant information to aid in thorough suicide assessment and dispatch of emergency services, if needed. Data sources available include the Department of Veterans Affairs (VA) medical records for registered Veterans and use Joint Legacy Viewer (JLV) to view the Department of Defense's medical records for Active Duty Service Members. Except in an emergency, for which VCL/MCL staff must dispatch emergency response, staff must ask for each caller's permission to access medical record information, and must respect callers request for privacy and not access records if denied permission. Typical access of records during calls includes: Past suicide attempts, recent assessments of suicidality and safety plan for suicide prevention, Past and current lists of medications and the conditions for which they were prescribed, Branch of service, dates of service, and combat status, Demographic information including address, age, social security number, and race, Next of kin information, and Recent medical or mental health care and upcoming appointments.

Mr. JONES. What is the Department of Defense and the services doing to determine what information sharing would be most helpful to help prevent suicides?

General EDIGER. Suicide prevention efforts within the Services have become increasingly integrated and standardized in recent years under the guidance and support of the Defense Suicide Prevention Office (DSPO). The DOD Suicide Event Report (DODSER) tool is the standard mechanism for the Services to report suicides and suicide attempts of Service members. The DODSER contains approximately 150 data fields that can be further analyzed at the Service and DSPO levels. Service Suicide Prevention Program Managers hold a monthly teleconference to coordinate their efforts and share information. Also, the Quarterly Suicide Prevention and Risk Reduction Council meetings provide opportunities for the Services to meet together with DSPO and a quarterly Tri-Service Suicide Prevention General Officer Steering Committee ensures senior leader engagement and interservice coordination. In September 2015, AF Suicide Prevention Summit brought the military Services and DSPO together to participate in forging recommendations to enhance suicide prevention efforts in the AF. Attendees included a wide cross-section of AF leaders and key stakeholders and brought them together with esteemed experts from agencies such as National Institute of Mental Health and Centers for Disease Control and Prevention, as well as academia. This positive shift in terms of the climate of col-

laboration has promoted alignment between the U.S. national strategy for Suicide Prevention, the DOD strategy and the individual Service strategies. The current status of information sharing represents a significant improvement in recent years and further integration and standardization of data collection, reporting and analysis are progressing consistently. From the clinical; while military healthcare providers have limitations in what they can share based on regulations such as HIPAA, they are required to inform commanders if there is a concern of harm to self or others, potential harm to the mission or duty impairment. Commanders and supervisors are encouraged to share information if they are concerned about a member. Medical information is shared and available in real time to all medical personnel across the military services through the AHLTA system, which is also available in the deployed setting and linked with VA data systems to facilitate Service member transitions. The AF has initiated systematic multidisciplinary reviews of suicides, while DSPO is working on developing an analytic framework for reviewing suicides to further capitalize on the opportunity to capture and share such information across Services and DOD. This data will be a critical next step in advancing our understanding of suicides in the military and informing our next wave of prevention and intervention efforts.

Mr. JONES. As I understand it, military members and veterans all access the same call center when they call in to a DOD/VA suicide prevention hotline. The person providing the immediate counseling must have as much information as possible to help prevent a suicide and get the military member or veteran the help they need. All information is vital to include medications, number of deployments, martial status, children, etc, anything that will help the counselor connect with the caller. Is this type of information readily available to the counselor and if not why not?

General EDIGER. Hotlines such as the DOD/VA Crisis Line follow a crisis response model that minimizes stigma and promotes autonomy for the user providing 24/7 access and allowing them to share only the information they are comfortable with. Callers may opt to use the service in lieu of traditional counseling or medical care and having control over disclosure of their medical and personal information may be crucial to allowing them to establish rapport. Crisis line counselors have access to the CAPRI system which contains medical information for those enrolled in the VA system, but must obtain the caller's consent and personal information before accessing the system. DOD/VA Crisis Line counselor can connect the member to counseling or medical care through a local crisis coordinator in their geographic region. These local coordinators can refer to military, VA or civilian resources for support, information or counseling and can alert command or civilian authorities for an emergency response if warranted. Each of the military services has medical liaisons to the Crisis Line to ensure seamless support and a rapid exchange of information to facilitate appropriate medical or mental health care referrals. By occupying a unique niche outside of established medical and mental health services the Crisis Line provides an additional option for veterans and Service members in distress.

Mr. JONES. What is the Department of Defense and the services doing to determine what information sharing would be most helpful to help prevent suicides?

General WHITMAN. The Marine Corps continues to address information sharing as a key element of preventing suicide, including what information is most helpful. We currently have several ongoing initiatives highlighting the importance of the availability of information. For example, we participate in quarterly Suicide Prevention and Risk Reduction and General Officer Steering Committee meetings in collaboration with the Department of Defense Suicide Prevention Office (DSPO) and sister services in an effort to determine best practices to prevent suicide. The Marine Corps recently completed an initiative to improve Commanders access to health information by training Commanders and behavioral health providers on confidentiality rules and effective coordination of care.

Mr. JONES. As I understand it, military members and veterans all access the same call center when they call in to a DOD/VA suicide prevention hotline. The person providing the immediate counseling must have as much information as possible to help prevent a suicide and get the military member or veteran the help they need. All information is vital to include medications, number of deployments, martial status, children, etc, anything that will help the counselor connect with the caller. Is this type of information readily available to the counselor and if not why not?

General WHITMAN. For specific information on the DOD/VA suicide prevention hotline, we defer to DSPO and VA. In general terms, when a call center responder speaks with a service member or veteran in crisis, s/he gathers information directly from the caller to appropriately respond to the crisis. This may include the caller's geographic location, service status, suicide-related intent, environmental safety, access to lethal means, and any active medical emergencies impacting the crisis. If the service member or veteran has contacted the call center previously, that information

is also available. Ultimately, a call center responder's ability to connect with a service member or veteran calling in crisis is fostered more by appropriate training and the ability to quickly build rapport.

Mr. JONES. What is the Department of Defense and the services doing to determine what information sharing would be most helpful to help prevent suicides?

Admiral BURKHARDT. Navy meets regularly with the other Services, in multiple venues that occur at various levels, from action officer to flag officer, to collaboratively identify and share best practices for suicide prevention across the Department of Defense (DOD). Additionally, the Armed Services collaborate with the Defense Suicide Prevention Office (DSPO), which collects evidenced-based best practices from the Services and civilian entities, and disseminates them throughout DOD.

Mr. JONES. As I understand it, military members and veterans all access the same call center when they call in to a DOD/VA suicide prevention hotline. The person providing the immediate counseling must have as much information as possible to help prevent a suicide and get the military member or veteran the help they need. All information is vital to include medications, number of deployments, martial status, children, etc, anything that will help the counselor connect with the caller. Is this type of information readily available to the counselor and if not why not?

Admiral BURKHARDT. The suicide prevention hotline is a Department of Veterans Affairs initiative in collaboration with the National Suicide Prevention Lifeline. The hotline operates 24 hours a day, seven days a week, and is staffed by trained mental health professionals prepared to deal with immediate crisis. As with all mental health professionals, VA hotline mental health professionals must rely on information provided by the person seeking their services. Callers must have the option of remaining anonymous, if they so choose, or they can disclose their identities to allow the staff to access VA medical records real-time during the call.

QUESTIONS SUBMITTED BY MS. TSONGAS

Ms. TSONGAS. What actions has DOD leadership taken to respond to the Inspection General on the observations and recommendations from the November 14, 2014, DOD Suicide Prevention Assessment? When do you expect DOD will have a response to all the findings and recommendations?

Dr. FRANKLIN. The Department agreed to implement the recommendations and is working to modify policy for the Department of Defense Suicide Event Report submission process. The Under Secretary of Defense for Personnel and Readiness published a memorandum to the DOD components which provided interim guidance in support of the recommendations contained in the report. At this time, many of the recommendations from the DOD Suicide Prevention Assessment have been addressed.

In addition, the Defense Suicide Prevention Office is working diligently with the Services to incorporate the recommendations into an upcoming Department of Defense Instruction (DODI), which is currently in development. We estimate completion of this DODI in 2016.

Ms. TSONGAS. What steps has leadership taken to allow medical record sharing with the VA's Military Crisis Line and service member's health records? Especially since the IG identified a substantial and specific danger to public health and safety with regards to the DOD appropriately transmitting relevant service records to the VA.

Dr. FRANKLIN. This recommendation is complete. The Veterans Crisis Line/Military Crisis Line staff received access to the Joint Legacy Viewer on July 31, 2015, to access Department of Defense medical records, and this capability has resulted in more timely access to crisis intervention services.

Ms. TSONGAS. Where is the DOD with the milestones they established with regards to the recommendations from the (DODIG–2015–016) report? Was DOD able to meet any of their established milestones? If milestones were missed has OSD established new milestones?

Dr. FRANKLIN. The Department has achieved a number of milestones with regard to the observations and recommendations from the DODIG–2015–016 report.

Refinement to the under/technical assistance has been completed, after a complete help text overhaul of the DODSER survey deployed in 2015.

After action reviews are an ongoing process that began in 2015 with the task of engaging in weekly After Action Reviews with actual DODSER users. The findings of these reviews have been presented quarterly to the Defense Suicide Prevention Office and the Service Suicide Prevention Program Managers.

Quality Assurance reviews are an ongoing process involving monthly data quality reviews of submitted DODSERs where "missing" or "unknown" responses are selected. Frequently occurring errors or missed data will be discussed with the Services' DODSER Program Managers so that findings from the Quality Assurance Review can be incorporated into feedback and guidance to their DODSER form completers. Items that are commonly "unknown" will be compared against the feedback from the After Action Reviews in Recommendation 3.c. to identify questions that are likely to cause confusion or that are difficult to answer.

The DODSER has been modified and the software development aspect of these recommendations has been completed and is currently being reviewed by an internal quality assurance team for overall compatibility with the system. This review will be completed in November 2015, at which point the software changes will be ready for deployment. We anticipate deploying these changes alongside the other Annual Changes on January 1, 2016, in compliance with the IG deadline.

With regards to trend data, official action related to this is pending the development of policy, per the IG recommendations, because of Protected Health Information/Personally Identifiable Information privacy concerns regarding the provision of raw, identified DODSER data to Installation Commanders. However, the DODSER software and web-interface already contain an automated reporting tool through which users can specify variables of interest and create a customized, de-identified data report containing counts and percentages. Additionally, if installations need identified data, there are processes that exist within the Defense Health Agency system to get approvals for sharing identified data.

Ms. TSONGAS. The November 14, 2014, DOD IG report identified shortcomings in the DOD Suicide Event Report (DODSER). How do the DOD, DSPO, and all services plan to fix these problems before implementation of a new policy that includes the Guard and Reserves?

Dr. FRANKLIN. The Department has made significant progress on efforts to address shortcomings identified in the November 2014 DOD IG Report, to be completed by the IG deadline of January 1, 2016.

The DODSER has been modified to allow for "No Known History of XXX" responses and to require an explanation for "don't know/data unavailable." The software development aspect of these recommendations has been completed and is being reviewed by a quality assurance team for overall Information Technology compatibility with the system. This change will be deployed alongside the other, Service Requested, Annual Changes set for January 1, 2016.

The refinement of the user/technical assistance has been completed. The completely revised help text was deployed on January 1, 2015, and has been available to users since that date.

The Department is conducting ongoing, weekly after action reviews with DODSER users as well as monthly Data Quality Reviews on 10% of a given month's submitted reports. Frequently occurring errors or missed data are discussed with the Services' DODSER Program Managers so that findings from the Quality Assurance Review can be incorporated into feedback and guidance to their DODSER form completers. Items that are commonly "unknown" will be compared against the feedback from the After Action Reviews in Recommendation 3.c. to identify questions that are likely to cause confusion or that are difficult to answer.

Official action related to software updates to allow unit and installation trend reports is pending the development of policy because of Protected Health Information/Personally Identifiable Information privacy concerns regarding the provision of raw, identified DODSER data to Installation Commanders. However, the DODSER software and web-interface already contain an automated reporting tool through which users can specify variables of interest and create a customized, de-identified report containing counts and percentages. Additionally, if installations need identified data, there are processes that exist within the Defense Health Agency system to get approvals for sharing identified data.

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