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PREPARED STATEMENT

OF

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Chairwoman Gillibrand, Ranking Member Tillis, and members of the Committee, thank you for the opportunity to testify before you today.

The Department of Defense (DoD) is committed to providing the highest level of mental health care to Service members. We are steadfast in our commitment to ensuring that those who serve our nation receive timely and quality health care, including care to address mental health needs, and access to suicide prevention resources. This is of even greater importance now given that we are coming up on the second full year of the coronavirus pandemic. During this time, Service members, Veterans, and family members may be experiencing heightened feelings of stress, anxiety, uncertainty, and disconnectedness. Clinically, such experiences can be associated with an increased risk for suicide.

Our rates of suicide are not going in the desired direction. Every death by suicide is a tragedy and weighs heavily on the military community. The DoD believes that suicide rates among our Service members and military families are too high. Like you, we are concerned about recent suicides in locations such as Alaska, and ensuring resources and support are available to our Service members and their families.

The increase observed in the suicide rate of our Active Component Service members between CY 2015 and CY 2020 highlights the continued need for a comprehensive, public health approach to suicide prevention across the military community. Likewise, a public health approach integrating clinical and non-clinical efforts remains essential in geographically-isolated and locations outside the United States as well. For example, individuals stationed in remote areas, such as Alaska, may have increased exposure to risk factors (e.g., isolation, depression, sleep disturbance) with more limited access to protective factors (e.g., social connections). Further, direct and indirect exposure to suicidal behavior has been shown to precede an increase in suicidal behavior in persons at risk for suicide, especially in young adults. Persons deemed at risk for suicide should be referred for mental health services. This exposure may be felt more acutely in remote settings where there may be limited social connections. Clinical interventions, a necessary capability to promote positive outcomes, are not the only solutions, and why the DoD implements a public health approach, which aims to promote health and prolong life through the strength of a connected and educated community. To this end, medical care and treatment exist as part of a broader ecosystem of caring working in concert with community-based prevention efforts involving military leaders, family, peers, spouses, and chaplains to address underlying risk factors while also enhancing protective factors.

Every life lost has a deeply personal story, and with each death, we know there are families – and often children – with shattered lives. We know this is a shared challenge throughout American society. Nationwide, death by suicide was a top 15 underlying cause of death from 1999 through 2020. None of us have solved this issue. Though suicides may have a similar pattern, no single case of suicide is identical to another case, and in a great number of other cases, even close friends and family members are surprised by an individual's suicide.

The DoD has the responsibility of supporting and protecting those who defend our country, and we must do everything possible to prevent suicide in our military community. We

seek to encourage help-seeking behaviors, eliminate stigma, and enable access to mental health clinical services.

Nationwide, demand for mental health services is outpacing the supply of mental health professionals. This continued trend will result in increased difficulty recruiting and retaining mental health professionals. Further investigation into the cause of national shortages is necessary in order to determine effective national strategies for mitigation.

As the DoD promotes the utilization of mental health services throughout the military community, the shortage of mental health providers is creating challenges in access to care. The DoD is working to develop a staffing model, which focuses on matching supply to demand, optimizing provider availability (supply) with the goal of treating 100% of Active Duty Service members (demand) in the Direct Care system.

The DoD offers comprehensive mental health services to Service members, Veterans, and other eligible DoD beneficiaries. Mental health care is offered to Active Duty Service members and their families through military medical treatment facilities (MTFs) (Direct Care), and through networks of civilian providers (Private Sector Care). To mitigate challenges in supply, we continue to rely on the civilian network, aiming to provide care within the access to care standards for appointment wait time. Additionally, as the Defense Health Agency (DHA) exercises authority, direction, and control of the MTFs, the market and MTF leaders work together with DHA leadership to determine the approximate percentage of appointments that need to be dedicated to tele-behavioral health as a way to efficiently and effectively provide behavioral health services to remote beneficiaries.

Service members are routinely screened for mental health throughout their service, to include: at first visit for new patients; annually during their Periodic Health Assessment (PHA), which includes a person-to-person mental health assessment; as clinically indicated for existing patients; within 60 days of deployment during the Pre-Deployment Health Assessment; 30 days after return from deployment during the Post-Deployment Health Assessment; and again 3-6 months after return from deployment during the Post-Deployment Health Reassessment. In addition to detecting warning signs of suicide, the screenings can help identify mental disorders and substance use disorders in Service members.

The DoD engages in programs and efforts to address comorbid alcohol and substance use in service members, leveraging evidence-based best practices and treatment to support positive health outcomes. These programs inform Service members about low-risk alcohol use and provides training and education that deters Service members from misuse of alcohol and drugs. Additionally, these programs provide services for mild-to-moderate substance use disorders to sustain and improve personal readiness.

The DoD co-develops clinical practice guidelines (CPGs) with the Department of Veterans Affairs (VA), not just for suicide, but for conditions that increase suicide risk such as Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury, depression, and substance use disorders. These documents are publicly available, and are considered a highly reviewed standard of care for clinical decision-making. The 2019 Joint VA/DoD Clinical Practice

Guidelines (CPGs) for Assessment and Management of Patients at Risk for Suicide guides providers through the care of suicidal patients – ensuring that leading clinical practices are standardized and used consistently. We know suicide results from a complex interaction of many factors – environmental, psychological, biological, and social. There is not one solution to suicide prevention, but CPGs help reduce unwanted variance in prevention and treatment of those contemplating suicide.

While most people with mental health problems do not attempt or die by suicide, and the level of risk conferred by different types of mental illness varies, mental illness is an important risk factor for suicide. As part of the public health model, clinical best practices are used to reduce suicide, particularly in high-risk patient populations. It is important to note that all of the clinical practices noted to be somewhat effective have small effect sizes. Clinical interventions include:

- Cognitive behavioral therapy-based interventions focused on suicide prevention for patients with a recent history of suicide related behavior, which reduces incidents of future suicide related behavior.
- Dialectical Behavioral Therapy for individuals with borderline personality disorder (a particular diagnosis, which is accompanied with a high lifetime risk of suicide and suicide-related behaviors) and recent self-directed violence.
- Crisis response plans for individuals with suicidal ideation or a lifetime history of suicide attempts.
- Problem-solving based therapy for patients with a history of more than one incident of self-directed violence to reduce repeat incidents of self-directed violence; a history of recent self-directed violence to reduce suicidal ideation; and/or hopelessness and a history of moderate to severe traumatic brain injury.
- Pharmacologic interventions.
- Home visits to support reengagement in outpatient care is indicated among patients not presenting for outpatient care following hospitalization for a suicide attempt.

In addition to ensuring access to, and participation in, evidence-informed clinical care, to be successful in suicide prevention, we must also address the perceived stigma we know our Service members face when deciding if and when to get help. Among Service members who experienced significant distress, one of the greatest barriers to receiving care is stigma.

Stigma continues to be a challenge for both the general and military population, and stigma, attitudinal factors, and logistical barriers may contribute to the underutilization of mental health services. Efforts to target and reduce stigma include:

- Promoting embedded mental health and integrated primary care mental health programs, which address stigma associated with mental health treatment by increasing immediate access, making it a routine element of primary care services, and improving mental health literacy. These programs make mental health resources routinely and readily available to Service members reducing barriers to seeking care.
- Reviewing and updating guidance, which establishes policy, assigns responsibilities, and prescribes procedures that enable providers to execute a balance between patient confidentiality and the combat and operational needs of the unit to build trust with those Service members seeking mental health care.

- Reviewing policies and procedures and developing a strategy to implement the self-initiated referral processes from a supervisor or commanding officer described in Section 704 of the National Defense Authorization Act for Fiscal Year 2022.
- Reviewing policies and procedures, and implementing Independent Review Commission on Sexual Assault in the Military recommendations, allowing survivors flexibility to take non-chargeable time off for seeking services or time for recovery from sexual assault, and implementing the “No Wrong Door” approach to sexual harassment, sexual assault, and domestic abuse across the Services and National Guard Bureau.

While we will remain vigilant in the effort to combat stigma, data suggests that we are trending in the right direction. The increase in demand for mental health services indicates a positive effect of stigma reduction. Additionally, the American Psychological Association reports that Generation Z (generally defined as Americans born between 1997 and the early 2010s), which represents our youngest and future military force, views mental health and mental health care dramatically different from previous generations. Generation Z is more likely than older generations to report poor mental health, are more open about their mental health, and are significantly more likely to seek mental health care than previous generations. We must continue our clinical and non-clinical stigma reduction efforts to ensure this cultural shift continues.

Mental health concerns, and demand for mental health care, appear to have been exacerbated by the coronavirus disease 2019 (COVID-19) pandemic. The nation, as a whole, experienced a significant change to daily routines, and with change can follow uncertainty, worry, fear, anxiety, and depression. Public health actions, such as social distancing, are necessary to reduce the spread of COVID-19; however, they also create a feeling of isolation, further augmenting our stress, anxiety, and depression. DoD undertook rapid action to sustain mental health services, and continued to deliver care in a virtual environment, establishing Health Protection Condition linked guidance to standardize mental health operations during the COVID-19 response in order to protect providers, protect patients, and maintain routine care safely.

We recognize that health care workers, especially on the frontline, are not immune to mental health challenges as a result of the pandemic. Health care members may be developing symptoms of PTSD, and self-isolation may increase these symptoms. The Military Health System has been proactive in addressing these issues in the patient and provider, Service member and family member. We supported development of products and resources to inform and educate all formations on the topics of managing stress, maintaining behavioral wellbeing, healthcare workforce preservation, and fostering individual, family, unit, and organizational resilience during the COVID-19 pandemic.

Scientific research surrounding prevention of suicide is both complex and ever-evolving. We leverage scientific, evidence-informed practices; partnership with Congress, Military/Veterans Service Organizations, research institutions, and other government agencies such as the Centers for Disease Control and Prevention – to constantly pull every idea, every possible effective initiative, into our toolkit to help Service members and their families. For example, the DoD supports and invests in suicide prevention research efforts, such as the Army Study to Assess Risk and Resilience in Service members — Longitudinal Study (STARRS-LS)

and the Military Suicide Research Consortium (MSRC). STARRS-LS (2015-2020 & 2020-2025), which aim to create practical, actionable information on risk reduction and resilience-building for suicide, suicide-related behavior, and other mental/behavioral health issues in the military. It continues and expands the vital work begun by the Army STARRS project that was conducted from 2009 to 2015. MSRC includes research on suicide intervention and suicide risk assessment, which comprises studies on lethal means safety, couples crisis planning, web-based interventions, and risk detection and management in primary care, to name a few.

We remain grateful for this Committee's long-term interest in military suicide, support for the Department's suicide prevention efforts, and the opportunity to discuss the Department's clinically-related suicide prevention efforts today. We recognize we have more work to do, and much more progress to make, to prevent this devastating loss of life. Our efforts will continue to address the many aspects of life that impact suicide, and we are committed to addressing suicide comprehensively through a comprehensive public health approach.