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Before the

Subcommittee on Personnel

COMMITTEE ON
ARMED SERVICES

UNITED STATES SENATE

HEARING TO RECEIVE TESTIMONY ABOUT
SERVICEMEMBER, FAMILY, AND VETERAN SUICIDES AND
PREVENTION STRATEGIES.

Wednesday, December 4, 2019

Washington, D.C.

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U.S. Senate
Subcommittee on Personnel
Committee on Armed Services
Washington, D.C.

The subcommittee met, pursuant to notice, at 3:19 p.m. in Room SR-222, Russell Senate Office Building, Hon. Thom Tillis, chairman of the subcommittee, presiding.

Committee Members Present: Senators Tillis [presiding], McSally, Scott, and Gillibrand.

Other Senators Present: Senator Sullivan.

OPENING STATEMENT OF HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator Tillis: The hearing will come to order.

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

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

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

Our topic today is a heavy one, one that is difficult

to discuss, but we must address it to ensure the readiness and the well-being of our troops, their families, and veterans. Suicide is a homefront threat to servicemembers and veterans. Tragically, rates of suicide for Active Duty servicemembers and veteran populations have increased in the latest reports, particularly affecting young men under 30, who make up nearly half the military. Veteran suicide is a national epidemic. As a member of the Veterans Affairs Committee, working to reduce the number of veterans who die by suicide is one of my top priorities.

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

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

While suicide represents a growing public health challenge in the civilian world, the unique composition and mission of our military makes this challenge one of particular importance that we must address. Ensuring

adequate care and support for servicemembers, families, and veterans facing stressors of deployments, transitions, financial difficulties, and access to healthcare, it must be a top priority.

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

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

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

STATEMENT OF HON. KIRSTEN E. GILLIBRAND, U.S. SENATOR FROM NEW YORK

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

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

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

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

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

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

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

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

necessary to accomplish the mission, so that they can develop more appropriate strategies for today's military.

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

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

Of course, DOD must have policies to keep their servicemembers and colleagues safe, but their standards for reporting mental health challenges are vague and go much further than the standards for civilian mental health

professionals or even military chaplains. This policy is more likely to force servicemembers to suffer in silence, and does nothing to help commanders maintain good order and discipline. I urge the Department of Defense to review the reporting rules for mental health professionals to ensure that they are allowing for maximum confidentiality for our servicemembers while also protecting them from those around them. If we can eliminate the barriers that stand between our servicemembers and access to mental health care, I believe we can begin to make progress towards addressing our suicide rate.

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

Senator Tillis: Thank you, Senator Gillibrand.

We'll just start from left to right.

Dr. Orvis.

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

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

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

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

Because data informs our ability to take meaningful steps and fulfill our commitment to transparency, the Department has expanded our reporting on suicide-related data. This past September, we published our first Annual

Suicide Report, or ASR, to supplement our longstanding DOD Suicide Event Report. In brief, the calendar year 2018 suicide rates are consistent with the prior 2 years across all components. When compared to the past 5 years, the rates have been steady for the Reserve and the National Guard; however, we've seen a statistically significant increase for the Active component. While hardly acceptable, military suicide rates are comparable to the U.S. population rates after accounting for age and sex differences, with the exception of the National Guard. We continue to observe heightened risk for our youngest servicemembers and our National Guard members.

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

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

Guided by the Defense Strategy for Suicide Prevention, the DOD has many ongoing and future efforts underway. These efforts support seven evidence-informed strategies, which include identifying and supporting people at risk, strengthening access and delivery of suicide care, teaching coping and problem-solving skills, creating protective environments, strengthening economic supports, and lessening harms and preventing future risk.

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

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

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

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

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

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

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

[The prepared statement of Dr. Orvis follows:]

Senator Tillis: Captain Colston.

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

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

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

Our military suicide rate was once low. When I was a resident at Walter Reid in 2001, our Active Duty suicide rate was half the rate of a similar population. But, like the rest of America, DOD has seen suicides increase. Even as we created a centralized suicide prevention infrastructure and enlarged community care, our Active Duty suicide rate now approaches 25 per 100,000. The National Guard rate is yet higher.

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

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

regard to suicide outcomes.

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

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

We need to continue work on precipitants of suicidal

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

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

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

Thank you. I look forward to answering your questions.

[The prepared statement of Dr. Colston follows:]

Senator Tillis: Thank you.

Dr. Miller.

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

Dr. Miller: Good afternoon, Chairman Tillis, Ranking Member Gillibrand.

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

Senator Tillis: Without objection.

[The information referred to follows:]

[SUBCOMMITTEE INSERT]

Dr. Miller: I appreciate the opportunity you have both created --

[Audio malfunction.]

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

Within my position, I'm often asked "Why?" in the context of suicide. I've this question myself for several years after losing my friend and my colleague, a Marine Cobra driver, to suicide during OEF/OIF. In my quest to learn what I may have done wrong or what I may have missed with John, it's become clear to me that suicide is a complex issue, with no single cause. Beyond, it's a national issue that affects people from all walks of life, not just veterans and servicemembers. Suicide is often the result of a complicated combination of risk and protective factors at the personal, communal, and societal levels. Thus, I have wholeheartedly signed on to fully commit heart and mind to the secretaries, to the executive in charge, and to the VA's top clinical priority: suicide prevention.

In response and in daily action, the VA is implementing a comprehensive public health approach to reach all veterans, including those who do not receive VHA health services. In this context, we look to the 2019 National

Veteran Suicide Annual Report to inform our current situational awareness.

One of the key ways in which this year's report is different from those in prior year is that it places veteran suicide in the broader context of suicide deaths in America. From the report, we know that the suicide rate is alarmingly rising in and across our Nation. The average number of adult suicides per day rose from 86 in 2005 to 124 in 2017. These numbers included 15.9 veteran suicides per day in 2005 and 16.8 per day in 2017. We know that suicide is one of the leading causes of death in the United States. As the father of four young daughters, the fact that suicide has become the second leading cause of death within their current age demographic is difficult for me to even comprehend.

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

veterans are at higher risk for suicide than their nonveteran peers, there was not an increase in suicide among female veterans with recent VHA care, compared to the rising rate of suicide in female veterans not recently using VHA services.

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

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

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

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

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

[The prepared statement of Dr. Miller follows:]

Senator Tillis: Thank you.

Dr. McKeon.

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

Dr. McKeon: Chairman Tillis, Ranking Member Gillibrand, members of the committee, thank you for inviting SAMHSA to participate in this important hearing on suicide prevention.

An American dies by suicide every 11 minutes. Suicide is the tenth leading cause of death in the United States and the second leading cause of death between ages 10 and 34. We've lost over 47,000 Americans to suicide in 2017, almost the same number we lost to opioid overdoses. For each of these tragic deaths, there are grief-stricken families and friends, impacted workplaces and schools, and a diminishment of our communities. The National Survey on Drug Use and Health has also shown that approximately 1.4 million American adults reported attempting suicide each year, and over 10 million adults report seriously considering suicide.

Our concern is intensified by the CDC's report that suicide has been increasing in 49 of the 50 States, with 25 of the States experiencing increases of more than 30 percent. These increases have been taking place among both men and women and across the life span. While Federal efforts to prevent suicide have been steadily increasing

over time, thus far they have been insufficient to halt this tragic rise. We know that our efforts must engage multiple sectors, including healthcare, schools, workplaces, faith communities, and many others.

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

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

SAMHSA also provides grants to support the Zero Suicide Initiative. Zero Suicide is a package of interventions that uses the most recent evidence-based science on screening, risk assessment, collaborative safety planning, care protocols, treatments, and care transitions. It's inspired by the success of the Henry Ford Health Care System and reducing suicide by more than 60 percent. Centerstone, in

Tennessee, has shown similar results. The State of Missouri achieved a 32-percent decrease in suicide deaths among clients served in community behavioral health centers.

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

NIMH's ED-SAFE study demonstrated that rapid telephonic followup after emergency department discharge reduced the number of suicide attempts. Similarly, the VA's SAFE VET study showed that a combination of collaborative safety planning in the emergency department and rapid telephonic followup reduced suicide attempts and increased linkage to VA care.

The ED-SAFE study showed that universal screening for suicide risk in emergency rooms led to a doubling of the identification of people experiencing suicidal thoughts. And those that were identified were at equivalent risk to those being seen in the emergency room because of known suicide risk.

The SAMHSA Suicide Prevention Program that touches the greatest number of people is the National Suicide Prevention Lifeline, a network of over 165 crisis centers across the

country that answers calls to the 800-273-TALK number through which the Veterans Crisis Line and the Military Crisis Line can be accessed by pressing "1." Last year, more than 2.2 million calls were answered. Evaluation studies have shown that callers to the Lifeline experience decreased suicidal thoughts and hopelessness by the end of the call. SAMHSA, the VA, and the FCC have worked together to implement the National Suicide Hotline Improvement Act, and the FCC has recommended that the number 988 be assigned as a new National Suicide Prevention Hotline number.

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

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

SAMHSA and the entire Federal Government is engaged in an unprecedented number of suicide prevention activities, but we know we all need to do more if we are to halt the tragic rise in suicide. We need to implement a

comprehensive public health approach that incorporates everything we now know about preventing suicide. We must constantly be looking to improve our efforts and to learn from both our successes and our failures. We owe it to those who have served this Nation and to all the people we have lost to suicide, as well as to those who have loved them, to strive to improve until suicide among veterans, servicemembers, and among all Americans is dramatically reduced.

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

[The prepared statement of Dr. McKeon follows:]

Senator Tillis: Thank you.

Dr. Kessler.

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

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

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

Suicide is also fundamentally a mental health problem. The vast, vast majority of people who die by suicide, psychological autopsies show, had mental health problems. Most people with a mental health problem have an onset in childhood or adolescence. In the United States, the best estimates suggest that the median age of onset, so 50 percent of the people who will ever in their life have a mental disorder, it starts at the age of 13. And military is no exception. When we, in the Army STARRS study, which is a big prospective study that I'm involved in with the Uniformed Services University of the Health Sciences, assessed a representative sample of people in the Army. The vast majority of the people who had a mental health problem told us that it started when they were a kid, before they

came into the military. Now, those early problems are, typically, relatively mild, they're not the kind of thing that would get somebody excluded from being in the service. They're also not the kind of thing that people get treatment for. It's only a number of years later when the problem, gets more recurrent and persistent and severe, and the suicidality starts. That's when people get into treatment. And it's tougher to treat it at that point. If they were nipped in the bud, it would be a much easier thing to do.

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

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

It's important to realize that these early treatments

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

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

trial and error is the way these things go. And because people who are depressed are depressed, they give up early, they don't stick through the whole trial-and-error process. Very often, they quit, and often with tragic consequences.

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

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

It would also be great to figure out a principled way of evaluating, when we do those early interventions: How do you know which one works? So, we need a commitment to a

strong evaluation process, where you have a -- you decide whether it works or not. The people who develop it don't do the evaluations, some independent people do, so you kind of stick with the good things and cut your losses on the bad things.

We need to integrate the many systems that DOD has.

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

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

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

[The prepared statement of Dr. Kessler follows:]

Senator Tillis: Thank you all for your opening statements.

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

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

Senator Sullivan: Thank you --

Senator Tillis: -- we will move to Senator Gillibrand.

Senator Sullivan: -- Mr. Chairman. And I appreciate you and Senator Gillibrand holding this very important hearing.

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

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

But, why it is -- you know, there's all kinds of things

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

Senator Sullivan: Thank you.

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

Dr. Orvis: Thank you for the question.

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

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

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

In terms of specific lessons learned, some of the takeways that I saw is, first of all, some of our common challenges that we see as risk factors for suicide were present at that installation -- relationship issues, financial issues -- but there were unique factors that were

coupled with that for the Arctic conditions, the more isolated and remote areas, and understanding ways that the Army could implement specific policies and programs to get after some of those specific challenges, too, are underway.

Senator Sullivan: Thank you.

Captain Colston.

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

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

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

Another thing that -- you know, just culturally, that

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

Senator Sullivan: Thank you.

Thank you, Mr. Chairman.

Senator Tillis: Thank you, Senator Sullivan.

Senator Gillibrand.

Senator Gillibrand: Thank you, Mr. Chairman.

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

Brandon joined the Navy to become a SEAL, but a broken leg during the qualification course ended that dream. According to his family and other members of the unit, in

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

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

Dr. Kessler: Well, the mental state of hopelessness is, in fact, a mental state. And why it is that some people become hopeless in the face of adversity, and others not, is a tricky thing. Now, as an actuarial matter, stresses in people's lives, and stresses that seem to not just be

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

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

we've got to do.

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

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

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

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

folks --

Senator Gillibrand: Yeah.

Dr. Colston: -- who might have hard-charging young sergeants who are less socially astute.

Senator Gillibrand: Yeah.

Dr. Colston: So, those are important. Those are important things.

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

Senator Gillibrand: Could I --

Dr. Colston: Oh, go ahead, ma'am.

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

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

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

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

Senator Gillibrand: Thank you.

Senator Tillis: Senator McSally.

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

I served 26 years in uniform. This issue, as I think back, first touched me personally when a cadet in my squadron at the Air Force Academy took his own life. And

this is something, as we see the trends going on in our society, all of us know someone or love someone who has either been in mental health crisis and suicide risk or taken their own lives. And, as, you know, someone close to me said, after having gone through this, that, you know, suicide doesn't transfer the pain that you're feeling -- sorry -- it doesn't end the pain you're feeling, it just transfers it to those who survive, and the deep wounds for children and other loved ones when somebody feels like they have no other hope.

And 20 veterans every day are taking their own lives right now. Twenty. I just -- you know, they deploy, they survive combat, and come back, and come to this place where the enemy hasn't taken their lives, but they've taken their own lives. And so, this is so important that we take all the efforts that are happening, both across the Federal Government, throughout society, and, I think, at the State and local level, like, our best efforts to try and address this issue. But, our veterans come from society, and we're seeing the trends that are going up. Like, we are, you know, a part of what's going on in our society, as well. It's not all combat related. It's these other factors that are happening.

You know, there's a couple of examples in Arizona, which ASU has done a study. Veterans are two times more

likely, overall, to commit suicide than the regular population. And, for the female veterans, it's three times more likely in Arizona. These rates are just way too high, and they're unacceptable.

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

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

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

There's one example of a -- in rural Arizona, a disabled veteran called Be Connected, and the question was,

Can someone help come clean up after his pets? In reality, once a volunteer showed up, they realized the pet and caring for the pet was actually a barrier for him to get treatment for substance abuse, but he wanted to make sure he wasn't going to lose his dog. And so, they were able to meet him where he was and show that they had someone who's going to take care of his dog while he actually went in and got the treatment that he needed through a 28-day program. And so, this is a great example. I've got many more. I know I don't want to spend all the time of where, at the local level, with local volunteers, with Federal support, we really could be empowering local communities in order to be the neighbor, be the friend, remove those barriers, and get people the care they need.

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

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

Senator McSally: Yeah.

Dr. Miller: -- there. I was trying to count, when you were talking, how many times you said "local" and "Federal," and the importance of the relationship between them. And

that's what I think that we can work on together, is combining the power and the resources at the Federal level with the local level, realizing that, at the Federal level, in the VA, we can't do it on our own. There is local-specific data and resources that we can't cover, but they can be covered in other ways, and partnered with that which we can do, and do so well. That's where taking a look at suicide prevention, not just from a clinically-based perspective, but from a community-based perspective, is so important. And your example is a great one.

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

The other concern I have is, if somebody is in crisis and they're a suicide risk -- again, I've seen this firsthand recently with a friend -- not a veteran, but -- there's not a lot of choices. They go to the emergency room, they get locked down because they're a risk, or then they get put into an inpatient mental health ward, where they are high-functioning, but they need some help, and they

don't fit in with the other population there. It can put them into a worse crisis. There's not a lot of great options in that moment for somebody who's high-functioning but really needs help.

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

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

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

But, there are other forms of crisis services when there's a comprehensive crisis continuum that has things like mobile outreach so that, rather than somebody being transported to an emergency room to receive an evaluation, that same evaluation can be done where the person is. There are also crisis stabilization units. There are some excellent ones in Arizona, in Phoenix and Tucson, that

provide 72 hours of crisis stabilization, not in a -- where police officers can drop somebody off if the police need to be involved. So, I think that improving crisis services is one very important component -- not the only component, but one very important component of improving our national suicide efforts.

Senator McSally: Great. Thanks.

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

Thank you.

Senator Tillis: [Inaudible.]

Senator McSally: Is that okay? Thank you.

Go ahead.

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

Senator McSally: Right.

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

The other thing, the big challenge of getting the right treatment to the right person, which is one of the things I mentioned, is that veterans are much more rural than the

rest of Americans. And the reason is, you know, the States with the highest proportion of veterans in America, in Kentucky, West Virginia, Tennessee, because they all came from there, they joined the military, then they moved back. And it's hard to get the specialized -- if you live in Los Angeles, they have, you know, these little ultra, ultra specialized things. So, how to figure out --

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

Dr. Kessler: That's right. That's right, yeah.

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

Senator McSally: Right.

Dr. Kessler: But, I think we could.

Senator McSally: Thank you. Appreciate it.

Dr. Kessler: There's a lot more.

Senator Tillis: Thank you, Senator McSally.

The -- I want to go back, just in terms of a level set on data. I think I have read that the incidents of suicide,

adjusted for age and sex, in the whole of the military, is roughly equivalent to civil -- civilian society, but for the National Guard. Is that right?

Dr. Kessler: Yes, sir.

Senator Tillis: And within the VA, Dr. Miller, is that roughly the same?

Dr. Miller: It is. It's equivalent to the -- the veteran is equivalent -- no, sir. It's higher.

Senator Tillis: It's much higher?

Dr. Miller: Yes.

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

consistent approach to what are the consistent causes of suicide?

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

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

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

It's incorporated in the U.S. National Strategy for Suicide Prevention. The National Action Alliance for Suicide Prevention has made it a priority to try to help

As part of a recent meeting in -- at SAMHSA, as part of the International Initiative for Mental Health Leadership, we met with mental health leaders from nine different countries to look at what we were doing in our different nations to prevent suicide, and how we can approach it comprehensively -- What were the different components that were working in different places?

-- so that we can all learn from each other. So, it's a critical -- but, we definitely need a comprehensive public health approach, but we also need more information about what can be most effective to help in the community.

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

Senator Tillis: And, Dr. Miller, Captain Colston, and Dr. Orvis, one of the -- I'm not an expert in this field. I'm trying to learn so that we can be instructive with public policy choices. But, one thing that just strikes me is, if we have a disproportionately high number of men and women in the National Guard. They have a unique circumstance, particularly now, with the operations tempo being what it is. Many are going -- I don't know if we have data about how many of them were actually in deployments or away from home and then coming back away from the structure of the military. But, in some ways, you would almost -- I could -- the layperson could draw the conclusion that if that seems to be a disproportionally high number of suicides in that population, and, Dr. Miller, we know that the suicides among veterans is much higher among those who have no connection to the VA or VHA, what does that tell us about what more we need to be doing? You mentioned there's a Mobile Vet

Center when they're on deployment. The problem is, oftentimes their suicides happen when they're not on deployment. So, what are we doing to better connect and provide access to our servicemembers and veterans who are -- what initiatives are going on right now that can give us some hope?

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

Dr. Orvis: I'll add, as well. Certainly, we know the National Guard has unique challenges, and locality and whether more geographically dispersed is a key factor there. We have a number of -- in addition to the VA Mobile Vet Centers, which I think is an exciting new initiative, and it's also on drill weekends, which is a -- more opportunity to have that regular care -- we've been partnering very closely with the National Guard Bureau with the approach of providing as many different

doors or avenues as we can. So, partnering with local resources in the community. There is Military OneSource that is available, getting -- to prevention if you're having financial challenges, relationship issues, parenting challenges, the whole host of everyday life challenges. Military OneSource is available to everyone and all family members in the military.

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

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

Dr. Colston: I'd just add, sir, financial security and healthcare security are big issues for this cohort. I have seen patients from the National Guard who were on Medicaid shortly before, patients who didn't have access to healthcare recently. When I've -- was deployed, I once saw a young man who had an opiate addiction, who was on buprenorphine, which is a great treatment. That's exactly what he needed to be on, but he didn't need to be in the desert on that particular therapy. So,

we need to standardize and optimize care for our Guard cohort, just as we do for the Active Duty forces.

Senator Tillis: Thank you.

Senator Gillibrand.

Senator Gillibrand: Thank you.

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

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

Dr. Miller: Yes. The -- you are 100 percent correct that the time of transition is -- represents a higher risk period for individuals, veterans, servicemembers, with regard to suicide.

That time of transition can be embodied by exactly what you're talking about with that which occurs from servicemember to veteran. I am optimistic regarding that which we have spent the last year working carefully on with regard to wraparound services, 360 days before separation to 360 days post. I'm optimistic about what started on Monday of this week, which was initiation of Executive Order 13822, step 1.1, which was the VA callbacks. Within the first month of separation, we are contacting every veteran that we receive on the list of those separating. We're introducing them to the VA, we're introducing them to services with the VA, and we're offering them connection and resources within that conversation. We offer them a followup letter to reiterate the sources, and we offer them connection to mental health services.

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

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

Dr. Miller: Yes, ma'am. I feel that we've been looking at

this for a few years, at the -- at least, particularly with opioids, and then opioid combinations, such as with benzodiazepines.

Senator Gillibrand: Right.

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

Senator Gillibrand: Okay.

Dr. Kessler, part of your testimony, you said that you thought it would be interesting to have an inception survey, since a lot of the data shows that many of our servicemembers come in with mental health challenges. But, as I said in my opening remarks, a lot of servicemembers don't want their commanders to know that they have a history of mental illness or that there might be some impediment to exemplary service. So, have you any thoughts about, if we did create an inception survey, how to allow it to be confidential? And I'm thinking

about the fact that our chaplains are able to provide guidance, spiritual counseling on a confidential basis that never goes to the commander. Is there an argument to be made to allow mental health guidance, mental health services to be given in a confidential setting, included with the inception survey, and then continue that throughout a servicemember's career, and then again upon separation, so that you have an entire continuum of care for mental health that is outside of the chain of command so it -- so that there's not that barrier, the fear of being degraded or devalued or being sidelined?

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

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

It's tough to rebrand that you tried to kill yourself. You know what I mean? It's just sort of -- and so, the idea of doing something that's more confidential, that sort of goes beyond Military OneSource -- and a lot of people do know that they can go to the chaplains. And chaplains are feeling beleaguered now, because they're getting a lot of this stuff. It makes a lot of sense. But, it's really -- I mean, as an outsider, it makes a lot of sense, but you really have to turn to the folks here who are the DOD people. But, as an outsider, I certainly think that is a -- has a lot of common sense to it.

Dr. Miller: Ma'am, I have a 20-second followup to that --

Senator Gillibrand: Yeah, anyone can --

Dr. Miller: -- if I may.

Senator Gillibrand: -- speak on this issue.

Dr. Miller: The most trouble I was in in the military when I was an officer and a clinical psychologist was when I did not report that the spouse of an F-16 driver was experiencing

substance-use-disorder issues. When there was a on-installation event involving this situation, the commanding officer was livid at me for not telling him about this. I said, "Why would I tell you?" And he said, "Because I wouldn't have assigned this person to be a 16 driver if I knew that." And I said, "How fair is that?" And what was really underlying his emotion was the fact that he was afraid that he was going to get in trouble and that fingers were going to get pointed.

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

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

So, one of the reforms we've put in place a long time ago is that we let people report if they've been sexually assaulted,

confidentially, so they can get access to the services. It does not -- it is not really working, because the men still have very low reporting. But, at least we've put that into place.

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

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

Senator Gillibrand: Right.

Dr. Colston: -- a cultural issue of how we practice, as psychologists and psychiatrists.

Senator Gillibrand: Well, I'd be grateful if you'd each do a recommendation to the committee by letter after you've had some time to think about this, because I do believe having a requirement by the chain of command to report any mental health issue is a significant barrier to seeking treatment. And we've seen it in the military sexual traumas context. So, I'd love your recommendations about ways you could implement something

like this that you think would be productive, based on your years of experience and expertise.

[The information referred to follows:]

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

Senator Gillibrand: Yep.

Dr. Orvis: But, one of the new pilot initiatives that we're working on is a training program focused on trying to talk about a lot of those concerns that servicemembers may have of what are those perceived barriers they're have, the concerns they have that it may have them, the impact it may have on their security clearance or the confidentially concern or their privacy concern, and talking through, What are the different resources that they can use? They could use chaplains, you know, the variety of different options, in addition to mental health professionals, to seek help. So, I think that's an important initiative that we're beginning, to help break that concern of, "I can't reach out," or maybe, "I'm not aware of the various portals of where I could reach out for support and resources."

Senator Gillibrand: Thank you.

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

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

And then, Dr. Orvis, how are we making sure that these things that are well-intentioned to identify people that may

need to seek help do not have the opposite effect of making them feel like they're about to get flagged and, therefore, perpetuating the stigma?

Dr. Orvis: That's a really important question.

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

I think what I would also add, too, is -- and we were talking about this earlier -- is, many times -- suicide is so complex, and it's caused by so many different factors. And there are, frankly, simple things that we can all do. Being connected with one another, having those conversations makes a

difference. And that's part of what this particular training is trying to do, is just open up an avenue to have that conversation, to not be afraid of saying, "Are you thinking about harming yourself?" We know that's a misconception, "If I say something, I could be at risk of putting a thought in someone's head, and they hadn't thought about it before." In fact, we know it's helpful. It allows that release in someone to share what they might be going through and get that connectedness and support.

Senator Tillis: Dr. Kessler or Dr. McKeon.

Go ahead.

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

thing.

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

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

think, is important.

And I also would want to mention that -- to reiterate something that Matt had mentioned, that it's so important that, to the extent we can, things occur within a just culture and not one of blame. It's very important within healthcare systems to -- you know, every -- if someone dies by suicide, they're under care, it's really important to take a look at that. But, we won't learn from those tragic events if everyone's -- if the psychiatrists, the psychologists, the physician, the social worker are afraid that they're going to be blamed. So, we need to look at these situations in a situation for the just culture, a culture that is not blaming, that's not looking to find the fault that caused the suicide, but that's hoping to understand it better and to learn from each death, to find ways that we can improve.

Dr. Miller: Sir, if I may add, there's an article coming out of -- I believe it's the Albany News, out of Senator Gillibrand's State, today, where they're talking about State leadership investing significantly in mental health counselors in the schools -- elementary, middle schools -- and then not just counselors, an increasing availability of clinical-type care, but also increasing education about mental health and mental health issues, and normalizing aspects of it at a very young age. I think that that's extremely powerful. I think that it's a great example of where we need to go. And I think

it's an example of the power of the PREVENTS Task Force, and what we can do through PREVENTS by combining the VA, the DOD with the Department of Education, and taking a look at how to extend this beyond the State of New York.

Senator Tillis: Thank you.

Senator Gillibrand.

Senator Gillibrand: No, thank you, Mr. Chairman.

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

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

feedback.

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

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

Committee is adjourned.

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