STATEMENT

OF

JACQUELINE GARRICK, LCSW-C

ACTING DIRECTOR OF THE DEFENSE SUICIDE PREVENTION OFFICE

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

HOUSE ARMED SERVICES COMMITTEE

CONCERNING

UPDATE ON MILITARY SUICIDE PREVENTION

ON

MARCH 6, 2013

Mr. Chairman and members of the Committee, thank you for the opportunity to present information on the accomplishments of the Department of Defense's (DoD) Suicide Prevention Program.

Suicide ranks as the tenth leading cause of death in the United States (U.S.), according to the Centers for Disease Control and Prevention (CDC).[1,2] Over the past decade, the national suicide rate has gradually increased for the general U.S. population.[3] For 2010, the U.S. suicide rate for males, ages 17-60 was 25.1 per 100,000, which rose from 21.8 per 100,000 in 2001. For comparative purposes, this adjusted rate best matches the U.S. Armed Forces population. The suicide rate among the U.S. Armed Forces also rose in the past decade, going from 10.3 suicides per 100,000 Service members in 2001[4] to 18.3 suicides per 100,000 Service members in 2009.[5] While essentially level in 2010[6] and 2011[7], the suicide rate for 2012 is expected to increase once death investigations have been completed and a final manner of death determination is issued.[8]

The Department has closely monitored and examined suicides since 2008 and suicide attempts since 2010 amongst its Service members. The DoD collects this data in the DoD Suicide Event Report (DoDSER), which standardizes suicide surveillance efforts across the Services (Air Force, Army, Marine Corps, and Navy) to support the DoD's suicide prevention mission.[9] The DoDSER collects crucial data, such as demographic information, cause and

[1] This is the ranking as of 2011, the most recent year (2010) for which CDC has data. Suicide was also the 10th leading cause of death for 2010, 2009, and 2008.
[2] Hoyert, D. L., & Xu, Jiaquan. (2012, October 10). Deaths: Preliminary Data for 2011. National Vital Statistics Reports, 61(6), 1-51.
[3] Centers for Disease Control and Prevention (CDC). (2012, May 11), National suicide statistics at a glance: Trends in suicide rates among persons ages 10 years and older, by sex, United States, 1991-2009. Retrieved from http://www.cdc.gov/ViolencePrevention/suicide/statistics/trends01.html
[4] 160 confirmed suicides
[5] 310 confirmed suicides
[6] 298 confirmed suicides, 17.8 per 100,000
[7] 301 confirmed suicides, 17.5 per 100,00
[8] As of March 1, 2013, the CY 2012 YTD numbers are:350suicides, 291 are confirmed and 59 are pending

[9] https://t2health.org/programs/dodser

manner of death or attempts, substance abuse and psychological health history, and deployment and combat experiences. It incorporates associated factors, such as marital status, rank, and educational levels. A comprehensive report summarizing DoDSER data is published annually.

According to the most recently published DoDSER Calendar Year 2011 Annual Report, the Department knows that the majority of military suicides were completed by enlisted Caucasian males, age 29 and below, with a high school education. In some cases, legal or financial issues were present and many had experienced a failed intimate relationship. Service members primarily used firearms to complete a suicide and died at home. The majority of Service members did not communicate their intent for self-harm nor did they have a known history of behavioral health problems. Less than half of those who died by suicide had deployed,[10] and a small number were involved with direct combat.

Service members involved in non-fatal suicide attempts were most often high-school educated, junior enlisted Caucasian males under the age of 25. Slightly more than half had a failed intimate relationship. The majority used drugs in their suicide attempt, which most frequently occurred in their own residence. The majority did not communicate their intent for self-harm, but, in contrast to those who died by suicide, most had at least one documented behavioral health disorder. Less than half of those who attempted suicide had a history of deployment,[11] and a small number had experienced direct combat.

With suicide on the rise in the military, the Department established the Task Force on the Prevention of Suicide by Members of the Armed Forces in response to Section 733 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2009. The Task Force issued a report in August 2010 that provided 76 recommendations for how the Department could more

---

[10] Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), or Operation New Dawn (OND)
[11] OEF, OIF, OND

effectively prevent suicide. First among its recommendations was the establishment of a centralized suicide prevention office that would uncover best practices and help identify and reduce inefficiencies and gaps across the Services.

DSPO began operations in November 2011, as a component of the Office of the Under Secretary of Defense for Personnel and Readiness. DSPO oversees all strategic development, implementation, standardization, and evaluation of DoD suicide and resilience programs, policies, and surveillance activities. The Office works very closely with the Army, Navy, Air Force, Marine Corps, Coast Guard, and National Guard Bureau through the Suicide Prevention General Officer Steering Committee (SPGOSC), which directs the implementation plan for the Task Force recommendations, and the Suicide Prevention and Risk Reduction Committee, which coordinates on action items and shares best practices to support Service members and their families. NDAA FY13 codified this office, which enhances the authority by which DSPO operates.

To fulfill the Task Force recommendations that the Department accepted for action, DSPO immediately developed a strategy to work with the Services and other key partners that is informed by the DoDSER data. The Department's strategy accounts for other key research findings and recommendations—such as President Obama's Executive Order on Mental Health, the National Strategy for Suicide Prevention, congressional mandates, the RAND Corporation study,[12] and DoD and Veterans Affairs (VA) joint Integrated Mental Health Strategy (IMHS), which includes action items for preventing suicide and enhancing resilience among Service members and their families.

[12] The RAND Corp. groups behind "The War Within" are the RAND Center for Military Health Policy Research and the Forces and Resources Policy Center of the RAND National Defense Research Institute.

To execute these actions and recommendations, the SPGOSC established nine priority groups. These focus on issuing suicide prevention policy, increasing data fidelity, reducing stigma, containing access to lethal means, standardizing death investigations, developing a research strategy, and evaluating programs, trainings and quality of care.

DSPO and the Services have made significant strides in the nine priority areas. Specifically, the Department is responding to the NDAA FY13 by issuing the first DoD-wide comprehensive suicide prevention policy. DSPO developed the DoD Directive 6490.rr, "Defense Suicide Prevention Program," which is anticipated to be released in 2013. Once published, the policy will determine applicability, standardize definitions, establish standards, and assign responsibilities for the Defense Suicide Prevention Program. For example, it will (1) require leaders to foster a command climate that encourages DoD personnel to seek help and build resilience; (2) mandate that the Department provides continuity to quality behavioral healthcare during times of transition; (3) require a sustainable Service-wide suicide prevention education and training program; (4) establish methods for standardized mortality data collection; and (5) requires each Service to staff, fund and maintain a Department level Suicide Prevention Program Manager.

To enhance the fidelity of suicide data, DSPO is coordinating and developing a process to improve DoDSER and other surveillance data, to analyze data, and translate findings into policy updates and program strategy. To create a joint Suicide Data Repository, DSPO is working with our VA partners to jointly purchase Service member and Veteran mortality data from the CDC National Death Index (NDI) going back to 1979,[13] which will facilitate comparative trending over time, improve analytical capabilities, and allow for a richer data set for mining mortality of

[13] The first year for which NDI data is available.

all who have served. In addition, DoD will affirm military service for the CDC, thereby enhancing its capabilities to track National Guard and Reserve deaths and Service members who die overseas. This mortality data will enhance research projects for longitudinal studies and population health surveillance activities. The Department also is reviewing and evaluating the non-criminal death investigations currently conducted to determine if the processes can be modified and enhanced to include more suicide-related information.

The 2010 Task Force noted[14] that there were nearly 900 suicide prevention activities across the Department and found that while the Department had attempted to evaluate its programs, there were inconsistencies, redundancies, and gaps in its approach. Recognizing that there are challenges with measuring prevention since outcomes of the counterfactual—that which did not happen—are difficult to capture and connecting programs to reduced mortality or morbidity are not easy conclusions to draw, DSPO responded by developing a comprehensive capacity analysis of suicide prevention programs and resources through an automated resource management tool that tracks requirements and funding across the Future Year Defense Plan. DSPO plans to unite these efficiency measures with effectiveness and engage in continuous process improvements reporting that will have pecuniary implications for decision makers. The objective of this approach is to be able to identify suicide prevention and resilience programs that align to strategic goals and areas where there are shortfalls or duplication of effort. This will result in potential savings by eliminating duplicative programs and generate fiscal efficacy by using those savings to cover identified gaps, or fund new evidence-based initiatives that leverages efforts to translate research. Eventually, the plan is to be able to case manage Service members at risk and track the changes in their wellness to the referral resources utilized.

[14] DoD Task Force on the Prevention of Suicide by Members of the Armed Forces, "The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives," August 2010.

To meet a similar goal, DSPO is conducting a comprehensive training evaluation to develop an overarching training strategy by the end of fiscal year 2013 that provides a framework of core competencies for the Services to implement training in a way that meets their individual and sub-population needs, such as at the peer, command, clinical, or pastoral level.

A significant achievement for the Department has been its annual suicide prevention conference partnership with VA, which is an Integrated Mental Health Strategy requirement. In June 2012, the conference was attended by over 1,100 participants; primarily mental health providers and peer counselors who were able to receive the latest research information and emerging best practices. The importance of this conference was underscored by the appearance of not only the Secretary of Defense, but the Secretaries of VA and Health and Human Services (HHS); together addressing the public health response needed to curtail suicide in the U.S.

The Department is tackling one of the most critical aspects of preventing suicide: eliminating the stigma that prevents some Service members or their families from seeking help when they have behavioral health and other problems. The Department is working to implement the Executive Order on *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families* issued by President Obama on August 31, 2012. To accomplish these requirements, the DoD and VA are leading a 12-month, help-seeking campaign to encourage Service members, Veterans, and their families to contact responders at the Veterans/Military Crisis Line by phone[15] or online[16] when they are in crisis. The DoD and VA created "It's Your Call" messaging for Service members and "Stand By Them" materials to involve family and friends. DoD and VA are also collaborating to develop several Public Service Announcements (PSAs) that encourage Service members and their friends and families to

[15] 1-800-273-8255, press 1
[16] www.militarycrisisline.com

contact the Veterans/Military Crisis Line. For instance, in December 2012, a Military Crisis Line PSA aired on the White House's Joining Forces Website,[17] encouraging help-seeking over the holidays. VA and DoD are also launching a PSA nationwide in March 2013 that urges families and friends to stand by Service members and Veterans and to get them help in their time of need.

In cooperation with the Services and VA, DSPO has worked to ensure that the Military Crisis Line is available in Europe, and we are in the process of extending that capability in Japan and Korea. The Military Crisis Line is available at larger bases in Afghanistan, but where it is not available, such as on many forward operating bases, DSPO worked with Task Force 14 Medical to establish a confidential peer support crisis hotline that utilizes local cell phone services. General Allen signed off on this hotline just before the holidays, and we trained a Combat Operational Stress Control team of medics to answer the lines using a similar protocol that the National Guard uses with the successful Vets4Warriors peer support call center.

In addition, the Department is focused on training and educating a wide variety of Service members and DoD civilian employees on how to cultivate a ready and resilient force. To foster this "Total Force Fitness," DSPO works closely with the office of the Joint Chiefs of Staff and the Services to present this model. To ensure that best practices in suicide prevention are widely instilled, DSPO hosted numerous educational sessions geared to a vast range of audiences including, senior military leaders, wounded warrior Recovery Care Coordinators, public affairs officers, and civilian supervisors.

Through these trainings, DSPO is increasing awareness among Service members and health providers about mental health exclusions related to their security clearances and the Standard Form 86 (SF-86), "Questionnaire for National Security Positions." Service members describe seeking behavioral healthcare as the "last resort" due to fear of negative career impacts,

[17] http://www.whitehouse.gov/blog/2012/12/11/taking-care-our-military-families-holiday-season

which include adverse determinations of personal security clearances. Although the vast majority of behavioral problems would not disqualify Service members from obtaining or maintaining their security clearances, they often believe that seeking care is career-ending. In reality, the percentage of all security clearance denials and revocations for cases involving mental health issues is very small-less than 1 percent.[18] To this end, we are working to ensure Service members understand that seeking help is a sign of strength and, when they proactively reach out for assistance, it does not jeopardize their security clearances.

Postvention, the response in the wake of a suicide, also has implications for prevention and reducing suicide contagion. A DoD Reserve Component stakeholder group identified the need for a Postvention Guide,[19] so one was created and published for Reserve Component Commanders. It gives them guidance on survivor support, memorial services, and community involvement in the wake of a unit member's suicide. The survivor perspective is informative in understanding the impacts of policies and practices. To further its surveillance efforts, DSPO engages in a monthly postvention debrief with the Tragedy Assistance Program for Survivors (TAPS) Suicide Program Director to review factors leading up to a Service member's death as reported by the families referred to TAPS by the Services for peer support. This dialogue builds a frame of reference that the DoDSER data alone does not provide.

In light of the fact that firearms are the main means for completed suicides, the Department established a working group to define policies that will contain at-risk Service members' access to both military and privately-owned weapons. As part of this effort, the Department is also providing clarifying guidance on Section 1057 of the NDAA FY13, which authorizes mental health professionals and commanding officers to inquire about plans to acquire

[18] Defense Personnel Security Research Center. June 2011.
[19] Department of Defense. "Reserve Component Suicide Postvention Plan: A Toolkit for Commanders." May 2012.

or possess privately-owned firearms, ammunition, and other weapons. Further efforts to promote safety involve a partnership with the Yellow Ribbon Reintegration Program and the Uniformed Services University of the Health Sciences to develop curriculum for a family home safety planning class that incorporates the use of gun locks. The Department has distributed over 70,000 gun locks across the Services and National Guard as a part of this effort.

Since suicides and suicide attempts were also associated with prescription drugs according to DoDSER data, the Department contracted a feasibility study to determine how to best implement a drug take-back program aiming to reduce drug-induced suicides and attempts by allowing recipients of pharmaceuticals to return unused medications to the pharmacy in compliance with Drug Enforcement Agency rules.

The Department continues to increase Service members' access to and quality of behavioral health care by expanding the practice of embedding behavioral health providers in operational units. These providers have a positive impact on mission readiness and safety. Behavioral teams are made up of several mental health providers who train, deploy and reside with their units. As integral members of the unit, the providers build a bridge between Service member and mental health professional, leading to early identification and intervention for those unit members who need their help.

Through its program evaluation approach, DSPO will be able to monitor appropriate access to care. Furthermore, DSPO is examining ways to more effectively identify and track risk and protective factors within the force to identify Service members whose wellness is at risk. DSPO is building a capability to identify active and Reserve components experiencing stressors that could impact their individual resilience, and then help to ensure that they receive outreach and/or care from an effective resource.

The Department is developing a unified, strategic, and comprehensive DoD plan for research in military suicide prevention and consults with the Military Suicide Research Consortium. This also includes working with the RAND Corporation to examine whether current research efforts map to the Department's strategic needs and congressional mandates for suicide prevention. This study will be completed by June 2013, and a plan that incorporates research goals for the National Suicide Prevention Strategy will be drafted by July 2013. DSPO established a team dedicated to translating knowledge accrued from evaluations, research and studies into clinical and non-clinical practices or policies that benefits leaders and support personnel. Moreover, the Department conducted the first systematic assessment of the Reserve Components' use of and satisfaction with suicide prevention and resiliency resources, which allowed it to obtain information about program oversight practices and command climate elements that influence planning and implementation of initiatives.

The Department is responding to Section 533 of the NDAA FY12, which accents the importance of collaborating with both public and private partners in several ways. First, DSPO created a Community Action Team approach, as described by the Office of the Joint Chiefs of Staff, that links Department experts with non-profit organizations, universities, and other entities in order to assess best practices in suicide prevention and share lessons learned in areas such as family and peer support education. Secondly, working with the Substance Abuse and Mental Health Services Administration, DSPO expanded Partners in Care, a chaplain program in which faith-based organizations provide services and support to members of the National Guard and their families. Next, through the DoD Joint Service Committee on Military Justice, DSPO is exploring the feasibility of developing policies that would recommend using therapeutic sentencing techniques developed by Veterans Treatment Courts in military justice proceedings

for Service members diagnosed with behavioral health problems. Finally, the Department has worked closely with the National Action Alliance, a group created by HHS Secretary Kathleen Sebelius and former Defense Secretary Robert Gates. The Honorable John McHugh, Secretary of the Army, is the public sector executive committee co-chair of the National Action Alliance, and the Department had several other key players who reviewed and provided recommendations for the National Strategy on Suicide Prevention (NSSP), which was issued in September 2012. The NSSP focuses on reducing suicide over the next 10 years, and DSPO has incorporated these strategic goals into its program evaluation approach.

Also in response to Section 533 of the NDAA FY12, the Department is taking steps to ensure the availability of suicide prevention resources or Veterans Crisis Line materials to Service members and their dependents during pre-separation counseling from the armed forces and at the VA benefits briefing during the Transition Assistance Program.

In closing, everyone in the Department fervently believes that even one life lost to suicide is one too many and prevention is everyone's responsibility. The Department has launched a vast array of initiatives in collaboration with the Services, and other Departments and agencies to most effectively prevent suicide in the military. The Department will continue to address the urgent need to standardize and enhance suicide prevention and resiliency activities and to disseminate all lessons learned and best practices across the armed forces. This issue is complex, and the challenges are great. However, while this fight will take enormous collective action—and the implementation of proven and effective initiatives—the Department remains optimistic that it will find better solutions that will save more lives.

Again thank you for allowing my testimony.