Prepared Statement

of

Dr. Keita Franklin

Director, Defense Suicide Prevention Office

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BEFORE THE

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MILITARY PERSONNEL SUBCOMMITTEE

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Introduction

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

Suicide Data and Trends across Department of Defense

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

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

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

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

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

Suicide Prevention Program Evaluation and Research

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

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

Leveraging Evidence Based Practices

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

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

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

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

Suicide Prevention Policies

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

Conclusion

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