Suicide Prevention and Related Behavioral Health Interventions in the DoD

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by
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Chairwoman Gillibrand, Ranking Member Tillis, and distinguished Members of the Subcommittee, on behalf of the team at Stop Soldier Suicide and the clients we serve, thank you for the humbling opportunity to share our experiences and perspectives on this critical readiness issue. I'm especially honored to sit alongside Dr. Craig Bryan, a fellow Air Force veteran and an esteemed member of Stop Soldier Suicide's Scientific Advisory Committee.

To be clear, I am neither a psychologist nor a suicide prevention researcher. But, I am a 20-year Air Force veteran with combat tours supporting Operations Enduring Freedom and Iraqi Freedom with two additional tours at the Pentagon where I retired from the Joint Staff supporting the Chairman's efforts to improve service member transition and veteran reintegration via community-based approaches. I've experienced first-hand the challenges of military service, combat, transition into society, and in the worst moments, the challenges and grief surrounding untimely deaths.

Most recently, I'm honored to serve as the CEO at Stop Soldier Suicide, the nation's largest nonprofit organization exclusively focused on reducing military suicide rates with a lofty goal of ensuring service member and veteran suicide rates match national parity by 2030. I am humbled that my board of directors invites me back every day to lead an amazing team of experts and professionals dedicated to saving lives. In this role, I've not only seen the complexity of suicide and the grief it causes surviving family members but also the hope and joy that comes from helping service members and veterans move from struggling to thriving as a direct result of our work.

Sadly, since 2001, more than 120,000 service members and veterans have died by suicide; enough to empty Washington Nationals Park three times. Leading research indicates each suicide affects 135 lives; meaning these untimely deaths have affected more than 16 million Americans in the last two decades; two times the population of New York City. Statistically, we know these tragic deaths are mostly young men, often ages 18 to 34, and likely experiencing a combination of factors such as intimate partner problems, substance use, financial strain, chronic pain, and more. It's easy at this level to focus on this problem in terms of numbers, percentages, and statistics but these are real people who had friends, family members, and loved ones.

People like Captain Austin Murga. According to his mom, "being his mom was the best job she ever had." From the time he could walk and talk he always wanted to chase the bad guy and be

in the military. After graduating from VMI, he went on to become an Army Ranger. During his years of service, he led with compassion, viewing his soldiers more so as his brothers than his subordinates. While in Afghanistan, his company was deployed with a special forces unit for 9 months. When he returned, a neighbor asked if he was glad to be back. He replied, “no, not really.” “Why?”, she asked. He said, “I had a real purpose over there.” Unbeknownst to most, Austin was struggling with PTSD. He died by suicide on September 7, 2020, at the age of 26. While describing the arrival of chaplains at their front door, his dad said, “you expected it to happen there [in combat] you didn’t expect it to happen here. We thought everything was good here, back home, everybody’s safe.” Austin hid his struggles all too well. Austin is just one of the thousands of young service members who have died by their own hands while serving our nation in the last two decades.

We must do better. To see immediate change, we need front-line leaders to look at their teammates eye-to-eye, have candid and open conversations about mental health, and remove the cloud of shame and stigma from help-seeking behaviors. Unfortunately, these same leaders, often only trained via computer-based training, feel under-equipped to identify the risks and refer their subordinates or peers for care. We don’t prepare service members for combat via Powerpoint slides alone; we have deliberate and recurring training and exercises offering hands-on, tactical experiences to prepare for combat. If we’re taking this problem seriously, we should be doing the same for this critical issue.

Additionally, we need to ensure DoD leaders at all levels view mental fitness on par with marksmanship, physical fitness, and other warfighting skills. Leaders embrace, if not evangelize, the need for strength, endurance, precision, and expertise in fighting and winning wars. Likewise, leaders must embrace mental fitness as the last spoke on the wheel required for military readiness and mission success.

I fear our society views suicide as an intractable part of the human condition instead of viewing it as a complex problem we can collectively solve and possibly eliminate. Just like our aspirations to rid cancer from this planet, so too, should we aspire to eliminate suicide from the US military.

My team at Stop Soldier Suicide works tirelessly every day aiming toward that lofty goal.

Since 2010, Stop Soldier Suicide has served more than 3,500 clients with an average duration of 8.5 months of care. Last year alone, we served more than 1,000 clients, delivering more than 17,000 hours of evidence-based care and ultimately saving 147 lives. To date, zero active clients have died by suicide. We do this by providing free, confidential, trauma-informed care using the leading treatments that reduce suicide attitudes, thoughts, and behaviors via telehealth solutions available in all 50 states. Our clinicians, using suicide-specific modalities such as Collaborative Assessment & Management of Suicidality (CAMS), Crisis Response Planning (CRP), and Brief Cognitive Behavioral Therapy for Suicide Prevention (BCBT), can effectively save lives via telehealth as evidenced by the recent program evaluation finding that 97% of our program graduates experience reduced and stable suicide risk.

Take “Susan”, for example. Susan, age 22, served in the Army for 4 years and was medically separated in 2021 after military sexual trauma. When she told her chain of command about her trauma, leaders tried to talk her out of reporting the crime, stating the perpetrator was a “good soldier.” She separated from the Army and quickly found herself homeless and disenfranchised from her family. Since working with our team, we have reduced Susan’s suicide risks, improved her family relationships, helped her secure a job and we’re connecting her to her VA benefits. Susan has a long road ahead but we’ve reversed her course from heading towards suicide to a life worth living. She is just one of the 420 clients our team is currently working with.

Based on cases like this over our 11 years of work with service members and veterans, and our engagements with Command Leadership at bases like Ft. Carson, Ft. Bragg, and most recently, bases in Alaska, I offer the following recommendations. Many of these recommendations were also shared with the Sergeant Major of the Army and his Senior Enlisted Council in August 2020.

1. Increase access to suicide-specific care. A significant number of service members are effectively disenfranchised from receiving high-quality behavioral care via telehealth by the snarl of state regulations governing this issue. As Dr. Mooney recently testified before the House Subcommittee on Military Personnel, DoD is increasing behavioral health access by as many as 63,500 tele-mental health appointments by the fall of this year. But this barely scratches the surface of need and wait times of weeks or months for a simple assessment, let alone treatment, can prove fatal. I would encourage the Subcommittee and DoD to prioritize service member access to evidence-based, militarily competent suicide-specific care within DoD or as delivered by community partners via federal exemptions enabling broader access to tele-mental health service across state lines. Such an exemption should certainly set a uniform standard of care for participating providers to meet. However, the dearth and cost of limiting any such carve-out to psychologists alone, will not put a dent in the problem. Service members ought to have a choice among clinically sound programs and clinical providers, in the channel of their choice, that are best suited to treat their suicidal thoughts and behaviors. Additionally, advancing the COMFORT Act of 2021, aimed at reducing interstate barriers to nonclinical telehealth would dramatically improve access to timely nonclinical care.
2. Eliminate mandatory reporting requirements from community-based care providers. While our services are proven to save lives, and DoD clearly is prioritizing mental health care and suicide prevention yet struggling to meet demand, the mandatory reporting requirements within the DoD for at-risk service member’s in treatment directly impede our ability to officially work with DoD and the Services. We know service members need confidential, trusted, evidence-based care. We know wait times for care have skyrocketed at some installations from 5-7 days to 6 months or more. We know Command wants us there to help their service members. But we also know if we sign a formal agreement or contract, we have to report service members in care back to command…eliminating a key component of our services: confidentiality. So, we can only operate informally, in parallel with Command efforts, spend our limited resources to advertise our services to service members, and practically fight our way into installations to help service members, their families, and help Commanders save lives while improving mission readiness. Any efforts

this Subcommittee and DoD can take to eliminate barriers impeding service members' access to community-based care will immediately save lives.

3. Better understand trauma and risks in service members that occur prior to their military experience by screening new service members for Adverse Childhood Experiences (ACEs). CDC and others acknowledge the strong correlation between ACEs and suicide. Research published by the AMA in 2014 also indicated service members have higher rates of ACEs than their non-military peers. Recent research funded by the Henry M. Jackson Foundation and published in 2020 found the presence of three or more ACEs increased suicide risk among service members and veterans. Add in combat exposure and those risks doubled. Also, add in moral injury and those risks doubled again. We must do a better job of understanding our service members and the traumas they may have already experienced when they first joined the military, help them manage those traumas while in service, and prevent these exposures from impacting their military readiness or worse, crippling their mental health for the rest of their lives.
4. Conduct annual behavioral health checkups just as we do for physical health. But don't stop there. Given the fluctuations of risk over months, weeks, days, and even hours, we need to do more between these checkups. Like annual physical fitness tests, one cannot be successful if you don't put in the time to exercise daily and eat right. Leaders and peers at ALL levels need to layer in daily mental fitness regimes into their routines to ensure all service members are mission ready and when not, referred to timely, relevant care.
5. Similarly, destigmatizing help-seeking behaviors and protecting service members from negative career implications for having the courage to ask for help MUST be addressed at ALL levels. During our work with Ft. Carson, we found internal voices, an Army Specialist and a Master Sergeant, within our focus groups who shared their mental health struggles, their uncomfortable but courageous decision to ask for help, and how their treatment returned them to full duty and mission ready were and are very powerful affirmations for others to know it's okay to not be okay, ask for help, and stay in the fight. Conversely, one single instance where a service member seeks help and faces negative career consequences will wipe these gains away immediately and have long-lasting effects on destigmatization.
6. Re-examine the timing of screening. Most commonly, trauma, risk, and suicide screens are conducted in the redeployment phase or before separation from military service. The timing of these screens disincentivizes truthful responses for service members who "just want to get back home to their families" or who are ready to leave the service and don't want anything impacting the timing and nature of their discharge.
7. Means matter. Given the complexity and lack of precision in defining "why" service members die by suicide, place increased emphasis on "how." More than 70% of all service member and veteran suicides are by firearm. Given the possibility of large shifts in risk (from a low state to an acute state) in a very short period, and the 83% lethality of firearms compared to other means with lethality rates as low as 4%, putting time and distance between firearms and service members experiencing stressful events or crises can reduce suicides dramatically. In fact, recent studies show that storing a firearm loaded increased the risk of suicide almost three-fold, and also storing it unlocked increased the risk by another 50%. The military community prides itself on firearms training, safety, and

accountability. Those same tenants, when employed by service members in their own homes, can go a long way in preventing future suicides by giving momentary crises time to subside and allowing service members to return to a lower risk state or seek help.

8. Replicate and expand the Air Force's Wingman-Connect Upstream Suicide Prevention Program in other Services and in operational units. This new program, tested in a training environment, could be the first universal prevention program to reduce suicidal ideation and depression symptoms in a general military population. Group training that builds cohesive, healthy military units is promising for upstream suicide prevention. Extension of the program to the operational Air Force and more broadly in DoD could have positive impacts on service member suicidal behavior.
9. Improve transition experiences for separating or retiring service members. Our work with service members and veterans shows our highest risk clients experienced terrible transitions out of uniform. A vast majority of our high-risk clients describe their transition experiences as poor or very poor (69%). Given DoD is the sole provider of veterans in America (save the 1% from the Coast Guard and other non-defense branches), DoD has an obligation to provide a better transition into society where veteran suicide rates dramatically increase due to unmet needs, unaddressed traumas, and poor community integration supports. While service members have a similar level of risk of suicide as the general population, veterans have about 1.5 times higher risk of suicide than the general population. We also know that suicide rates after transition peak at 6 to 12 months after separation. Younger individuals (17-19) who separate from the military have a 4.5 times higher risk of suicide after separation compared to older individuals (40+). It is, therefore, imperative that DoD address in-service trauma and exposures prior to and during separation from the military.