



Testimony  
Before the  
Subcommittee on Personnel  
Committee on Armed Services  
United States Senate

**Activities of the  
Department of Health and Human Services  
That Can Help Prevent Suicides  
Among Active Duty Military**

*Statement of*  
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Mr. Chairman, Mr. Ranking Member, and Members of the Committee, good afternoon. I am Kathryn Power, Director of the Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA). I am pleased to offer testimony this morning on behalf of Dr. Eric Broderick, Assistant Surgeon General and Acting Administrator of SAMHSA, an agency of the U.S. Department of Health and Human Services (HHS).

Thank you for asking me to testify at this hearing about the role that the mental health community in general, and HHS in particular, can play in helping prevent suicides among the young men and women who proudly serve our country in the Armed Forces.

This topic has special meaning to me. As a retired Captain in the United States Naval Reserve, I am intimately familiar with the courage and commitment our service members show, even under the most extreme conditions. We owe these men and women a debt of gratitude for their service to our country.

But we owe them much more than that. As a mental health professional, I am keenly aware of the tragedy of suicide among all segments of our population. In 2005, the most recent year for which we have national data, suicide resulted in 32,637 deaths, according to HHS's Centers for Disease Control and Prevention (CDC). Sadly, *suicide was the third leading cause of death among young people aged 15 to 24*. Rates of suicide are higher among males than among females, but studies indicate females have higher rates of suicidal thoughts and nonfatal suicidal behaviors than males. Although suicide is problematic throughout the lifespan, overall

rates of death from suicide are highest among those aged 80 or older, followed by those aged 45 to 49.

However, the number of suicides reflects only a small portion of the problem. Many more people are hospitalized due to non-fatal suicidal behavior than are fatally injured—and an even greater number are treated for injuries from suicidal acts in ambulatory settings or not treated at all. For example, in 2006, there were 594,000 visits for self-harm injuries seen in U.S. emergency departments. Further, research indicates that over 50 percent of people who engage in suicidal behavior never seek health services.<sup>1</sup>

Clearly, suicide is a major, preventable public health problem in America and it demands a public health response. Within the public health context, all individuals in a community—whether that community is a school, a neighborhood, a military unit, or an entire base—are affected by the health of its individual members. As a public health agency, our mission at SAMHSA is to promote mental health; prevent and treat mental health and substance use problems; and build resilience in individuals, in communities, and in the Nation as a whole. A new report by the Institute of Medicine and the National Research Council, which was commissioned by SAMHSA and HHS's National Institutes of Health (NIH), recommends that we make the mental, emotional, and behavioral well-being of our young people a national priority.

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<sup>1</sup> Crosby, A.E., Cheltenham, M.P., & Sacks, J.J. (1999). Incidence of suicidal ideation and behavior in the United States, 1994. *Suicide and Life-Threatening Behavior*, 29, 131-140.

Many of our young people are active duty military, and their mental and emotional well-being is equally important. I was pleased to serve as a member of the Department of Defense Task Force on Mental Health. In its final report, called “An Achievable Vision,” the Task Force concluded, *“Maintaining the psychological health, enhancing the resilience, and ensuring the recovery of service members and their families are essential to maintaining a ready and fully capable military force.”* In order to foster a prevention-oriented, public health approach to maintaining psychological health in the military and in the country as a whole, we must act to prevent the ultimate act of hopelessness—the taking of one’s life.

At SAMHSA we provide national leadership for suicide prevention, leading a broad group of Federal partners—including the Department of Defense (DoD) and the Department of Veterans Affairs (VA)—to implement the National Strategy for Suicide Prevention.

Within the Center for Mental Health Services, we have three major suicide prevention initiatives. One of these initiatives is the Garrett Lee Smith Youth Suicide Prevention grant program. As of October 1, 2008, 43 States and 18 Tribes and Tribal organizations, as well as more than 68 colleges and universities, are receiving funding for youth suicide prevention through this program.

A second cornerstone initiative is the Suicide Prevention Resource Center, a national resource and technical assistance center that advances the field by working with States, Territories, Tribes, and grantees and by developing and disseminating suicide prevention resources.

The third major initiative is the National Suicide Prevention Lifeline, which is a network of 137 crisis centers in 48 States that receives calls from the national, toll-free suicide prevention hotline number, 1-800-273-TALK. When a caller dials the hotline, the call is routed to the nearest crisis center, based on the caller's area code. The crisis worker listens to the individual, assesses the nature and severity of the crisis, and links or refers the caller to services, including emergency medical services when necessary.

Routing calls to an individual's community links him or her to resources close to home; if the nearest center is unable to pick up, the call automatically is routed to the next nearest center. All calls are free and confidential and are answered 24 hours a day, 7 days a week. Every month, more than 46,000 individuals call the National Suicide Prevention Lifeline, an average of 1,500 individuals every day.

Early in 2007, SAMHSA and VA—both members of the Federal Working Group on Suicide Prevention—began exploring strategies for a potential collaboration. It quickly became apparent that using the National Suicide Prevention Lifeline as a front end for a Veterans Suicide Prevention Hotline would offer numerous advantages. We knew that on the very first day of operation, by using a number that had already been heavily promoted for several years, more than 1,000 callers in crisis would hear the following message when they dialed 1-800-273-TALK: “If you are a U.S. military veteran or if you are calling about a veteran, please press ‘1’ now.” Callers who press “1” are routed to the VA call center in Canandaigua, NY, staffed by VA professionals. On the very first day of operation, 73 callers pressed “1.”

In fiscal year (FY) 2008, the Call Center in Canandaigua responded to more than 67,000 callers. Calls from veterans led to more than 6,000 referrals to VA Suicide Prevention Coordinators and more than 1,700 rescues—calls to police or emergency medical personnel for immediate responses for callers judged to be at imminent risk. There have been only two known suicides among the 6,000 referrals.

Of special interest to this Committee, during FY 2008, 780 callers identified themselves as active duty military. They received the same expert services as any veteran or family members who called, including several times when the Call Center coordinated with the service member's base to arrange an emergency rescue. Thus far this fiscal year, 434 callers to the hotline—nearly 3 a day—identify as being on active duty.

Possibly as a result of the newly expanded GI Bill, one of our Garrett Lee Smith grantees at Kansas State University discovered that distance learners in the military from Pakistan, Afghanistan, and Iraq have visited one of their Web sites (<http://universitylifecafe.org/>), which features a set of topics on mental well-being. As a result, Kansas State added items tailored for the military, including a suicide prevention video produced by DoD that features Major General Mark Graham, who commands the Army's Division West and Fort Carson in Colorado and who lost a son—an ROTC cadet—to suicide. At SAMHSA, we are encouraging all of our Campus Suicide Prevention Grantees to welcome active duty military and veterans onto their campuses and to provide specialized services for them.

Our soldiers, sailors, airmen, and Marines deserve the best knowledge we have to offer in suicide prevention. I am pleased to share with you several innovative practices that we know are effective in preventing suicides. These can be and already have been adapted for use with active duty personnel.

Indeed, we are learning more about what leads to suicide and, therefore, what can be done to prevent it. We know that what leads an individual to take his or her own life is usually complex, involving a number of risk factors and warning signs, such as depression, substance abuse, and hopelessness. Suicide does not usually come out of the blue, as an impulsive act in a moment of crisis. Rather, suicide risk can build over time, bringing a person closer and closer to the brink of tragedy. Usually, individuals who die by suicide have spent some time thinking about suicide and may have even communicated, directly or indirectly, to someone else—such as a friend, family member, colleague, or fellow soldier—they are thinking about suicide or are feeling hopeless or desperate.

Because people who die by suicide have often communicated about it with others, or might be willing to talk about it if asked, a promising approach to suicide prevention is called **gatekeeper training**. In this type of program, community members are taught the warning signs of suicide, along with instruction on how to arrange help for a person who is at risk for suicide. The best evidence suggests that suicide prevention is most likely to be effective when everyone in a community is involved and when everyone knows what to do when encountering this kind of crisis. The first step, which is at once simple and agonizingly difficult, is asking “Are you thinking of killing yourself?”

Examples of these kinds of gatekeeper training approaches include QPR, or Question, Persuade, Refer, and ASIST, Applied Suicide Intervention Skills Training. These approaches are being implemented and evaluated in SAMHSA's Garrett Lee Smith Youth Suicide Prevention grants program. We are also working together with the National Institute of Mental Health (NIMH), part of NIH, to study the effectiveness of ASIST training with crisis telephone workers at the Lifeline.

Just as suicide risk does not usually appear for the first time at a single overwhelming moment of crisis, neither does it disappear as a crisis begins to lessen. Recent research has shown that the period after an acute suicidal crisis is also a high risk time for suicide. A study conducted by VA found high rates of suicide among individuals receiving depression treatment in the 12 weeks following discharge from inpatient hospitals, a finding also documented in other countries. Similar results have been found among those discharged from emergency departments.

Fortunately, there is some evidence that providing **systematic contact and follow-up** in the time following an acute suicidal crisis can save lives. A study recently published by the World Health Organization found a significant reduction in deaths by suicide among those who received such follow-up contacts after being discharged from an emergency department. SAMHSA is working to promote follow-up to individuals who call the National Suicide Prevention Lifeline and has awarded six grants to implement and evaluate this approach. We are also closely collaborating with VA in its extensive efforts to provide follow-up to veterans who call the suicide hotline.

Finally, we know that suicide deaths adversely affect those who are left behind. When a service member dies, his or her family and friends are affected, but so too are fellow service members, commanding officers, first responders, chaplains, behavioral health staff, and others. In many ways, a suicide death is more difficult to deal with than a combat death. As a unit commander told one of our Garrett Lee Smith grantees, “When my unit lost a soldier in Iraq in an IED attack, it was difficult but we dealt with it. It was painful returning home from deployment without him, but I was relieved that the rest of my unit was safe. When one of my soldiers killed himself 10 weeks after we returned, it was absolutely devastating and had a profound impact on our unit. Personally, I felt like I had failed him, his family, and the other soldiers in my unit.”

In addition, we know that survivors of suicide are at risk for killing themselves, a phenomenon termed “cluster” suicides. This is what happened in Houston where four Army recruiters from one battalion died by suicide in a 3-year period. As a result of the increased risk to survivors, a critical part of suicide prevention work is called “**postvention**,” which is an intervention conducted after someone dies by suicide. Postvention helps survivors cope with the many complicated, difficult feelings that naturally occur following such a sudden, catastrophic loss. An active suicide postvention program that addresses the needs of all individuals who have been impacted by suicide is an essential component of any community’s suicide prevention activities and can help stem the tragic tide of future loss. Postvention has been recognized by CDC as an important strategy for preventing cluster suicides.

NAMI New Hampshire, one of SAMHSA's Garrett Lee Smith grantees, developed a postvention model called Connect/Frameworks, which is recognized as a best practice by the Suicide Prevention Resource Center's Best Practice Registry. Originally developed for civilians, the program has been adapted by the New Hampshire National Guard to build resilience, promote healing, and reduce risk in the aftermath of a suicide. This training ensures consistent and appropriate response in the aftermath of a suicide and helps survivors—including family, fellow soldiers, chaplains, and the entire National Guard community—with grieving and healing.

Also, in January 2008, Major General Jeffrey J. Schloesser, commanding officer at Fort Campbell, Kentucky, and its 45,000 service personnel invited Tennessee's Garrett Lee Smith grantee to provide guidance in the aftermath of several suicides on and off base, involving both service personnel and family members. Beginning with presentations on posttraumatic stress disorder (PTSD) for troops and the development of a task force, the collaboration now includes ongoing debriefings of all suicide incidents, postvention and support for survivors and fellow warriors, and the implementation of base-wide awareness campaigns. The grantee credits the commitment of General Schloesser with the program's success, noting that leadership at the top is required for a base to engage fully in suicide prevention efforts.

Leadership at the top is critical, as evidenced by the witnesses at this hearing. But no one individual, agency, or military branch can solve this problem alone. As former Surgeon General Dr. David Satcher said, "Because its effects are societal in scope and tragic in their consequences, suicide prevention is everyone's business."

At SAMHSA, we work closely with two of our sister agencies in HHS—CDC and NIMH. The data and evaluation information that CDC collects and the research that NIMH conducts help shape the suicide prevention services SAMHSA provides. In turn, our services offer data and key research questions.

CDC is working with DoD and VA on combining relevant data from CDC's National Violent Death Reporting System, which collects data on violent deaths within the civilian population, with DoD's Suicide Event Report. This effort is designed to characterize more comprehensively those factors that contribute to suicide incidents among current and former military personnel. Having a better understanding of the most common contributing factors could help focus military suicide prevention initiatives. CDC is also working with the U.S. Army Center for Health Promotion and Preventive Medicine to develop an evaluation of its ACE (Ask, Care, Escort) suicide intervention program. CDC has proposed several options to evaluate and enhance the U.S. Army's ACE Program and their online interactive video, "Beyond the Front."

NIMH and the U.S. Army have entered into a memorandum of agreement to conduct research that will help the Army reduce the rate of suicides. This research study will: (1) examine the mental and behavioral health of soldiers, with particular focus on the multiple determinants of suicidal behavior; (2) identify modifiable risk and protective factors and moderators of suicide-related behaviors; and (3) identify specific interventions for reducing suicide risk by addressing empirically identified risk and protective factors. The Funding Opportunity Announcement, "Collaborative Study of Suicidality and Mental Health in the U.S.

Army,” was released on January 5 at <http://grants.nih.gov/grants/guide/rfa-files/RFA-MH-09-140.html>.

Ultimately, the key to effective suicide prevention for all Americans, including members of the Armed Services, is found in collaboration among each and every one of us who has a stake in the outcome. At SAMHSA, that has meant ongoing partnerships with DoD and VA in two Federal workgroups, one on Returning Veterans—chaired by Brigadier General Loree Sutton and co-chaired by Dr. Antonette Zeiss from VA—and the other on Suicide Prevention—chaired by Commander Aaron Werbel from DoD and co-chaired by Dr. Richard McKeon from SAMHSA. The Federal Working Group on Suicide Prevention has prepared a complete compendium of suicide prevention efforts across participating Federal agencies—including DoD and VA. Our collaborative activities are further exemplified by such activities as The National Behavioral Health Conference and Policy Academy on Returning Veterans and Their Families, a conference we cosponsored with DoD and VA in 2007 and 2008. In these collaborative partnerships, we meet together as concerned citizens, mental health professionals, and members of the Armed Forces—all proud supporters of our Nation’s military. Our goal is to improve the health and wellbeing of all Americans, particularly those who fight and die for us. No one—least of all members of our Nation’s fighting forces—should ever die by his or her own hand.

The poet John Donne once wrote, “. . . any man’s death diminishes me, because I am involved in mankind.” So, too, is each and every one of us here today. We must do all that we can, individually and collectively, to restore a sense of community that helps protect individuals from psychological distress, substance abuse, and suicide. In many ways, America is losing the

spirit of community that was previously fostered by extended families, religious organizations, and community centers. Today, we are more likely to eat alone, study alone, and even, as author Robert Putnam pointed out, to bowl alone.

But there is an *esprit de corps* in the military that bodes well for reconnecting individuals to a source of strength and hope that will protect them during difficult times. And while young people may no longer congregate in the town square, they meet in virtual town squares on such sites as MySpace and Facebook. SAMHSA is taking full advantage of these social networking sites to get the word out about the National Suicide Prevention Lifeline. We know that every time we actively promote the Lifeline, calls go up and more individuals are saved from an untimely death.

We look forward to continued collaboration with members of Congress, DoD and VA, and the American people as we strive to stem the tide of suicides among the brave men and women in our Armed Forces.

Thank you for the opportunity to address you today. I would be happy to answer any questions you may have.