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THE CURRENT STATUS OF SUICIDE PREVENTION PROGRAMS IN THE MILITARY

HEARING

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

HEARING HELD
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THE CURRENT STATUS OF SUICIDE PREVENTION PROGRAMS IN THE MILITARY

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Friday, September 9, 2011.

The subcommittee met, pursuant to call, at 9:03 a.m. in room 2212, Rayburn House Office Building, Hon. Joe Wilson (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. JOE WILSON, A REPRESENTATIVE FROM SOUTH CAROLINA, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL

Mr. WILSON. Ladies and gentlemen, good morning.

Today the subcommittee meets to hear testimony on the efforts by the Department of Defense and the military services to prevent suicide by service members, family members, and civilian employees.

I want to preface my statement by recognizing the tremendous work the Department of Defense and the service leadership has done to respond to the disturbing trend of suicide in our Armed Forces. I understand this has not been an easy task, and I thank you for your hard work.

I particularly see military service as an opportunity to be all that you can be. And I want service members to know they are talented people who are important and appreciated by the American people. They can overcome challenges.

I am also grateful for Ranking Member Susan Davis' work she did as chairman of the Military Personnel Subcommittee to bring attention to the psychological stress in the military and the behavioral health needs of service members.

With that said, clearly there is more work to be done. Suicide is a difficult topic to discuss. Every suicide is a tragedy, but suicide by members of our military is even more difficult because they have given so much to this Nation. Ultimately, it is an individual decision to take one's own life. But we must make sure every opportunity to redirect or change that decision is available before it is too late.

Suicide is a multifaceted phenomenon that is not unique to the military. Unfortunately, in addition to the unique hardships of military service, our military members are subject to the same pressures that plague the rest of society. They are exposed to the same stressors, such as the current unemployment and economic situation, that may lead to suicide by their civilian counterparts. I am very concerned those stressors will only get worse in the com-

ing months, as debate regarding cuts to the Department of Defense budget intensifies.

Each of the military services and the Department of Defense has adopted strategies to reduce suicide by our troops. I would like to hear from our witnesses whether those strategies are working. What are your benchmarks for success? How do you determine whether your programs incorporate the latest research and information on suicide prevention? I am also interested to know how Congress can further help and support your efforts.

With that said, I want to welcome our witnesses, and I look forward to your testimony.

Before I introduce our panel, let me offer Congresswoman Susan Davis from San Diego an opportunity to make her opening remarks.

[The prepared statement of Mr. Wilson can be found in the Appendix on page 33.]

STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL

Mrs. DAVIS. Thank you. Thank you, Mr. Chairman.

I am pleased that this subcommittee is maintaining its attention on suicides in the military. Over the past several years, as we have seen the number of suicides by service members grow, the subcommittee has been forward-leaning in attempting to support the services and the Department of Defense in their efforts to develop a strategy to reduce and prevent suicides in the force.

Mr. Chairman, I want to acknowledge particularly your opening comments that this is a very difficult, a very emotional, and yet a very important issue for us all to deal with. Every suicide, as you said, is a tragedy. But I think for the families the pain of suicide doesn't go away, and we need to acknowledge how tremendously difficult that is for all involved.

Suicide in the military has been a focal point for this subcommittee, but we are not the only ones focused on this issue. In 2007, suicide was the third leading cause of death for young people ages 15 to 24. While our forces share this demographic, it is important that we share what we learn and what is learned by others if our country is to be successful in addressing this societal issue.

The subcommittee's efforts have included the establishment of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces in the Duncan Hunter National Defense Authorization Act of Fiscal Year 2009. The task force, comprised of 14 individuals, civilians and military, with expertise in national suicide-prevention policy, military personnel policy, research in the field of suicide prevention, clinical care and mental health, and other similar backgrounds, submitted their final report in August of 2010.

There were 76 recommendations made by the task force, the majority of which were directed at the Department of Defense and the Services. I am interested in learning from the Department and the Services where they are in implementing many of these recommendations.

So I want to welcome our witnesses. I look forward to hearing from them.

And I want to welcome all of the members of the committee, of course.

Thank you, Mr. Chairman.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 35.]

Mr. WILSON. Thank you, Ms. Davis.

We are joined today by an outstanding panel. We would like to give each witness the opportunity to present his or her testimony and each Member an opportunity to question the witnesses. I would respectfully remind the witnesses that we desire that you summarize, to the greatest extent possible, the high points of your written testimony in 3 minutes. I assure you your written comments and statements will be made part of the record.

Let me welcome our panel: the Honorable Jonathan Woodson, M.D., Assistant Secretary of Defense for Health Affairs; Lieutenant General Thomas P. Bostick, U.S. Army, Deputy Chief of Staff, G–1, U.S. Army; Rear Admiral Anthony M. Kurta, director of military personnel, plans, and policy, U.S. Navy; Lieutenant General Robert E. Milstead, Jr., USMC, deputy commandant for manpower and reserve affairs, U.S. Marine Corps; Lieutenant General Darrell D. Jones, U.S. Air Force, deputy chief of staff for manpower and personnel of the U.S. Air Force.

Admiral Kurta, since this is your first time appearing before the subcommittee, I want to give you a special welcome. It is good to have you join us today on this very important issue.

I now ask unanimous consent that Ms. Chu of California and other committee and non-committee members, if any, be allowed to participate in today's hearing after all subcommittee members have had an opportunity to ask questions. Is there any objection?

Without objection, non-subcommittee members will be recognized at the appropriate time for 5 minutes.

And we shall now proceed with Dr. Jonathan Woodson.

STATEMENT OF HON. JONATHAN WOODSON, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Secretary WOODSON. Thank you, Mr. Chairman.

Mr. Chairman, Ranking Member Davis, distinguished members of the subcommittee, thank you for the opportunity to appear before you today to update you on the Department of Defense's ongoing efforts to prevent suicides in the Armed Forces.

We all know the facts. The rate of suicide among members of the Armed Forces has steadily increased over the last 10 years. And after many years in which the rate of suicide among military members was below the rate of the civilian population, over the last 3 years we have seen suicide rates for service members approach the civilian-sector experience. In fact, when updates to the civilian population rates are made available, we may even see that they exceed the adjusted civilian rates.

The Department has invested tremendous resources to better understand how to identify those at risk of suicide, treat the at-risk individuals, and prevent suicide. We continue to seek the best minds from both within our ranks, from academia, other Federal

health partners, and the private sector to further our understanding of this complex set of issues.

One example of our research agenda is the Army Study to Assess Risk and Resilience in Service members, or Army STARRS, program. This is the largest single epidemiologic research effort ever undertaken by the Army and is designed to examine mental health, psychological resilience, suicide risk, suicide-related behaviors, and suicide deaths.

Renowned experts from the Uniformed Services University of the Health Sciences, the University of California, the University of Michigan, Harvard, and the National Institute of Mental Health are conducting retrospective and prospective studies of approximately 90,000 Active Duty soldiers to evaluate the relationship between soldiers' characteristics and experiences to subsequent psychological health issues, suicidal behavior, and other relevant outcomes.

We are working exceptionally closely with other colleagues across Federal Government. With the Department of Veterans Affairs, we are developing shared clinical practice guidelines for providers in both organizations that use evidence-based guidelines for assessment and prevention of suicidal behavior. We are working with the Substance Abuse and Mental Health Services Administration in HHS [Department of Health and Human Services] to increase access to critical services for members of our Reserve and Guard communities. We continue to benefit from the addition of over 200 mental health professionals from the Public Health Service who are providing critical resource support in our medical facilities. And we have taken steps through our TRICARE [health care program] network to also expand access to services in our civilian communities.

Within the Department, we have amended medical doctrine and embedded our mental health professionals far forward in-theater to provide care in the theater of operation. We have modified our electronic health record, AHLTA [Armed Forces Health Longitudinal Technology Application], to securely share needed information on at-risk individuals so that the entire care team understands the diagnosis and treatment plan and can communicate more effectively. And we are standardizing the collection and analysis of suicide data to better inform our prevention strategies.

As important as any step, we have also made great attempts to remove stigma from seeking mental health services—a stigma that is common throughout society and not just in the military. This is a long-term effort, but both senior officers and enlisted leaders are speaking out with a common message. We are encouraged by the increased willingness of service members to seek professional help when it is recommended, and we continue to emphasize this message through every communication vehicle at our disposal.

Suicide prevention involves far more than medical intervention. The efforts I have discussed today represent the input and involvement of multidisciplinary organizations across the Department of Defense, led by the Deputy Assistant Secretary for Readiness.

While we have made real progress, there is much to be done. We have identified risk factors for suicide and factors that appear to protect an individual from suicide. As you well understand, the

interplay of these factors is very complex. Our efforts are focused on addressing solutions in a comprehensive and holistic manner.

Mr. Chairman, members of the subcommittee, your interest in and support for our efforts has been invaluable. I thank you again for the opportunity to share with you the progress we have made in addressing this very difficult and heartbreaking matter, and I look forward to your questions.

[The prepared statement of Secretary Woodson can be found in the Appendix on page 36.]

Mr. WILSON. Thank you very much, Doctor.

Next, we have General Thomas Bostick.

STATEMENT OF LTG THOMAS P. BOSTICK, USA, DEPUTY CHIEF OF STAFF, G–1, U.S. ARMY

General BOSTICK. Chairman Wilson, Ranking Member Davis, distinguished members of the subcommittee, thank you for the opportunity to appear here today to provide the status of the United States Army's ongoing efforts to reduce the number of suicides across our force.

On behalf of our Secretary, the Honorable John McHugh, and our chief of staff, General Ray Odierno, I would also like to take this opportunity to thank you for your continued strong support and demonstrated commitment to our soldiers, Army civilians, and their family members.

Our Nation has been at war for nearly 10 years. That has undeniably put a strain on the men and women serving in the United States Army and their families. Many individuals have deployed multiple times, and many have suffered the visible and the less visible wounds of war. This conflict continues to put a significant strain on our force. The most tragic indicator of this stress is the historically high number of suicides that we have experienced in recent years.

We achieved modest success in reducing the number of suicides of soldiers serving on Active Duty this past year. We attribute this modest decrease in Active Duty suicides to the programs and policy changes that have been implemented since the establishment of the Health Promotion/Risk Reduction Task Force and Council in March of 2009. Our research is showing we are influencing soldiers serving on Active Duty and helping to mitigate the stressors affecting them.

Conversely, it is much more difficult to do this for the Reserve Component soldiers not serving on Active Duty because they are often geographically removed from the support network provided by military installations. The challenge is that, in many cases, these soldiers have limited or reduced access to care and services as well as the oversight of a full-time chain of command.

Over the past year, our commitment to health promotion, risk reduction, and suicide prevention has changed Army policy, structure, and processes. We have implemented a multidisciplinary approach and a team effort by leaders and soldiers at all levels, together with the Department of Defense, Congress, civilian healthcare providers, research institutes, and care facilities, all to ensure that we are providing our soldiers with the most effective programs, treatment, and support. We still have much work to do.

I assure the members of this committee that there is no greater priority for me and the other senior leaders of our United States Army than the safety and well-being of our soldiers. The men and women who wear the uniform of our Nation are the best in the world, and we owe them and their families a tremendous debt of gratitude for their service and their many sacrifices.

Thank you again for this opportunity to appear before you concerning this important topic, and I look forward to your questions.

[The prepared statement of General Bostick can be found in the Appendix on page 41.]

Mr. WILSON. Thank you very much, General.

And, again, it is an honor for the first time to have Admiral Kurta.

STATEMENT OF RADM ANTHONY M. KURTA, USN, DIRECTOR, MILITARY PERSONNEL, PLANS, AND POLICY, U.S. NAVY

Admiral KURTA. Chairman Wilson, Ranking Member Davis, distinguished members of the subcommittee, thank you for the opportunity to discuss the Navy's efforts to promote the psychological health of our sailors and their families. Prevention of self-harm and suicide remains a high priority in the Navy, and we are grateful for your continued support of this critical issue.

The loss of a single sailor to suicide is a tragedy deeply felt by all those who are left behind. Suicide takes away a future, shatters a family, and affects our unit cohesion and morale.

From 2009 to 2010, we observed a decrease in our suicide rate. Regrettably, in 2011 we are seeing an increase over our rate from last year. In the face of high operational demands, we remain committed to fostering an environment where dealing with stress can be free of stigma and whereby seeking help is a sign of strength.

Strengthening the resilience of our sailors and their families remains the cornerstone of our suicide-prevention efforts. Our Operational Stress Control and our Reserve Psychological Health Outreach programs and an integrated structure of health promotion, family readiness, and prevention programs are critical elements of our approach. We continue to adapt these programs to meet the needs of our sailors and their families.

Our suicide-prevention efforts go well beyond these programs. We view suicide prevention as an all-hands, all-of-the-time effort. It involves sailors, family members, peers, and leadership.

One example is the Navy's Coalition of Sailors Against Destructive Decisions, a peer-to-peer mentoring program that empowers our most junior sailors to make responsible decisions and to reach out to their shipmates in need. Initiated in 2008, this program continues to grow, with more than 200 chapters across the Navy.

Another example to raise awareness about suicide risk and ensure all sailors and their families have access to the resources they need 24 hours a day, every Navy Web site now includes a link to the National Suicide Prevention Lifeline and the Veterans Crisis Line.

As a navy, we ask an incredible amount of our sailors and their families. In return, we remain committed to providing them with the level of support and care commensurate with their sacrifices.

On behalf of the men and women of the United States Navy and their families, I extend my sincere appreciation to the committee and the Congress for your commitment to this issue and of your continued support to our Navy families.

Thank you, and I look forward to your questions.

[The prepared statement of Admiral Kurta can be found in the Appendix on page 54.]

Mr. WILSON. Thank you very much, Admiral.

General Milstead.

STATEMENT OF LT. GEN. ROBERT E. MILSTEAD, JR., USMC, DEPUTY COMMANDANT FOR MANPOWER AND RESERVE AFFAIRS, U.S. MARINE CORPS

General MILSTEAD. Good morning. Chairman Wilson, Ranking Member Davis, and distinguished members of the subcommittee, it is my privilege to appear before you today to discuss this critical issue.

In 2010, we had an almost 30 percent decrease in our Marine Corps suicides from 52 to 37, and so far this year we are tracking even lower than in 2010. We are hopeful that this decrease represents the beginning of a downward trend, but we are not satisfied and will continue to aggressively implement and improve our suicide-prevention programs.

Our main focus is building a resilient force and encouraging our marines to seek help early. Leaders at all levels of the Marine Corps are personally involved in efforts to help address and prevent future tragedies. As marines, we pride ourselves in taking care of our own. A marine struggling emotionally is a wounded comrade, and we don't leave our wounded on the battlefield.

Thank you.

[The prepared statement of General Milstead can be found in the Appendix on page 65.]

Mr. WILSON. Thank you very much, General.

And we now will be concluding with General Jones.

STATEMENT OF LT. GEN. DARRELL D. JONES, USAF, DEPUTY CHIEF OF STAFF FOR MANPOWER AND PERSONNEL, U.S. AIR FORCE

General JONES. Chairman Wilson, Ranking Member Davis, and distinguished members of the subcommittee, thank you for the opportunity to appear before you today to represent the men and women, the officers, the enlisted, and the civilian airmen of the United States Air Force.

Last year, 4,500 officers, 28,000 enlisted members, and 18,000 civilians stepped forward to join the total force of more than 693,000 airmen. Each member plays a critical role in accomplishing the Air Force mission and supporting our national objectives. As we know, people are our most important asset, and we must do everything we can to take care of them so that they will take care of the mission.

Despite our best efforts, regrettably, 56 total force airmen—officer, enlisted, and civilian combined—took their lives so far this year. Although that number of suicides is lower than the same pe-

riod last year, it is still a major area of concern for our force as it sends ripples across the family, the unit, and the community.

We have redoubled our efforts on post-suicide care at the unit level. In cooperation with our health-care professionals, we developed a comprehensive guide designed to assist leaders in their initial response. We are keenly aware that a proactive response by unit leadership plays a role in prevention of additional suicides and attempts.

We are encouraged by over 370,000 documented mental health visits for Active Duty members in 2010. This number includes initial appointments as well as repeat visits. In addition to our comprehensive mental-health-care programs, we also offer care through chaplains, military family life consultants, and our Military OneSource.

How we care for our airmen is continuing to evolve. Recently, the Air Force developed a resilience-based program called Comprehensive Airmen Fitness, focused on bolstering the strength of our airmen through physical, mental, spiritual, and social fitness. By doing this, we put our airmen in the best possible position to handle whatever life stressors they happen to face.

We will continue to develop our programs and improve them. We know that as society changes so do our airmen, and it is important that our strategies for building resilient airmen continue to be as resilient and as flexible as our force.

I assure you, the leadership of the United States Air Force is personally committed to addressing the tragedy of suicide. On behalf of the chief of staff of the United States Air Force, we appreciate your unfailing support in this area, and I look forward to taking your questions.

[The prepared statement of General Jones can be found in the Appendix on page 74.]

Mr. WILSON. Thank you very much, General.

And we now will begin under the 5-minute rule of asking questions individually. A person above reproach, Jeanette James, will be keeping the time—and we know that she is accurate—beginning right now. And I am under the 5-minute rule.

First of all, I would like to thank each of you. As you were presenting your situation, I could tell it was heartfelt; it is not just another duty as assigned. And it fulfills my view, having served 31 years in the military, of a military family. People really do care about each other. I see it as I get around the district. I run into people who truly are our lifelong friends.

And then I was happy to point out to General Bostick that our fourth son, Hunter, was just commissioned Second Lieutenant, Combat Engineer. And so we have four sons serving in the military, and it is truly like a family. So I want to thank you for what you are doing.

Particularly, General Milstead, I was impressed by the success of the Marine Corps. And beginning with you, which of your suicide-prevention programs do you think are having the biggest impact on preventing suicides by members of the military, family members, and civilians?

And beginning with you, and then each can join in.

General MILSTEAD. Yes, sir. First of all, we are so hesitant to use the word "successful." We don't know what we don't know. We are still trying to connect the dots. You know, after a disturbing increase in '08 and '09, as I mentioned, last year we did see a slight decrease. We remained, I would put it, cautiously optimistic.

I would offer that it is really three things that jump right to mind. One is engaged leadership, especially at the NCO [noncommissioned officer] level. Our NCOs told us, give us this problem. And we are allowing them to deal with it, to a great degree. And I think that has borne some fruit.

I would also say our efforts in unit cohesion, which is part of our resiliency effort, the sense of belonging. Especially, we started out with unit cohesion being trying to ensure that we had the adequate, you know, leaders-to-led ratio prior to a deployment. And we quickly discovered that it was on the backside of that deployment where it was even more important, as we have come to call the "dark side," for at least 90 days when a young marine returns from a deployment and may have to dance with some dragons of things that he has seen.

Our efforts in the resiliency, our four pillars of resiliency: the physical, you know, things like diet, life skills; the psychological; the social, back to unit cohesion, belonging, that sense of belonging, being with the unit; and then the ever-important, the spiritual. I mean, it is a holistic approach, how we look at this.

And I would just sum it up, as many have mentioned, the word "stigma," reducing stigma. Change the culture. It is okay—it is okay to hurt, it is okay to ask for help, it is okay to be less than 100 percent. And I would offer that that surmises where we are heading.

Mr. WILSON. Thank you very much.

Would anyone else like to respond to which program that you have seen progress?

General BOSTICK. Mr. Chairman, I would say I agree with my brother Marine Corps brethren there, that talking about success with suicides, unless you have no suicides, is really not appropriate. This is a complex problem; it has no simple solutions.

I think what our leadership has done, both at OSD [Office of the Secretary of Defense] and the Army, is to try to better understand the problem and then to get the leadership involved at every level in what we learn from those conversations, what we learn from our monthly reviews of these suicides.

And our vice chief of staff, General Chiarelli, has led a 15-month study to really understand this, and published a book. And one of the things it talked about was the lost art of leadership and the lack, due to our rotation, due to the OPTEMPO [operations tempo] of our force coming in and out of Iraq and Afghanistan and not having the frontline leader able to help manage and work and understand the challenges of the individual soldier.

So our main point is to reduce the stressors on these individuals, these soldiers, by increasing their resiliency, by ensuring that, as we talked about, we reduced the stigma and that we reduce high-risk behavior. But it is a complex issue, and we are tackling it on all fronts.

Mr. WILSON. Well, again, I appreciate all of your efforts, and you are making a difference.

In accordance with the 5-minute rule, Congresswoman Susan Davis of San Diego.

Mrs. DAVIS. Thank you, Mr. Chairman.

I would like to go to you, Dr. Woodson, and ask, in further detail—I think you certainly referenced some of this, but the Military Suicide Research Consortium has a number of proposals, targeted priority research areas.

What do you believe we could really achieve in some of these research areas, and what do you think that they should be? Do you think they should be—or anybody on the panel—different from, perhaps, what you think they are looking at? Are we looking at the right things?

Secretary WOODSON. Well, thank you for that question.

And I think the first point to put out is, there is much that we don't know about suicide, factors that put individuals at risk, and factors that are protective.

You know, we commissioned a study by RAND to try and catalog, of course, all of the suicide-prevention programs that we have within the services and within the Department of Defense. And one of the things we realized is that we don't have enough metrics against these programs to properly evaluate them so that we know which ones work and which ones don't. And one of the things we have to really be careful of in a resource-constrained environment is that we don't fund programs that are not effective and we allow others that would be effective to wither on the vine. So one of the clear issues for our research is to put metrics against these programs and evaluate them over time.

I think that the issue is that, if you look over the literature, there are some programs that seem to work better than others. The Air Force has a program, which has been evaluated, in which individuals which particularly have gotten into legal difficulty and taken into custody are at risk, and ensuring that they get properly evaluated for their suicide risk is very important.

We know some information out of the New York City Police Department, for example, that peer-to-peer programs seem to work, so that when an individual can confidentially go to someone who has been trained to recognize when an individual is at risk for suicide, allow them to talk to a peer, and then also secure any means with which they might commit suicide, a weapon, that becomes very important in trying to prevent suicide.

The other issue that we know about is that having access to mental health care, and, more importantly, high-quality mental health care, by mental health professionals who understand how to evaluate for suicide risk and treat that appropriately also seems to be very important.

So, in summary, I think the issue is that we need to spend our research efforts intensively looking at the broad programs that are out there, making sure that they have metrics so that we can define what success looks like.

Mrs. DAVIS. As you mentioned on the metrics—and perhaps others can weigh in on this—how do we really assess the climate for people seeking help within their environment? How do you do that?

How do you go about—leadership has been mentioned, certainly. But I am just wondering what kind of metrics you use to do that.

Because that really is a problem. And I continue to hear, no matter how much we talk about stigma, people fear for their careers and that that is one reason that they don't seek help.

Secretary WOODSON. That is an excellent question. And we have some indirect indicators that we are getting at that issue by the number of behavioral health referrals that have gone up, the numbers of individuals who have actually sought care, and we have seen a tremendous increase.

Now, the good news is that, in some sense, we see the numbers plateauing, so that what we are thinking is that we have enough capacity. But we have seen a dramatic increase in the number of referrals of people seeking care. So if that is an indirect indicator that people are reaching out, that is appropriate.

Mrs. DAVIS. Thank you. I think my time is almost up, but I appreciate that and hope that we will join in the rest of the discussion. Thank you.

Mr. WILSON. Thank you, Ms. Davis.

We now proceed to Mr. Jones of North Carolina.

Mr. JONES OF NORTH CAROLINA. Mr. Chairman, thank you very much.

And I thank the panel for being here today.

And, as many know, I have the privilege to represent the 3rd District of North Carolina, the home of Camp Lejeune Marine Base, Cherry Point Marine Air Station, Seymour Johnson Air Force Base. We have done a tremendous amount—I want to give credit to a young man on my staff who served in the Marine Corps, Jason Lowry. The number of calls that we get from family members, from primarily Camp Lejeune—and, General, I want to commend the Marine Corps for seeing a reduction in the number of suicides at this point—sometimes is overwhelming for Jason.

One area that through the years I have noted that he has brought to my attention—and, Dr. Woodson, this is for you, sir—is the medical board process. It seems that, too many times, that those—and I am sure it is probably true in the Army, as well—who come back with PTSD [post-traumatic stress disorder] or TBI [traumatic brain injury], and they do acknowledge—the command acknowledges that you have a problem, and many of these want to go ahead and move through the medical board process, and the complaint that we have been hearing, that maybe—maybe—leads to some suicides—I can't say it does, and I am not sure anyone on the panel can say it does. But the process itself, when it lingers, then that creates more of an environment for that individual to think about his or her problems and maybe sees that there is no help for them and they decide to take their life.

Dr. Woodson, how do you feel with the medical review process across the board? Are you satisfied with the length of time that it takes for the board to come to a resolution on an individual, or do you see a problem there? Do you think it could be improved?

That will be my first question. I have two.

Secretary WOODSON. Thank you very much for the question. And let me just say up front, there is definite room for improvement in the process.

Let me just create, if you will, a context about the disability evaluation system and the medical evaluation board system. Historically, it was never designed as a system. It was a set of administrative processes and medical evaluations that were disconnected in two bureaucratic agencies, meaning Department of Defense and the Veterans Administration.

With, of course, our recent experiences and with 10 years of war, it has become very clear that, in fact, it needs to be designed into a system so that you have a series of actions that feed into each other in an efficient way to produce the most rapid outcomes with the clearest decisions in support of our service members.

What we have found is that there is room for improvement in the efficiency of the medical evaluations and in the administrative process. And we have made significant strides to coordinate the Department of Defense evaluation and adjudication with the Veterans Administration process to shorten the entire process. But there is more work to be done.

I just want to address for a second the first part of your question, which has to do with the impact of mental health issues in this population. Many service members come into the medical evaluation process obviously for physical injury, but a substantial number of them have a co-morbid issue that relates to behavioral health, mental health, PTSD. And, in fact, we do bring substantial resources into this MEB [medical evaluation board] process to make sure that the mental health issues are evaluated. One of the things we have done is to bring more psychologists and psychiatrists into the process to complete the forensic evaluations, the forensic psychological evaluations, which has been shown to slow the process down.

So we are working diligently on this, but much more work needs to be done. Thank you for that question.

Mr. JONES OF NORTH CAROLINA. Mr. Secretary, thank you for your answer.

And, if you would, just touch—I have about 19 seconds. You mentioned mental health professionals. Are the numbers, status current? Are they going up? Are more and more professionals coming into the military?

Secretary WOODSON. Again, thanks for that question because it allows me to highlight two points.

One, we have done, I think, a very good job of bringing more behavioral health and mental health specialists. And we are really tracking in the high 90s to almost 100 percent when you look at the global numbers. And we can provide for the record, if you wish, the breakdown of these individuals.

Mr. JONES OF NORTH CAROLINA. Please.

[The information referred to can be found in the Appendix on page 89.]

Secretary WOODSON. But the important issue for committee members to recognize is that not every behavioral health specialist is the same, that we have different levels of competencies, from psychiatrists, psychologists, social work, mental health nurses, nurse practitioners. And, really, the job for us, the challenge for us, is using all of those professionals appropriately.

And so the strategy that is being unrolled is to bring in to primary-care practices individuals who can appropriately screen individuals, embed mental health specialists in units where they can appropriately screen, and then save, if you will, our high-end specialists to treat the more complex problems. So it is not only a question of numbers, it is a question of the right distribution of specialists to make sure that we get the job done.

Mr. JONES OF NORTH CAROLINA. Thank you, Chairman.

Mr. WILSON. Thank you, Mr. Jones.

We now proceed to Mr. Loebsack of Iowa.

Mr. LOEBSACK. Thank you, Mr. Chair.

Thanks to all of you for being here today, for your service, and for what you are trying to do to clearly deal with a significant problem within our military. And I think we can all agree that, as was mentioned, that even one suicide is too many. And I appreciate your take on what progress means, what success means, and going forward.

As was mentioned, I think everybody here is all too aware that it is not just the Active Duty folks that we have to be concerned about, but it is the Reserve Components as well. And that was acknowledged, and I very much appreciate that, especially at a time when, I think it was mentioned too, we have a lot of economic problems—unemployment, what have you. A lot of these Reserve folks, these National Guard folks come home, they can't even find a job. Maybe their spouse has been put out of work. They have a lot of family issues.

And what is interesting too, last year, half of the Army National Guard soldiers who committed suicide had never been deployed. So it is not just a deployment issue, although it is that too. In the case of the Iowa National Guard, we just had about 2,800 or so National Guard return from Afghanistan this summer. Many of them had been deployed multiple occasions. But, again, it is not just a deployment issue. I think that is something that we all need to acknowledge.

We also know, as you mentioned, that it is particularly hard to get the Guard and Reserve folks because they don't have a base where they are located, where they would perhaps have access on a regular basis to mental health professionals.

So it is a particular problem when it comes to the Reserve Component, so that is why I introduced my Embedded Mental Health Providers for Reserves Act. And thanks to the chairman and ranking member, we did get that incorporated into the National Defense Authorization Act. And that is designed, of course, to increase access on the part of our Reserve Components to behavioral professionals, whereas they wouldn't have that normally when they don't have a regular base that they are attached to.

But if you would, Dr. Woodson, what is the military doing at the moment to try to reach those Reserve Components, in particular? And are we being successful with that? Is that access available? And are folks, in fact, taking advantage of whatever services there may be?

Secretary WOODSON. Thank you for the question. It is an extraordinarily important one. Our Reserve Component service members

contribute so much to the defense of this Nation, and, clearly, they need not be forgotten in terms of all of their needs.

My answer is along several lines. First of all, we do appropriate post-deployment screening to identify individuals at risk, and referrals are made. So, on the immediate front end, we do everything possible to identify individuals who might need care.

But we know issues like PTSD and other mental health issues don't show up immediately. And, of course, we have transitional assistance medical care. They do get TRICARE benefits for 180 days, and in cases where it is identified as service-connected, it can be extended.

But, more importantly, we partnered with the Department of Veterans Affairs to really open up all of their assets and services, in terms of mental health services, to Reserve Component service members.

Also established within the 54 States and territories are State behavioral health counselors, whose sole job it is to coordinate care for our Reserve Component service members and allow them to get access to care and to be, if you will, staff counselors to commanders to ensure that they have the appropriate programs and access to care.

And then, finally, let me just say we have partnered with the Department of Veterans Affairs to address the issue of Reserve Component service members in rural areas by really enhancing the whole concept of tele-behavioral health. And this is a very interesting concept which will allow via Internet connection for someone who might be in crisis or have a problem to talk directly with a behavioral health specialist and get care. And preliminary results suggest that it is a very acceptable means to provide care.

So, along a number of different lines we are trying to address this very important question.

Mr. LOEBSACK. I appreciate that. I think it really important, too, that CBOCs [community-based outpatient clinic], you know, especially in rural areas like Iowa and other places, those CBOCs provide mental health care, as well. I think that is really critical.

But, again, I want to stress that half of those suicides that happened were for folks who had not been deployed yet. You mentioned post-deployment. I think we have to think about pre-deployment, too. And that is why I think it is important that we do embed mental health professionals or at least make sure that people are aware of the situation prior to deployment when they meet on the weekends when they get together, and their families as well.

Thanks to all of you. I appreciate it.

And thank you, Mr. Chair.

Mr. WILSON. Thank you, Mr. Loebsack. As a former National Guard member, I appreciate your questions.

We now proceed to Dr. Heck of Nevada.

Dr. HECK. Thank you, Mr. Chair, for holding this hearing, and to Mrs. Davis for her continued interest and support on this important issue, and to the panel members for everything you are doing.

This is, especially right now, a bit of a personal issue for me. I just had a soldier recently under my command commit suicide. And this happened—he was actually seen 2 hours earlier by another member of his unit. And both had been through the Army Reserve

suicide-prevention training program. And his colleague did not recognize anything that was out of ordinary, and 2 hours later this other soldier took his own life.

General Woodson—sorry, still calling you "General." As people may remember, Secretary Woodson used to be my rater when he was General Woodson.

I have copies, as I have seen, you know, the PDHA [Post-Deployment Health Assessment] and the PDHRA [Post-Deployment Health Reassessment], which we use for post-deployment assessments and reassessments. And I guess it goes back to the issue of the stigma. And this is self-report. That is how we are doing it, is by self-reporting. And there are a lot of issues with self-reporting, one, because of the stigma, but, two, because a lot of folks know that if they check a box that is what is going to stand between them and getting home or getting back to their unit or getting their leave.

So how are we looking at changing how we actually do these post-deployment assessments so that it is not so reliant on self-reporting when we know there is a lot of barriers to folks being forthcoming on self-reporting?

Secretary WOODSON. Thank you very much, Dr. Heck, for that question.

You know, this is part of the difficulty and challenge of this problem. You can do periodic assessments, but what happens in between those assessments? So one issue is, we need to do them regularly to see if we can pick up individuals who have risk factors and then address them.

But I really think the answer to the question is a very diligent, more robust, concerted, constant effort at educating the broader public, families who come in contact with individuals who might be at risk. Let me give you an example of what I am talking about.

A couple of months ago, I was in my office, and we received a call. And one of my office staff took the call, and it was from a veteran who, on the surface, was inquiring about his pharmacy benefit, but, luckily, the staff member picked up on something that was not quite right and gave me the phone. And I engaged this veteran, who was very agitated and had, sort of, erratic thought.

To make a long story short, this veteran was in another State, in Texas. And I was very concerned about the individual. And we held, collectively, the staff, this individual on the phone until we could get the emergency medical services to this individual. The individual was eventually hospitalized and taken care of.

What am I really saying here? Is that all of us, no matter who we are, need to understand who is at risk, because it is going to be that personal encounter that you are going to pick up on something that will allow you to ask the question, care for the individual, and then escort the individual to treatment. I can't impress upon that enough, because any periodic assessment is going to create gaps.

So I think that what the services have done in terms of raising the awareness, training leadership, training the enlisted officers and leadership, and training peers is so important in trying to address this issue.

Dr. HECK. Thank you.

General Milstead, in your written testimony, you briefly mentioned the pilot program, DSTRESS [Marine Corps 24/7 counselor hotline]. And you mentioned that you are looking at perhaps rolling it out Corps-wide, which would make me think that there have been some indicators of success. Could you briefly talk a little bit about that program that you have done in conjunction with TriWest [Healthcare Alliance]?

General MILSTEAD. Yes, sir. And it kind of goes back to your question about the Reserves. You know, the further you get away from the flagpole, the little more challenging it becomes.

The DSTRESS program was begun with TRICARE West as a pilot program. To date, they say maybe eight saves. But people will call, and it is a by-marine, for-marine. If you do Military OneSource, you are going to have to give your Social Security number. Marines, when we call the number, if we get a social worker or someone, they are going to know it is not a marine. But when there is a marine there or someone that talks marine, then they will open up. It goes back to that social pillar of resiliency.

And we have been able to work on it, and we are indeed looking at expanding that. But we have not yet done that. But we are very, very happy with what we are seeing from that DSTRESS.

Now, what is important to add is that DSTRESS, although it is TRICARE West, they will take a phone call from anybody. If a marine from Camp Lejeune gives them a call, or that area, they are going to talk to him and they are going to deal with him and take care of him.

So, thanks for asking about that because that is going to be a challenge to continue that program fiscally and to expand it. But we are not about to lose the momentum that we have seen in it.

Dr. HECK. Well, thank you. And I believe that that reinforces what Secretary Woodson talked about with the one-on-one connection as opposed to just looking at a computerized, generated form. So thank you very much.

Thank you, Mr. Chairman. I yield back.

Mr. WILSON. Thank you, Dr. Heck.

We now proceed, Ms. Tsongas of Massachusetts.

Ms. TSONGAS. Thank you, Chairman Wilson.

And thank you all for being here and the extraordinary work you are doing to address this issue. We all know how very challenging it is.

And we have been hearing some of the conversations about how to minimize the stigma associated with the seeking out help. And this summer, as we were back in our districts, I had the opportunity to meet with a young man who had just returned from Afghanistan. He was an extraordinary young man. I was so impressed by him. And his task had been to be the driver in the lead of the convoy whose job it was to go out and find IEDs [improvised explosive devices]. And so, as he had come back, he recognized he needed to get some help, that he was suffering from post-traumatic stress disorder. And he alluded to it, he said, you know, I know there is sort of still a stigma associated with it, but he recognized that he really did need to get some help.

And just a quick story he told me was that because in that role he played his task was to drive very, very slowly, and as he was

back in the civilian world out driving his family's car, he was stopped by a police officer, not because he was driving too fast, but because he was driving too slow.

So it does take time for our young troops to come back and reintegrate and, sort of, absorb the fact that they are now in a very different environment. And I appreciate all of the work that you are doing to help them in that transition and to hopefully transition to a very safe place for them and for their families.

But I wanted to ask a slightly different question. Secretary Woodson, in your written testimony, you have spoken about the importance of data collection through the Department of Defense Suicide Event Report system and how that data collection system helps the DOD [Department of Defense] target prevention strategies. And we have heard questions around just how important it is that we have real facts to sort of assess the work that you all are doing.

But is the DOD currently collecting data on suicides among female service members? If it is, what are the findings? And is the DOD currently looking at a causal relationship between military sexual trauma and suicide? Because we do know—and it is another issue that this committee has had to deal with—the extraordinary prevalence of military sexual trauma.

A study conducted by a researcher at Portland State University that was published in December 2010 found that female veterans, age 18 to 34, are 3 times as likely as their civilian peers to die by suicide. And we have anecdotal evidence of a number of suicide attempts that are related to military sexual trauma. As we are too painfully aware and as we often discuss here, as many as one in three women leaving military service report that they have experienced some form of military sexual trauma. In the civilian world, victims of sexual assault are four times as likely to contemplate suicide than people who have not experienced this kind of trauma.

So, again, my question, in the context of data collection, are you looking at the prevalence of suicide among female veterans for service members and any causal relationship between being a survivor of military sexual trauma and suicide?

Secretary WOODSON. Thank you for that important question. And the answer is "yes." We would hope, as the database matures, that we will be able to dissect out a number of different demographics and subgroups.

As you know, there is a separate effort to look at the whole strategy about sexual assaults in the military. We do know that mental health problems arise at a much higher frequency in individuals who have experienced sexual abuse or sexual assault. And so we have redoubled our effort to make available to these individuals mental health counselors so that they can get the type of care that they need and assessed for their risk of suicide.

To date—and I will take for the record—I have not heard of any directly related death by suicide as a result of sexual assault. But, as I said, I will take for the record to ensure that I am speaking true facts. But let me just say that we consider this a very important set of issues and will be examining this problem, as well.

[The information referred to can be found in the Appendix on page 89.]

Ms. TSONGAS. But by gender you are not collecting data separately to, sort of, track the prevalence of—you know, the numbers, the men who are committing suicide versus the numbers of women?

Secretary WOODSON. Oh, yes.

Ms. TSONGAS. You are?

Secretary WOODSON. Yes.

Ms. TSONGAS. You are. So you are segregating the information by gender.

Secretary WOODSON. Yes.

Ms. TSONGAS. I would be interested to get a report on how that breaks down.

Secretary WOODSON. Sure.

Ms. TSONGAS. Thank you.

Secretary WOODSON. Absolutely.

[The information referred to can be found in the Appendix on page 89.]

Mr. WILSON. Thank you, Ms. Tsongas.

We now proceed to Colonel West of Florida.

Mr. WEST. Thank you, Mr. Chairman, and also, Ranking Member.

And thanks to the panel for being here today.

And I will kind of dovetail off of what my colleague Ms. Tsongas was talking about. I would like to look at, you know, some trend analysis here. Because as we sit down and look at some of these years, it seems that 2009, 2010, we definitely saw a little bit of a spike.

So my first question would be, did we go back and maybe look at those years and maybe do an overlay with some previous combat operations, be it World War II, Korea, Vietnam, to look and see if there is some type of trend, some type of cultural, generational things that we could learn lessons learned from there?

And then the second part of the question I would like to ask is, are we seeing a correlation between the length of combat tours and also the repetitiveness of combat tours? As well, do we see any trends with any certain MOSs [military occupational specialty] or certain units so that—I think it is so important, when we talk about these programs, maybe if we can identify certain types of trends, we can focus our resources to where we see a prevalence of these type of things occurring so that—you know, it is the difference between precision-guided munitions and carpet bombing. I guess that is what I am trying to get at.

So those are my two questions, looking at trend analysis across our services as they deal with this problem.

General JONES. Since you used an Air Force analogy, sir, I will jump in with that one.

Sir, we have looked at our career fields to see which ones are more susceptible. And, obviously, we have discovered that our security forces, our aircraft maintenance, and our intelligence career fields have a higher incidence of suicide.

To counter that, we have done specific supervisor training in those career fields. Because as we have all said, it is the person who is looking them in the eye. This is a leadership issue, not a medical issue, not a personnel issue, and the person who sees them

every day at the officer level, at the NCO level, that has to look for what RAND describes is that trigger event. We all know the things that contribute to suicide—the legal problems, mental problems, alcohol abuse, things like that—but there is usually a trigger event that is overlooked when we go back to do an analysis of a suicide event.

In the Air Force—I know it differs by service—it is not related to deployment, ironically. In fact, 68 percent of everyone in the Air Force who has committed suicide has never deployed. And of those who actually—of the small number who actually do commit suicide, only 10 percent of that small number were deployed in the last 6 months. And so, really, we can't find the direct causal relationship there.

But we continue to look. The data has to be analyzed and read over and pored over, over, and over again. But we are trying to focus, in our service, on those career fields that tend to have a higher incidence. And I can tell you, specifically in security forces, they are paying great attention to this on the individual basis.

General MILSTEAD. We, too, sir, have taken a look at this and gone back through a forensic psychological autopsy, if you would, to look back. And to kind of dovetail on what my brother said, it is interesting: Only 3 of the past 100 suicides have any issue—hint of an issue with PTS. And in '08 and '09, which were our peak years for our suicides, less than 20 percent of those had ever seen combat.

So it is almost counterintuitive here. Again, it goes back to, as we were talking about, we don't know what we don't know. And there are still these dots out there that we are trying to connect, and we are working pretty hard.

General BOSTICK. The Army has also done a lot of deep analysis on the trends. And as we have talked about before, this is very complex. There is not one solution; there is not one type of person that you can say is going to commit suicide. Ninety-seven percent are males that commit suicide. Most of them are Caucasian. Most of them are in the range of 17 to 25.

In previous years, we thought that, up until this year, that if you had one deployment—no deployments or one deployment, you were highly at risk. For example, in 2009, about 76 percent of those that committed suicide had one deployment. That is starting to change. This year, we are seeing those with multiple deployments starting to—that number, for the first time, is starting to increase. It is early. We don't know why that is happening, but we are looking at it very closely.

But for us, it is the stressors: the work-related, financial and legal, and failed relationships. Those are the primary areas where much of the stress on individuals is focused and where we place a lot of our attention.

Admiral KURTA. And, Congressman, I would just add, much like the Air Force, we do not see a causal relationship between the deployments and our suicide rate.

I will say, though, that we have had seen a general correlation that after periods of great drawdown in the force, particularly in the Navy, the next year we often see a spike in our suicide rate. So we have seen that three times over the past 20 years. So it

makes us remain ever-vigilant as we go into a period now here of potential end-strength reductions. But that is one of the factors that we have identified.

Secretary WOODSON. Just one quick comment on the first part of your question, about the historical comparisons. It is hard to do, simply because our thinking about mental health issues in the Second World War and Vietnam were so dramatically different. Remember, PTSD was defined really after Vietnam and given—and codified. And the criteria for making that diagnosis really came after that conflict.

So, to be able to compare—and, culturally, we were in a different place in even recognizing and giving credence to this very important problem. So I don't know that we can make accurate historical comparisons that will help us in this effort.

Mr. WEST. Thank you very much, panel.

And thank you, Mr. Chairman. I yield back.

Mr. WILSON. Thank you very much, Colonel.

And we now proceed to Ms. Pingree of Maine.

Ms. PINGREE. Thank you very much, Mr. Chair.

Thank you to the entire panel. We, I think, all appreciate your sensitivity and hard work on what is an excruciatingly sad issue. I think sometimes it is hard to picture that we are here talking about military suicide, those very people who served the country feeling so desperate about their own lives. And I appreciate, on the other hand, that we are here to talk about it and the work that you have done, as you say, to reduce the stigma, bring it out in the open, and try a whole variety of programs to make it work better. And I am impressed with both my colleagues' questions but also all the things that you have brought forward today.

One thing I wanted to ask a little bit about—we are often talking about the individual, themselves, who chooses or considers committing suicide, but I am interested in the families and the spouses. I know that many times it is the spouse who sees the red flags who wants to reach out for help. And I am interested—I know there are probably a lot of privacy concerns, but what is the protocol when a spouse contacts a service member's chain of command with those kinds of warnings? And how are you dealing with that side of it?

To anyone; I am interested in anyone.

General BOSTICK. One of the things we have really learned over the last 10 years of war is that we are successful because of our families. We have always known that, but the strength of the Army is our soldier, the strength of our soldiers is their families. So we have wrapped our arms around our families during Family Readiness Groups and throughout their deployments.

And there is not a chain of command in the Family Readiness Group, but there is a partnership and the sharing of information and a knowledge that you can go to your leaders either within that Family Readiness Group or you can seek out help through the chain of command, and the chain of command would be more than happy and more than willing to assist.

We have also asked through a buddy system that our young soldiers, who really know their friends the best, that when they see something, that they ask about the challenges that may be there and that they care for them, they escort them to where they need

help. So there are multiple venues where spouses have the opportunity to engage.

The last thing I would say is, as I talked about before, one of the high stressors is failed relationships. And the program that we have with Strong Bonds, led by our chaplains, and bringing in—in a retreat-type format—bringing in those families that wish to talk about things that are ongoing, that is another venue where they can go and feel no obligation, no concern about risk to their spouse's career and talk openly about what is happening.

General MILSTEAD. We, too, are concerned about the families. There is a dual-edged piece to this. You know, we are a Corps of 202,000, but we have about 207,000, 208,000 dependants, we have 90,000 spouses. So what do we do for the spouses? I mean, it is more than just, how does the spouse recognize something with her husband or his wife and report it to the chain of command? But what about that spouse that is bearing some of that burden of multiple deployments?

So we, too, are looking at this. We are expanding programs. And the family readiness is the centerpiece of our efforts at this time.

Secretary WOODSON. I appreciate your question, and I am going to take a little bit of a different spin because my colleagues have so directly addressed the issue of the spouse recognizing symptoms in the service member. But, as was just said, there is an important issue in terms of the stress of the family, and we understand that there is increased stress in the spouses and children.

What I would like to say is that we have recognized this and that we have enhanced the ability for spouses to get mental health care and counseling, as well as children to get mental health care and counseling.

Now, one of the challenges in society is, in particular, finding enough pediatric mental health counselors, but we have expended every effort to ensure that the network has those available for children, as well.

Ms. PINGREE. Well, thank you for your answers. I do think—I appreciate that you are looking at it from this side. We certainly hear about that, that spouses and families are an important place for early warning. And also reducing the stigma with families, which I think you are talking about, making it possible for them to talk about it, is also critically important.

I have run out of time, so I will end. But thank you, Mr. Chair, and thank you, to the panel.

Mr. WILSON. Thank you, Ms. Pingree.

We now proceed to Mr. Coffman of Colorado.

Mr. COFFMAN. Thank you, Mr. Chairman.

Let me go over a number of points, and if somebody could address them when I raise a question.

First of all, I think that suicide in the military is a failure of small unit leaders really at the noncommissioned officer level. And so I think that everything has to be done to make sure that the NCOs at the fireteam level, at the squad-leader level, or whatever the equivalent in the respective branch of service is for that position, feels responsible for those under their leadership.

Secondly, I think it is important that we preserve deployments as units and never revert back to individuals being deployed, as

was done in Vietnam, where I don't think you develop that unit cohesion. And I think unit cohesion is essential to reducing suicides.

I think that what the military has done in terms of decompression from members who have been deployed before they return home to their families or before they revert to a Reserve status, again united with their families, I think is very important. And I think we have gone a long ways in doing that. I want to encourage that.

I was in Marine Corps Light Armored Reconnaissance in the first gulf war. A lot of stress in the buildup to the ground war in anticipating casualties at a level that did not occur, fortunately. But strong, interdependent bonds are built, certainly in ground combat units and I suspect in other components, as well. And then, all of a sudden, I was released back as a civilian. And so it took 72 hours, literally, to process us out. Once I hit the ground in North Carolina to being home in Colorado was about 72 hours. That is way too—you know, that is way too fast. And I think that we know better, in terms of doing that, now.

I understand that the United States Army has gone forward with some innovative programs in terms of having collateral assignments, I think even down to the small unit level, of folks that are trained in terms of stress management, if I understand that correctly. And I would like to know if the Marine Corps, in terms of its ground combat units, has done the same. If you could comment on that.

Post-traumatic stress disorder, we have to elevate it to the status of a wound. And we don't. In any other wound, we require treatment and we do everything we can to mitigate that wound before we release that individual. And we need to—and we don't do that in post-traumatic stress disorder, it is my understanding. We need to do that. And I would love to have somebody comment on that.

I think that, having also served in Iraq with the United States Marine Corps in 2005–2006, when I look back between the first gulf war and the Iraq war, I think a big difference is, in the Iraq war, you could go out on patrol in the day, come back to whether it is a forward operating base or a major base camp and have access to electronic communications in realtime with your family. And I think in the first Gulf war, we just checked out. I think people that went to Vietnam checked out. They didn't have that access. And so, they departed the pattern, went off to war, only communicated by snail mail.

But I think the notion of communications in realtime is a stressor, in and of itself. I mean, obviously, we want that to occur, but now they are dealing with problems at home and they are dealing with the problems of being in a combat environment. And I think the confluence of those things is tough on people.

And so I have raised some issues and some questions, and take it away.

General MILSTEAD. Well, I will answer the first one, Congressman.

We do have an embedded program. We are very proud of it. It is called OSCAR. And this is our Operational Stress Control and Readiness program. And we have three tiers to this OSCAR. The first are the providers. These are the mental-health-care special-

ists. And we have them at the division and down at the regimental level. Then our next one is we have what we call the extenders. And these are Corpsmen and other professional health care, as well as our chaplains. And they receive some training. And then we have what we call the mentors. And we have approximately 75 mentors per unit.

And this is battalion level, battalion/squadron level, but right now it is focused on the battalions. And so we have embedded this in these forward units that are forward deployed so that they can ask for help and so that they can receive that quick referral while they are forward deployed and still dancing with the dragon, if you will.

Your other point about NCO leadership, I think you are spot-on. And that is why we did our Never Leave a Marine Behind program. We began our peer-to-peer suicide prevention bystander intervention-type training with the NCO program, focused on the NCO.

I think it was in 2009, on our peak of our suicides, that we were having an Executive Force Preservation Board, and the NCOs that were represented there said, "Give us this problem. Let us take this on." And we gave it to them, as I mentioned in my statement, and we have seen some benefits.

So I hope that answers your two questions. We are embedded, and we are embedded forward, and we have seen some fruit.

General BOSTICK. The only thing I would add is that our noncommissioned officer corps is the backbone of our Army. I mean, they carry the heavy load in our Army each and every day. And when there is a suicide, it is all of us—officers, the noncommissioned officers, the civilians, the families—we all hurt and we all feel terrible about it.

But to your point, we understand the importance of leadership and frontline leadership. Some of the second- and third-order effects that we are feeling from our own rotation process, the strength of rotating units is very sound. And then when you bring those units back and you have to break them apart to get the next units ready, that lack of leadership and knowledge and transition of that individual soldier that was on a hilltop in Afghanistan under all types of stress and not having the same noncommissioned officer there in the next year when he moves to his next unit or when he goes to a school, sometimes there is a breakdown there.

And that is what we are trying to get after. How do we identify, within the HIPAA [Health Insurance and Portability and Accountability Act] laws and all the requirements, to manage that individual's personal well-being but also let leaders and behavioral health specialists where he is going know the challenges and stresses that he is under?

Mr. WILSON. Thank you, Mr. Coffman.

We now proceed to Ms. Hartzler of Missouri.

Mrs. HARTZLER. Thank you, Mr. Chairman.

Thank you, each of you, for being here today and all that you are doing on this very, very important topic.

It is just tragic to look at your testimony and to see the numbers that you are, you know, sharing. In 2010, 37 marines died. In 2010, 39, Navy; 56, Air Force; 300, Army. Those are, you know, soldiers,

those are fathers, those are husbands, those are sons, those are husbands, those are wives, and it just is tragic. And so we want to do everything we can in Congress to support you and to help you in these efforts.

And I know that you have a lot of prevention efforts that you are trying to do. And I wondered, what processes are in place to evaluate the success of the prevention programs that you have tried to implement? And have you done away with some that you have found are not successful? Are you moving forward with some others that are more successful? What is working and what isn't? And what evaluation processes are in place with the programs that you are attempting to do?

General BOSTICK. Let me take on a couple of those.

First, the answer to your question, it is very, very difficult to assess the effectiveness of the programs. I think some are very early; some we are still in the progress of piloting. And because it is not one-solution-fits-all, we really need to come at this at multiple levels from multiple directions. It is very, very complex.

Let me take an area, alcohol and substance abuse, which sometimes is involved in some of the suicides. And what we have done there is to make sure that we have a solid alcohol/substance abuse program, that we also have a confidential alcohol treatment education program. What we found is, if you have an alcohol problem, you probably don't want to run to your squad leader and tell him about it. So we have tried in three locations, and now we have piloted in six locations, where you can come in and confidentially say, "I have an issue with alcohol, and I would like some help," and we work with those individuals.

We believe that we have to continue to work these programs and, over time, decide which ones are working and which ones are not. We are finding some great success in the virtual world with telebehavioral health, as Dr. Woodson said, and virtual behavioral health, where we are able to allow the individual to talk virtually to some of these behavioral health specialists and have the privacy but get the care that they need.

But the bottom line is, these are complex problems. There is no simple solution. And we need to move on a broad front to try to tackle these.

Mrs. HARTZLER. Uh-huh.

Go ahead.

General MILSTEAD. I would echo that. We have integrated our behavioral health efforts. We have put our Combat Operational Stress—to go back to your question, ma'am, our Sexual Assault Prevention and Response is now a part of that. We have wrapped in the substance abuse. Many times, we see that there are multiple of these involved in this complex issue, and so we have wrapped them and put them under an umbrella of our integrated behavioral health.

Again, it is an extremely complex issue, and we have to continue to kick over rocks and look at successes and where we have done better and where we haven't done better and continue to morph this program. And even when you do get to zero, zero, zero attempts and zero suicides, there are still—you got to keep going, because now you are into the maintaining.

Mrs. HARTZLER. Right.

Just very quickly, I was wondering, with the families and the stresses that they are undergoing, are there any statistics on suicides within the military family community?

Secretary WOODSON. So, we have very little data on that. And part of the issue is that the family members are not subject to the same scrutiny that the service members are. And we are looking for ways to sensitively, in a sensitive way, get at that so that we can provide assistance. But it is different; they have other rights and protections that we need to be aware of.

Mrs. HARTZLER. Thank you for all your efforts.

Thank you, Mr. Chairman.

Mr. WILSON. Thank you, Ms. Hartzler.

And at this time I am going to be turning the gavel over to Mr. Coffman. As I leave, I want to thank the panel, I want to thank the subcommittee members. They have all been so dedicated on this issue, particularly Ms. Davis.

And I know that we have also been very appreciative of DOD and VA [Department of Veterans Affairs] personnel for what they have done. A volunteer organization in my home community is Hidden Wounds, established by Anna Bigham in memory of her brother, Lance Corporal Mills Bigham, who passed away. So we have seen what can be done.

I am departing to go to the funeral at Arlington of Colonel Charles P. Murray, Jr., a recipient of the Medal of Honor, a great American hero of World War II, Korea, Vietnam.

We now proceed to Mr. Coffman, who will recognize Mr. Scott.

Mr. COFFMAN. [Presiding.] Mr. Scott of Georgia, 5 minutes.

Mr. SCOTT. Thank you, Mr. Chairman.

Gentlemen, most of my questions have been answered. I again want to thank you for the work you have done here.

General Bostick, you gave a lot of the statistics about who it is where we have the highest rates. And my question would then focus on statistics of when. Is there a month that stands out where we have the most suicides where maybe we should turn up the prevention? Is it the first of the month, the middle of the month, the last of the month where we see that? Do we have the statistics on when it is happening, and are we working to turn up the prevention based on those statistics?

General BOSTICK. Yes, Congressman, we have taken a very close look at that, as well.

And the other thing we find is transitions—anywhere in life and in the Army, transitions can be a very difficult time. And, up until last year, those soldiers that were one-time deployers and coming back to a unit, so they enlisted in the Army, went to their first unit, deployed, came back to their unit, that that period when that unit was breaking apart after going through a deployment together, that was a high-risk period for us.

We know months where it is traditionally high.

We also know that another period that we have to watch is when a unit deploys and a new soldier is assigned to that unit but has not yet deployed, that soldier is now—the welcome and the entrance into the traditions of the Army and all of the chain of command that he is going to have when he deploys may not be as

strong as when the unit is there. So we are making sure that how we welcome soldiers into units that have already deployed, that that is sound.

But it is any time that we are transitioning. Those periods of transition are very important for us to focus on.

As I said in my opening comments, we are now seeing a higher number of the multiple deployers. And this is very recent, in 2011, where those that have been on two, three, and four deployments, the numbers of suicides, which had been low in the past, have more than doubled this year.

Mr. SCOTT. Thank you.

Mr. COFFMAN. Ms. Chu of California for 5 minutes.

Ms. CHU. Thank you.

I want to tell you about something that happened in April of this year. Lance Corporal Harry Lew was moved to a unit in his first tour in Afghanistan and sent to Helmand province. Eleven days after transfer, he was found asleep on watch. It had happened before in those 11 days. And his fellow marines believed he let them down, and they let him know it.

At 11:30 p.m., the sergeant called for peers to correct peers. At 12:01 a.m., Lance Corporal Lew was beaten, berated, and forced to perform rigorous exercise. He was forced to do pushups and leg lifts wearing full-body armor, and sand was poured in his mouth. He was forced to dig a hole for hours. He was kicked, punched, and stomped on. And it did not stop until 3:20 a.m.

At 3:43 a.m., Lance Corporal Lew climbed into the foxhole that he had just dug and shot himself and committed suicide.

Lance Corporal Lew was my nephew. He was 21 years old. And he was looking forward to returning home after 3 months. He was a very popular and outgoing young man known for joking and smiling and breakdancing.

But he wasn't the only soldier that this happened to. And, in fact, in June, *Stars and Stripes* shared the story of Army Specialist Brushaun Anderson, who was severely hazed and mistreated by his superior officers on a remote base in Iraq. They said that he was dirty, that he performed poorly, and they made him wear a plastic trash bag and made him perform physical exercise in his body armor over and over again and made him build a sandbag wall that served no military purpose.

In 2009, Army soldier Keiffer Wilhelm shot himself in a portable toilet after being accused of being overweight and forced to perform excessive physical exercise while his superiors showered him with verbal abuse.

Your data shows that 40 percent of the individuals who committed suicide last year were involved in a legal or disciplinary problem in the year before they died.

I would like to know, for each service, is hazing expressly prohibited under your regulations? How are you actually preventing suicide from hazing? And in each of these cases, superior officers were involved. What are you doing to actually enforce the regulations pertaining to hazing with superior officers?

General MILSTEAD. Yes, ma'am. This is unfortunate. Hazing, to use the term that you have used, is inconsistent with the Marine Corps core values. It is expressly prohibited, and by regulation.

And when found, it is investigated. And where substantiated, it will be dealt with appropriately. We don't condone hazing in the United States Marine Corps.

Ms. CHU. Dr. Woodson, what is actually being done about the—well, first of all, I would like to know whether, for each service, whether you know hazing is expressly prohibited and what is actually being done about it.

General BOSTICK. I can say, for the Army, hazing is specifically prohibited. It is written clearly in our regulations that it is prohibited. And if it occurs, then we take the appropriate actions based on investigations that we hold commanders accountable for executing.

But we expect soldiers to treat each other with dignity and respect and adhere to the Army values, and that is the bottom line. And if they don't, then we will investigate and take appropriate actions.

Admiral KURTA. And, Congresswoman, for the Navy, as with the other services, hazing is not consistent with our core values and is definitely expressly prohibited. And, again, like the other services, when actions of hazing come to light, we take very strong and proactive action to bring all of those involved to justice.

General JONES. Congresswoman, first off, we are very sorry for your loss. And I promise you that, from the Air Force standpoint, that we do not condone hazing. We have regulations against it.

And having been a commander five different times, including command of the Air Force's Lackland Air Force Base's 37th Training Wing, where we do all basic training for the Air Force, we watch for things like that. Whenever we have someone who is in subordinate position and, obviously, superiors, like military training instructors, instructors of tech training, we watch for that very carefully. And when someone does get out of line, we take swift action. It is inconsistent with our core values, and we do not tolerate it.

Secretary WOODSON. I, too, want to express great sorrow for your loss and state affirmatively that hazing is inconsistent with Department of Defense policy.

It is also clear that the uniformed services, each of the services, have the UCMJ [Uniform Code of Military Justice] responsibilities. And so we want to assure that we enforce the policies of carrying out the appropriate investigations, but it is each of the service's responsibilities to conduct those investigations and apply UCMJ as appropriate.

Mr. COFFMAN. Ms. Davis of California.

Mrs. DAVIS. Mr. Chairman, thank you. I know that the votes are going, and so I know that we need to stop.

I think the concern that we would all have, of course, is that the reports that are done on all the suicides that occur within the services are done in a comprehensive manner so that we have a good understanding and the ability to go back and really understand what is going on when those times of transition occur and how that impacts those; what role, if any, the military plays obviously in the tragic story that my colleague has shared, and that we are certain that everything is done as properly and the investigations go forward.

So I think that this is certainly a difficult topic, as we all talked about. I had a few more questions, but I know that we will be back again.

And I just want to thank you all, as I know my colleagues have all done, because as we began over the last number of years in first Iraq and Afghanistan, we know that this issue has escalated and is difficult. It involves families, great sacrifices on the part of those families. And we want to be certain that we are doing all within our power, I think, to understand it as best we can and make certain, as has been stated, that we are down to zero. That would be certainly something that we would hope we could look forward to in the future.

So thank you very much. I appreciate it.

Mr. COFFMAN. Secretary Woodson, I am wondering if there is one question you could get back to me on the record with on a related behavioral health issue, and that is on post-traumatic stress disorder.

And it is my understanding that when someone self-reports post-traumatic stress disorder and they are placed in a Warrior Transition Unit for potential out-processing that there is no mandatory requirement for treatment. And I am wondering if you could confirm that back to the committee in writing.

Again, I believe we ought to elevate post-traumatic stress disorder up to a wound and that we ought to make every effort to treat folks before they are released from Active Duty.

Secretary WOODSON. Yes, sir.

[The information referred to can be found in the Appendix on page 89.]

Mr. COFFMAN. Thank you.

And the committee is adjourned.

[Whereupon, at 10:35 a.m., the subcommittee was adjourned.]

A P P E N D I X

September 9, 2011

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

SEPTEMBER 9, 2011

Statement of Hon. Joe Wilson

Chairman, House Subcommittee on Military Personnel

Hearing on

The Current Status of Suicide Prevention Programs

in the Military

September 9, 2011

Today the Subcommittee meets to hear testimony on the efforts by the Department of Defense and the military services to prevent suicide by service members, family members and civilian employees.

I want to preface my statement by recognizing the tremendous work the Department of Defense and the service leadership has done to respond to the disturbing trend of suicide in our Armed Forces. I understand this has not been an easy task and I thank you for your hard work. I particularly see military service as an opportunity to be all you can be and I want service members to know they are talented people who are important and appreciated by the American people. They can overcome challenges.

I am also grateful for Ranking Member Susan Davis's work she did as Chairman of the Military Personnel Subcommittee to bring attention to psychological stress in the Military and the behavioral health needs of service members.

With that said, clearly there is more work to be done.

Suicide is a difficult topic to discuss. Every suicide is a tragedy but suicide by members of our military is even more difficult because they have given so much to this Nation. Ultimately, it is an individual decision to take one's own life. But we must make sure every opportunity to redirect or change that decision is available before it's too late.

Suicide is a multifaceted phenomenon that is not unique to the military. Unfortunately, in addition to the unique hardships of military service, our service members are subject to the same pressures that plague the rest of society today. They are exposed to the same stressors, such as the current unemployment and economic situation that may lead to suicide by their civilian counterparts. I am very concerned these stressors will only get worse in the coming months as debate regarding cuts to the Defense Department budget intensifies.

Each of the military services and the Department of Defense has adopted strategies to reduce suicide by our troops. I would like to hear from our witnesses whether those strategies are working. What are your benchmarks for success? How do you determine whether your programs incorporate the latest research and infor-

mation on suicide prevention? I am also interested to know how Congress can further help and support your efforts.

Statement of Hon. Susan A. Davis

Ranking Member, House Subcommittee on Military Personnel

Hearing on

The Current Status of Suicide Prevention Programs

in the Military

September 9, 2011

I am pleased that the subcommittee is maintaining its attention on suicides in the military. Over the past several years, as we have seen the number of suicides by service members grow, the subcommittee has been forward-leaning in attempting to support the Services and the Department of Defense in their efforts to develop a strategy to reduce and prevent suicides in the force.

Suicide in the military has been a focal point for the subcommittee, but we are not the only ones focused on this issue. In 2007, suicide was the third leading cause of death for young people ages 15 to 24, while our forces shares this demographic, it is important that we share what we learn and what is learned by others if our country is to be successful in addressing this societal issue.

The subcommittee's efforts have included the establishment of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces in the Duncan Hunter National Defense Authorization Act of Fiscal Year 2009. The task force, comprised of fourteen individuals—civilians and military—with expertise in national suicide prevention policy, military personnel policy, research in the field of suicide prevention, clinical care in mental health and other similar backgrounds, submitted their final report in August 2010. There were 76 recommendations made by the task force, the majority of which were directed at the Department of Defense and the Services. I am interested in learning from the Department and the Services on where they are in implementing many of these recommendations.

Let me welcome our witnesses. I look forward to hearing from them on where we are in our efforts.

STATEMENT
BY

THE HONORABLE JONATHAN WOODSON, M.D.
ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

REGARDING

MILITARY SUICIDE: AN UPDATE

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
MILITARY PERSONNEL SUBCOMMITTEE

SEPTEMBER 9, 2011

Mr. Chairman, Ranking Member Davis, and distinguished members of the subcommittee, I thank you for the opportunity to provide you with an update on the Department's efforts to prevent suicides in the Armed Forces.

Over the past ten years of war, the rate of suicide among members of the Armed Forces has steadily increased. The deaths of these brave men and women who volunteered to protect their country are a great loss not only to their families and friends, but to each and every one of us.

As a nation, we have struggled to find solutions and strategies to prevent suicide. We have identified risk factors and factors that appear to protect an individual from suicide. We have a National Strategy for Suicide Prevention and dedicated state and federal programs to reduce the civilian rate. If suicide were simply a matter of providing more mental health programs and medications for depression, suicide rates would be much lower. In order to prevent suicides, the complexity of behaviors and drivers of those behaviors need to be understood and addressed in a comprehensive or holistic approach – particularly for members of our Armed Forces.

The Department of Defense (DoD) has long been aware of the particular tragedy of suicide among members of the Armed Forces, and the Services have implemented programs and strategies to address the issue. Historically, suicide rates among Service members were lower than rates in the civilian population for comparable years. Unfortunately, reporting of civilian data lags military data by several years, so it is difficult to compare current military and civilian suicide rates. Regardless, any suicide is a tragedy, so we are greatly concerned.

This concern has resulted in action on several fronts. One of these efforts was the recent DoD Task Force on the Prevention of Suicide by Members of the Armed Forces. Their report, released last year, provided the Department with a careful analysis of our current efforts and thoughtful recommendations for improvement. The Deputy Assistant Secretary of Defense for Readiness is leading the review of these recommendations with a multi-disciplinary working group and a General Officer Steering Committee. Their collective work provided an initial response to Congress in March 2011 regarding the thirteen foundational recommendations. This group is currently finalizing a second response to Congress, due in September 2011, regarding the remaining 76 targeted recommendations.

One of the Task Force's foundational recommendations called for a Department-wide strategic approach to suicide prevention. In response to this recommendation and in recognition that solving the military suicide problem requires a cross-cutting approach, the Under Secretary of Defense for Personnel and Readiness (P&R) established a DoD Suicide Prevention Oversight Council under the leadership of his Principal Deputy. Composed of leaders from the military services, the Joint Chiefs of Staff, and every office within Personnel and Readiness, this Council will provide governance and oversight of policies and programs to focus, synchronize, and strengthen our collective suicide prevention efforts. The Council will not only ensure that the Task Force recommendations are implemented, but that the ongoing and current efforts to prevent suicide result in the change we all want and need – a decrease in suicide among members of the Armed Forces.

The leaders, comprising the Council, will act collectively, to integrate the committees, task forces, and work groups focused on suicide prevention. The Suicide Prevention and Risk Reduction Committee (SPARRC), which was established in 1999, and any future suicide-focused task forces will report directly to the Council.

Any successful strategy for preventing suicide must address the interrelated elements of risk and resilience along with specific characteristics of the at risk population. This requires collecting and analyzing standardized data. The Services have been collecting and analyzing their own suicide data for years. In 2007, the Department invested in a surveillance system to capture these data centrally in a more standardized way. This system, the DoD Suicide Event Report (DoDSER) application, provides data that improves our understanding of suicide behaviors among military personnel and helps us target prevention strategies. We continue to work on improving our data collection efforts and are actively engaged with the Department of Veterans Affairs (VA) in those efforts.

As we know from the National Strategy for Suicide Prevention, effective, accessible, and supportive clinical care for mental, physical, and substance use disorders are protective factors in preventing suicides. We also know that access to care is just one facet in a comprehensive strategy. Many of the clinical initiatives I will now discuss are also reflected in the insightful and comprehensive recommendations of the Task Force, specifically in the area of access to high quality care.

Access to care means we will have enough providers and programs to address the specific health-related behaviors that we know are associated with increased risk of suicide. Last year, my office developed a sophisticated statistical model to determine the number of mental health providers needed to meet the utilization of mental health services by active duty Service members. The Services have additional models to project their needs for mental health providers. Despite the models, our ability to find and hire these providers has proved to be difficult. Consequently, modest shortages exist within particular specialties and within particular Services, so we are continuing our recruitment and retention incentive policies to help resolve the shortages.

We know that providing early mental health support is critical. As a result, many of our mental health providers are in theater providing Combat and Operational Stress Control (COSC) prevention and treatment to our forward-deployed units. We have also updated DoD policy regarding early detection and intervention for combat and operational stress reactions in the deployed setting.

Of course when we deploy our mental health providers, we create gaps at home. In order to address this issue, we entered into a Memorandum of Agreement (MOA) with the Department of Health and Human Services for up to 215 mental health providers from the U.S. Public Health Service Commissioned Corps. Currently, U.S. Public Health Service has provided approximately 160 Commissioned Corps officers to meet our shortfall of mental health professionals in garrison. In addition, we have worked closely with the Substance Abuse and Mental Health Services Administration (SAMHSA) to promote adequate community-based treatment and support for members of the National Guard and Reserve. Eighteen States and

Territories have engaged in SAMHSA's Policy Academies and subsequently established interagency teams and developed strategic plans to support mental health systems serving Service members, Veterans, and their Families.

The Services are also integrating mental health providers into the primary care patient centered medical home initiative. To assist with this effort, we have provided additional funding for 429 new primary care mental health positions. The goal is to provide at least one mental health provider in every direct-care primary care clinic with 1500 or more enrollees.

Just providing sufficient mental health providers and programs is not enough. Awareness of who is at risk is vital. All Services have interdisciplinary treatment plans requirements and processes in place for Service members at risk for suicidal behavior. A new DoD Instruction, currently in coordination, will help ensure that command leadership is brought into the process at the appropriate time. Field testing is complete on the behavioral health component of DoD's electronic health record, AHLTA, with implementation scheduled for later this year. This system will allow any provider to enter a "Behavioral Health Alert" that designates a patient as either a danger to self or a danger to others. Once the Alert is put in the system, AHLTA users will see the alert when the patient's record is reviewed, and all providers will be able to see the treatment plan established by the mental health provider.

The Task Force recommendations to coordinate care plans and manage care during transitions are currently addressed through the Team Strategies and Tools to Enhance Performance and Patient Safety (STEPPS) program and the Joint Commission's requirement for communication during transitions of care. In addition, we have implemented the *inTransition* Program to bridge the gap between the time a referring provider terminates behavioral health care with a Service member to when the gaining provider initiates contact. This program is sponsored and promoted by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) and will be incorporated into the DCoE's Outreach Call Center.

The Task Force report emphasized implementation of evidence-based approaches to suicide prevention. A joint VA/DoD Clinical Practice Guideline (CPG) for the Assessment and Management of Suicidal Behaviors is under development by the VA/DoD CPG committee's panel of subject matter experts. This guideline will provide clinicians with evidence-based or evidence-informed guidance on the assessment and management of an individual with suicidal ideation.

In additional to this effort, DoD and VA have had additional longstanding partnerships to improve mental health access and care to Service members, Veterans, and their families. For the last 10 months, DoD and VA have been implementing a DoD/VA Integrated Mental Health Strategy (IMHS) consisting of 28 strategic actions with specific milestones and outputs. One of these strategic actions specifically addresses suicide risk and prevention, but all will improve our collaboration in providing mental health care and outreach to Service members and Veterans. For the last several years, we have partnered with the VA in hosting an annual suicide prevention conference. This conference has been invaluable for sharing information and strengthening the provider network between our two health care systems.

We must also ensure that those who need help are not afraid to ask for that help. We recognize, as did the Task Force, that seeking help for mental health issues is still viewed as a sign of weakness by many Service members. To counter this perception, the DCoE implemented the Real Warriors strategic communications campaign designed to increase public awareness about mental health and positively change beliefs, attitudes, and behaviors about seeking mental health care. The Services have also implemented a variety of strategies to clearly articulate that asking for help is a real sign of strength. We believe that these efforts are beginning to change behavior. Over the past year, we have seen our mental health utilization rates increase among our Active Duty population.

In addition to providing access to quality, evidence-based care, ongoing research is a critical component of suicide prevention. Only through targeted research can we hope to understand the complex variables associated with high risk individuals and, using the results of this research, accurately identify, treat, and prevent suicide and suicide-related behaviors for men and women in uniform.

The Military Suicide Research Consortium (MSRC) coordinates and focuses military and civilian research efforts across the Department from internationally and nationally recognized suicide researchers. Research findings will assist in the development of evidence-based screening and risk assessment measures to accurately identify high risk individuals, prevention strategies, interventions, and postvention strategies for units, families and communities. At present, the MSRC has put forth six proposals for funding consideration targeting identified priority research gap areas.

In addition, each of the Services supports a variety of research efforts. The Army "Study To Assess Risk and Resilience in Service members", or Army STARRS, is the largest single epidemiological research effort designed to examine mental health, psychological resilience, suicide risk, suicide-related behaviors and suicide deaths in the Army to date. A group of renowned experts from the Uniformed Services University of the Health Sciences (USUHS), the University of California, San Diego, University of Michigan, Harvard Medical School, and the National Institute of Mental Health (NIMH) are conducting retrospective and prospective studies with approximately 90,000 active duty soldiers (including mobilized Reserve Component and National Guard Soldiers) to evaluate the relationship between soldiers' characteristics and experiences to subsequent psychological health, suicidal behavior and other relevant outcomes.

Mr. Chairman, members of the subcommittee, I thank you for your continued and generous support and demonstrated commitment to the outstanding men and women of our Armed Forces and their families. I look forward to your questions.

STATEMENT BY
LIEUTENANT GENERAL THOMAS P. BOSTICK
DEPUTY CHIEF OF STAFF G-1
UNITED STATES ARMY

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON MILITARY PERSONNEL

FIRST SESSION, 112TH CONGRESS

ON SUICIDES AND SUICIDE PREVENTION IN THE ARMY

SEPTEMBER 9, 2011

NOT FOR PUBLICATION
UNTIL RELEASED BY
THE COMMITTEE ON ARMED SERVICES

STATEMENT BY
LIEUTENANT GENERAL THOMAS P. BOSTICK
DEPUTY CHIEF OF STAFF G-1
UNITED STATES ARMY

Chairman Wilson, Ranking Member Davis, distinguished Members of the Subcommittee; I thank you for the opportunity to appear here today to provide a status on the United States Army's ongoing efforts to reduce the number of suicides across our Force; and, also detect and care for Soldiers suffering from post-traumatic stress, traumatic brain injury and other behavioral health issues.

On behalf of our Secretary, the Honorable John McHugh and our Chief of Staff, General Martin E. Dempsey, I would also like to take this opportunity to thank you for your continued, strong support and demonstrated commitment to our Soldiers, their Families, and Army Civilians.

It has been a busy time for our Nation's military. We are at war; we have been at war for nearly ten years. That has undeniably put a strain on the men and women serving in the Army today – and their Families. Many individuals have deployed multiple times. A significant number of them suffer physical injuries, such as musculo-skeletal damage, amputations, bullet or shrapnel wounds, traumatic brain injury, or burns. These wounds are easy to see. However, there are also those who suffer from the "invisible wounds of war;" behavioral health issues, such as depression, anxiety and post-traumatic stress. The resiliency of these men and women is astounding exactly because of the challenges they face, not in spite of them. These are well-trained, highly-motivated, and deeply patriotic individuals; and they are doing an outstanding job on behalf of the Nation.

As leaders, we are responsible for both the physical and psychological well-being of these individuals. The Army continues to work diligently to address these invisible wounds of war by identifying ways to alleviate some of the stress on our Force while also improving our ability to detect, prevent, and treat these injuries. We are dedicated to improving resiliency; eliminating the long-standing, negative stigma associated with seeking and receiving help; and, ensuring that Soldiers, Army Civilians and Family Members who may be struggling get the help that they need.

Calendar Year (CY) 2010 and CY 2011 Army Suicide Reports

Between 2004 and 2010, suicides in the United States Army were on the rise. In CY 2009, we had 162 active duty suicide deaths (including activated members of the

National Guard and Army Reserve), with 244 across the total Army. During this same period, we had 1,679 known attempted suicides.

In CY 2010, we continued to see an increase in suicide numbers. The Army had 155 active duty suicide deaths (including activated members of the National Guard and Army Reserve), with 300 across the total Army. During this time we also had 1079 known attempted suicides.

To date in 2011, we are seeing what appears to be a leveling off of suicide numbers, rather than an increase.

As of 30 Jun 2011, there were 76 active duty suicide deaths (includes 2 activated USAR Soldiers and 4 activated ARNG Soldiers); for the same time period last year there were 79.

Among the Reserve Component Soldiers not on active duty we have seen 49 suicides as compared to 68 for the same time period last year. For Army National Guard, we have seen 33 suicides as compared to 53 for the same time period last year. For Army Reserve, we have seen 16 suicides as compared to 15 for the same time period last year.

We also track suicides among Department of the Army Civilians [total as of 30 Jun 11 for DA Civilians is 17 as compared to 19 for the same time period last year] and Family Members [total as of 30 Jun 11 for Family Members is 3 as compared to 5 for the same time period last year].

The loss of any Soldier or Army Civilian to suicide is tragic, incomprehensible, and unacceptable. Each of these suicides represents an individual and a Family that has suffered an irreparable loss. Army leadership is working to better understand the causes of the current trend in Soldier suicides and we've instituted prevention measures that recognize everyone in the Army must be part of the solution.

Stress, High Risk Behavior, and Leadership Awareness

The act of committing suicide is generally preceded by not one, but a combination of events that together triggers a feeling of helplessness. Examination of suicide events has shown that common risk indicators include substance abuse, encounters with law enforcement, relationship issues, and financial concerns. The Army has dedicated a number of resources to training our Soldiers and Leaders to identify these factors and intercede on the Soldier's behalf to get them the assistance that they need to address these concerns. We are training both Leaders and Soldiers to becoming more aware of

the challenges individuals in the Army face, and the programs and services available to help support them.

Army Suicide Prevention Task Force –A Team Approach

Since the inception of the Army Suicide Prevention Task Force (ASPTF) – a group of multi-disciplinary representatives from across the Army staff – in March 2009, the Army has completed a number of actions to combat high risk and suicide behavior.

Over the past two years, the task force identified risk factors and indicators that help potentially illuminate correlations to high-risk and suicidal behavior in the Army. Their effort resulted in the publication of the Army Health Promotion, Risk Reduction and Suicide Prevention Report in July 2010. This report provides a comprehensive review of Army policy, process, structure, and programs, and identifies gaps in how we see, identify, engage, and mitigate high-risk Soldiers.

The task force, together with the Army Suicide Prevention Council (an interim HQDA-level organization chartered under the authority of the VCSA and mandated to expedite solutions from HQDA through appropriate commands), is charged with facilitating the implementation of these recommendations. Its unique governance, policy, structure and process have greatly expedited implementation of many strategic changes, including:

- Produced two interactive training videos that included scenarios for Active, National Guard and Reserve Soldiers; Army Civilians; and Family Members: "The Home Front" and "Beyond the Front."
- Produced the "Shoulder to Shoulder" training video series, which includes "Soldier to Soldier: No Soldier Stands Alone" and "Soldier to Soldier: I Will Never Quit on Life" training video. A third video is scheduled to be released in the Fall.
- Initiated "face-to-face" post-deployment behavioral health screening (in person or virtual) for all Brigade Combat Teams.
- Increased the number of Military Family Life Consultants (MFLCs) that work with children and families to provide them support during transitions and separations. Increased from 23 in FY07 to over 270 in FY10. These MFLCs are embedded in youth service facilities and in on- and off-post schools.
- Implemented "Pain Management Task Force" in August 2009 to make recommendations to appropriately manage the use of pain medications and adopt best practices Army-wide. The Pain Management Task Force Final Report was published in May 2010 and current efforts are underway to implement the recommendations.

- Implemented a "Comprehensive Behavioral Health System of Care Campaign Plan" to improve the coordination of behavioral health care across all medical disciplines.
- Implementation of the Army Confidential Alcohol Treatment and Education Pilot at six installations (Schofield Barracks, JB Elmendorf-Richardson, JB Lewis-McCord, Ft. Carson, Ft. Riley, and Ft. Leonard Wood).

VCSA Suicide Senior Review Group

In an effort to learn as much as possible from every suicide, in March 2009 the Vice Chief of Staff of the Army established the monthly VCSA Suicide Senior Review Group (SRG). The SRG involves senior commanders from affected commands across the Army. The SRG reviews approximately 15 to 20 suicide cases each month. The cases are discussed to glean lessons learned and identify trends and themes in an effort to help prevent future suicides. In addition to lessons learned, this is a chance to share success stories and learn best practices from the various Army commands.

Also, to aid in gaining as much information as possible from every suicide, the task force developed a suicide event collection report, comprised of data fields to be filled in by the Field Army. The report provides Army leadership with instant, actionable information on each individual Army suicide within approximately 72 hours of the Criminal Investigation Command's initial response.

Learning More Through Research

The Army recognizes that effectively addressing the challenge of Soldier suicides will require a team effort across all Army components, jurisdictions, and commands, as well as continued cooperation with partners outside of our organization.

U.S. Army Medical Research and Materiel Command (MMRC) is currently managing thirteen medical suicide prevention research projects; a total investment of $79 million. These projects include Walter Reed Army Institute of Research project on suicide ideation in a combat environment.

In addition, the Army has entered into a Memorandum of Agreement with the National Institute of Mental Health (NIMH) in connection with the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). The Army STARRS effort represents the largest DoD longitudinal epidemiologic study of mental health, psychological resilience, suicide risk, suicide-related behaviors, and suicide deaths in the Army, and is the largest single study on the subject of suicide that NIMH has ever undertaken. Army

STARRS aims to guide the development of data-driven methods to reduce or prevent suicide behaviors and improve Soldiers' overall mental health and functioning by identifying the most important risk and protective factors. . The Study includes Soldiers from every component of the Force – Active Army, Army National Guard, and Army Reserve. The Study consists of four components:

- The Historical Data Study involves the examination of more than 1.1 billion redacted historical health and administrative records to detect risk and protective factors related to psychological resilience, mental health, risky behaviors, and suicide. To date, NIMH has conducted preliminary data analysis and is currently in-process of beginning analysis of the full data set.
- The All Army Study will assess Soldiers' psychological and physical health; events encountered during training, combat, and non-combat operations; and life and work experiences across all phases of the Army service. Researchers will use this information to determine how these factors affect Soldiers' psychological resilience, behavioral health, and risk for self-harm. Data collection began in January 2011.
- The New Soldier Study will assess the health, personal characteristics, and prior experiences of volunteers from the pool of newly inducted Soldiers as they begin their Army career. Data collection began in January 2011.
- The Soldier Health Outcomes Study is comprised of two comparison studies in which investigators will identify characteristics, events, experiences, and exposures that predict negative or positive health and behavior outcomes using study participants from across all phases of the Army service. NIMH has been working on study plan development and obtaining approval of research protocols; they anticipate beginning data collection in the 3rd quarter of 2011.

The Military Suicide Research Consortium is a long-term, multidisciplinary suicide research collaboration between the University of Colorado Denver/Denver Veterans Administration Medical Center and Florida State University. This consortium supports the development and evaluation of evidence-based interventions, including screening, treatment, prevention and postvention. Among the research projects supported within this forum, there is a current effort to develop an integrated digital library of suicide research that will serve as a resource for researchers, policymakers, and others to inform current screening, treatment, prevention, and postvention methods, as well as future research efforts.

Other MRMC supported research initiatives include a study into the association between antidepressant use and suicidal behavior among younger veterans (Harvard University); an evaluation of the efficacy of brief safety planning interventions on hospitalized active duty military patients and outpatients though the Uniformed Services

University of Health Sciences; and a retrospective study of theater evacuations for suicidal behavior to examine suicidal ideation in combat zones.

Through these partnerships, we are confident that we can develop a better comprehensive understanding of the manifestation of suicidal behaviors, as well as effective screening, treatment, prevention, and postvention strategies within the military population. We hope that collectively these studies will lead to a more thorough understanding of the cumulative effect of transitions of all types (accession, permanent change of station, death of family member, temporary change of station, retirement, etc.) and stressors across a Soldier's entire career to develop tailored interventions based on known or predictive levels of stress. The results will benefit the Army, the other military Services, as well as the U.S. population overall, and may lead to more effective interventions for both Soldiers and civilians.

Behavioral Health Care

As mentioned previously, our Soldiers are under a great deal of strain. It is our responsibility to ensure that they are not only taking care of themselves physically, but psychologically as well. The Army continues to emphasize the importance of seeking behavioral health care and to dispel the myth that seeking care might jeopardize a Soldier's career prospects or reputation among his/her peers.

Soldiers are recognizing the importance of individual help-seeking behavior and commanders are realizing the importance of intervention at the leadership level. In FY 2010, 257,537 Soldiers accessed outpatient behavioral health care (ranging from screening to therapy) and 9,392 Soldiers received inpatient behavioral health care. This is an increase from 216,222 and 9,201 in FY 2009. Within behavioral health clinics, the Army increased the number of monthly clinic encounters from 94,784 to 105,898 during FY10, a 12% increase. These numbers indicate that our efforts to emphasize the importance of behavioral health are working.

The Army also continues its efforts to provide a sufficient number of behavioral health providers. The nationwide shortage of behavioral health care providers continues to present a significant challenge, but we have made great strides in meeting the Army's needs. The Army has approximately 4,600 behavioral health providers on-hand, an increase of 1,745 since 2007. This represents 92.7% of the total number of behavioral health providers needed. Psychiatrists, Marriage Family Therapists, and Social Workers are the greatest shortages; the Army continues efforts to recruit these professionals.

Our continued focus on access to behavioral health care led to the funding of 40 unique psychological health programs in FY 2010. These programs provide a range of

expanded healthcare services to our beneficiaries and obligated over $168 million additional dollars to behavioral health services. This includes the implementation of programs such as RESPECT-MIL and the medical home model, to increase opportunities for behavioral health monitoring in the primary care setting.

Web-based Behavioral Health Care Services

For Army men and women who are geographically isolated or otherwise may not have easy access to in-person behavioral health care, TRICARE has implemented the TRICARE Assistance Program (TRIAP) for Soldiers and Family Members. The program is open to:

- Active duty Servicemembers
- Members eligible for the Transition Assistance Management Program (TAMP) for 6 months after demobilization
- Members enrolled in TRICARE Reserve Select, as well as Spouses and Family Members 18+ years

Soldiers and Family Members can access unlimited short-term, problem-solving counseling 24/7 with a licensed counselor from home, or any other location, with a computer, Internet, required software download, and webcam. If more specialized medical care is deemed necessary, an immediate warm handoff can/will be made to a medical provider.

From August 2009 to May 2011, 4283 calls were recorded. The Army was the primary branch of Service represented in this population (40% of callers were Army). Among the calling population, the six most common concerns of the callers were: partner relational problems, stress management, next of kin relational problems, stress related to deployment, phase of life problem, and self esteem. We are pleased to see that this program is being used across the components. This provides yet another avenue for Soldiers to seek support when they need it.

In conjunction with TRIAP, the Army continues to work to build a network of locations and on-line providers for telebehavioral health services, using medically-supervised, secure audio-visual conferencing to link beneficiaries with offsite providers. This network will be able to provide the full range of behavioral healthcare services, including psychotherapy and medication management. Our long-term goal is to create a network of counselors and certified behavioral healthcare providers that encompass the entire U.S. to ensure that all Soldiers have access to care no matter where their location.

Support for Geographically Isolated Populations

The Army is continuing to bridge programs and services to RC Soldiers and Families when not on AD.

- Telehealth services are just one means by which the Army is addressing the needs of geographically isolated populations, and specifically our Reserve Component Soldiers and Families.
- The Army is improving awareness of and access to training and resources; working with employers and private sector to mitigate economic stress; and improving the quality and access to health care for all RC Soldiers.
- We have implemented a number of programs, including:
  - The Yellow Ribbon Reintegration Program pro-actively reaches out with information, education, services, and referrals through all phases of the deployment cycle.
  - The Strong Bonds program's mission is to increase Soldier and Family readiness through relationship education and skills training. Strong Bonds helps single Soldiers, couples and Families thrive in the turbulence of the military environment.
  - The Army Strong Community Center program was established by the Army Reserve to support Military Members and their Families who live away from the larger military installations where support is readily available. There are currently 3 Army Strong Community Center locations in Rochester, NY; Brevard, NC; and Coraopolis, PA.
  - The Employer Partnership (EP) is a key program to help mitigate economic stress on Reserve Component Soldiers. EP was created as a way to provide America's employers with a direct link to some of America's finest employees – Service members and their families. EP's partnering with over 1,000 employers who include 96 of the 2010 Forbes Fortune 500 Companies, and the list is growing.
  - The Transitional Assistance Management Program (TAMP) provides 180 days of transitional health care benefits, including psychological health care, to demobilized Reserve Soldiers and their families.
  - Military OneSource. Military OneSource is an information and referral clearinghouse that can guide AR members to the right resources. Through Military OneSource, the Soldier and each family member has access to up to 12 in-person counseling sessions with a licensed counselor at no cost.

Changing Culture

In the past, there has been a stigma associated with seeking help from any kind of behavioral health professional. Soldiers avoided seeking this type of assistance for fear that it might adversely affect their careers. However, that is not the case; and, we are taking the necessary steps to change this misperception across the Army.

We have implemented novel, broad-based approaches to raising awareness about behavioral health and suicide prevention. These include public service announcements using celebrities, Army leaders, and Medal of Honor Recipients; advocacy and outreach messages and programs through organizations like Blue Star Moms; focused efforts in publications such as PS Magazine; and educational videos such as Shoulder to Shoulder. Through these and other programs, we are slowly changing the Army culture concerning the perceived stigma of behavioral health.

The Army has implemented confidential support programs such as Military OneSource to act as a bridge while we move forward in removing the stigma from behavioral health concerns. In the future, we hope that we do not need confidential support programs; that a Soldier can recognize he or she needs help and can seek it out without fear of professional fallout.

The Hidden Challenges: Traumatic Brain Injury and Post-traumatic Stress

One of the challenges in preventing suicide is recognizing that an individual – even a close family member or good friend – is considering taking his or her own life and may need help. Too often individuals will suffer in silence. They may be dealing with severe depression or anxiety and choose to hide their concerns from family and friends.

Traumatic brain injury (TBI), post-traumatic stress (PTS), and behavioral health issues can present similar significant challenges. These injuries pose unique challenges, especially as compared to easily-detectable wounds such as amputations and burns. PTS and TBI are among the most difficult to correctly diagnose and treat, while their debilitating effects are constant hurdles to effective treatment, and recovery. The study of the human brain is an emerging science; there is still much to be learned about these and other highly-complex injuries involving the brain. This pertains not just within the military community, but throughout the global medical community.

In a concerted effort to minimize the number and severity of injuries, the Army implemented a new TBI management strategy across the force aimed at prevention, early detection and effective treatment of injuries. Additionally, the Army is instituting a revised program of instruction for medics and other behavioral health providers that includes training specific to TBI and PTS injuries. We're also incorporating instruction

on this important issue into training programs at the National Training Center, Joint Readiness Training Center and other locations.

The new TBI management strategy, *"Educate, Train, Treat & Track,"* is also being successfully implemented downrange. Deploying Soldiers receive training prior to their arrival in theater. The new TBI management strategy also includes strict "event-based" protocols that govern exactly what Leaders and Soldiers must do if involved in a concussive event. This strategy specifies criteria to determine an event and specifies the protocol that every exposed Soldier must undergo, to include a medical evaluation and, pending the findings of the exam, a mandatory 24-hour downtime period and a second exam before returning to duty. We cannot permit the proud "Warrior Spirit" of our Soldiers, which leads many of them to ignore their concussions and remain in the fight, to needlessly expose them to another brain injury during the vulnerable period of healing.

Since 2002, the Department of Defense has opened over 50 TBI treatment centers across the country. These centers are staffed with multidisciplinary teams of medical providers capable of treating the full range of TBI, from mild to severe. The National Intrepid Center of Excellence, in Betheseda, MD, a state of the art research, diagnosis, and treatment facility for Servicemembers and Veterans with diagnosed traumatic Brain Injury and psychological health conditions, was officially opened in June 2010. It is the DoD's largest and most advanced medical complex and is across from the National Institute of Health—a key partner in advancing the science and treatment of these injuries and illnesses.

We are making progress, but it remains an incredibly challenging endeavor and the Army remains committed to advancing research to inform screening and treatment of these conditions. We are continually making improvements to the care and services provided to our Soldiers through sharing best practices and lessons learned.

Prescription Drug Use

Given the nature of the injuries sustained by the men and women serving in the Army, prescription drugs, including pain, depression, and anxiety medications may be prescribed as part of a comprehensive treatment plan. While we recognize the utility of these medications to treat the injuries, the Army is also aware of the potential for prescription drug abuse. Army Health Promotion, Risk Reduction and Suicide Prevention Report in July 2010 found that prescription drug abuse is on the rise in the Army. The Army is pursuing a number of avenues to address this issue.

We are working with the legal and medical communities to improve transfer of information between commanders, medical professionals, and program and service providers, while ensuring we protect the privacy rights of patients.

We have recently implemented a program that limits the prescribing of most Schedule II controlled substances (including opiates and narcotics for pain relief, and amphetamines such as those used to treat attention deficit disorder or depression) to a 30-day prescription rather than the previously accepted 90-day prescription. Additionally, we have implemented a policy whereby Soldiers found using Schedule II controlled substances six months from the date the final refill was obtained can face disciplinary action. These measures are meant to decrease the prolonged access of Soldiers to Schedule II controlled substances without medical supervision.

To complement this effort, the Army is also pursuing permission from the DEA to implement a drug take-back program at all Military Medical Treatment Facilities. Beginning in 2010, the DEA implemented a National Drug Take-back Day where citizens were allowed to relinquish their Schedule II controlled substance prescriptions to authorized facilities. On April 30, 2011, the Army participated, giving Army Soldiers and Families the opportunity to dispose of unused or expired prescriptions. Thirty-eight collections sites at twenty-seven installations reported collecting over 1150 pounds of unused or expired medications. The program was a resounding success, and demonstrates the need for regular access to this type of service.

We are addressing the need for more comprehensive management of prescription medication. In doing so, we are decreasing the likelihood that illicit use of prescription drugs might influence a suicide attempt or event.

Closing Remarks

Any time a Soldier, Army Civilian, or Family member chooses to end his or her life, the loss is devastating to Family and friends, fellow Soldiers, and the Army. Throughout my career in the Army, I have never dealt with a more difficult or critical mission than the current charge to reduce the number of Soldier suicides and properly diagnose and treat individuals suffering from TBI, PTS and behavioral health issues.

Over the past year, our commitment to health promotion, risk reduction and suicide prevention has changed Army policy, structure and processes. We have implemented a multi-disciplinary approach and a team effort by Leaders and Soldiers at all levels of command and across our Active and Reserve components – together with DoD, Congress, and willing civilian health care providers, research institutes, and care facilities – to ensure that we are providing our Soldiers with the most effective programs,

treatments, and support. We have seen success in our efforts, including more Soldiers seeking behavioral health care, more programs to support our Reserve Component, and a greater awareness among Soldiers and Leaders about suicide and high-risk indicators.

Our success notwithstanding, we still have much more to do. We face an Army-wide problem that can only be solved by the coordinated efforts of our commanders, leaders, program managers and service providers. The Army remains committed to this effort and to supporting all of the men and women who serve in the Army.

I assure the esteemed Members of this committee that there is no greater priority for me and the other senior leaders of the United States Army than the safety and well-being of our Soldiers. The men and women who wear the uniform of our Nation are the best in the world, and we owe them and their Families a tremendous debt of gratitude for their service and for their many sacrifices.

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UNTIL RELEASED BY THE
HOUSE ARMED SERVICES
COMMITTEE

STATEMENT OF

REAR ADMIRAL ANTHONY M. KURTA, U.S. NAVY

DIRECTOR,

MILITARY PERSONNEL, PLANS AND POLICY (OPNAV N13)

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

HOUSE ARMED SERVICES COMMITTEE

ON

CURRENT STATUS OF SUICIDE PREVENTION

PROGRAMS IN THE MILITARY

SEPTEMBER 9, 2011

NOT FOR PUBLICATION
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HOUSE ARMED SERVICES
COMMITTEE

Chairman Wilson, Ranking Member Davis, and distinguished members of the House Armed Services Committee, thank you for the opportunity to discuss the Navy's efforts to promote the psychological health of our Sailors and their families. Prevention of self-harm and suicide remain a high priority in the Navy, and we are grateful for your continued support of this critical issue.

The loss of a single Sailor to suicide is a tragedy that affects many. A suicide takes away a future, shatters a family, and affects unit cohesion and morale. In the face of high operational demands on the force, we remain committed to creating an environment where dealing with stress can be free of stigma and where seeking help is a sign of strength.

Since 1993, the average Navy suicide rate has been 11.5 per 100,000 Sailors, ranging from a high of 17.3 in 1995 to a low of 9.5 in 2005. Navy's calendar year 2010 suicide rate of 11.1 per 100,000 Sailors represented a decrease from the 2009 suicide rate of 13.1. There were 46 active duty and six Selected Reserve Sailor (SELRES) suicides in 2009 and 39 active duty and four SELRES deaths in 2010. Regrettably, recently we have experienced a reversal of this positive trend, having lost 36 active duty and four SELRES Sailors to suicide so far in 2011.

We remain vigilant concerning stress on our Sailors and their families, and continue to carefully monitor the health of the force. Every suicide and suicide attempt is thoroughly investigated, providing important data about the conditions and chain of events leading to the suicide and critical lessons learned that inform training content, communications, and policies. This information is reviewed by Navy's senior uniformed leadership on a weekly basis. The data has provided us with important information. First, the demographic distribution of suicides largely mirrors the demographics of the Navy as a whole. Second, while a recent deployment experience may be a contributing factor to suicide in some individual cases, overall, deployment

history in and of itself does not appear to increase suicide risk.[1] Third, Sailors who commit suicide tend to experience stress factors across multiple aspects of their lives,[2] the most common of which are relationship problems. Relationship problems can affect suicide risk in a number of ways – they can be a source of distress, often reducing the social support that is a key protective factor for the individual, or a reflection of other underlying problems such as mental illness.

Recent evidence suggests that as many as half of Sailors who commit suicide have experienced transition-related factors, such as permanent change of station, recent return from deployment, temporary duty, or upcoming separation or retirement. These transitions appear to increase stress, interrupt social support systems, and leave established organizational systems less aware of changes in the individual. Factors that influence judgment, such as alcohol, anger, and sleep disruption or deprivation appear to act as catalysts to increase the risk of suicide.

Over the past 20 years, we have observed that in times of significant organizational change, suicide rates tend to be higher. Periods of change increase stress and uncertainty, which may strain existing organizational protective factors. Pressures to meet operational demands may leave less time for intrusive leadership, peer engagement, morale-boosting activities, and time with family. In a high stress work environment, Sailors may be less likely to take time from work to solicit early support services or seek help for substance abuse and other problems.

While stressors have been shown to increase the risk of suicide, we believe resiliency is strengthened through leadership and peer support, strong family bonds, support services, and a sense of purpose. Our efforts remain focused on strengthening this resiliency for Sailors and their families. Our 2010 Behavioral Health Quick Poll indicated the majority of Sailors are confident in their ability to effectively respond to a Sailor who talks about suicide and the ability of their commands to support Sailors seeking help for suicidal thoughts or actions. Thus far in

[1] CNA May 2010, CNO Executive Panel (CEP) 2010
[2] DONSIR Technical Report, DODSER

2011, over 1,000 Sailors have requested and received assistance through their commands for reported suicidal ideations. Others have sought help from chaplains, family services, and medical professionals. Leadership plays a critical role in creating an environment that promotes resilience, encourages early use of support resources to address potential problems before thoughts of self-harm occur, and actively supports reintegration into the unit after a Sailor has received intervention or treatment.

Suicide Prevention – All Hands, All of the Time

Suicide prevention is an "all-hands – all of the time" effort, involving Sailors, family members, peers, and leadership. We are expanding from our historic suicide surveillance and annual awareness training to a more comprehensive and tailored approach to resilience building, suicide prevention training, intervention, research, and analysis. This includes maintaining and expanding a solid foundation of unit level suicide prevention coordinators, refreshing mental health provider skills, providing installation first responders with the skills necessary to respond to behavioral emergencies, and raising family awareness of suicide risk, warning signs, and support resources.

Command awareness and intervention is an important component of our suicide prevention strategy. Our leaders play a critical role in providing a clear sense of mission and purpose to our Sailors and creating an environment characterized by trust and unit cohesion where Sailors and their families can thrive in the face of multiple demands and stressors. Additionally, leaders must continue to remain vigilant about the effects of relationship issues, work, financial, and legal problems, and deteriorating physical health on the psychological well-being of their Sailors, and offer assistance early.

Our approach to suicide prevention focuses on four key areas:

- Fostering resilience in Sailors and their families
- Vigilance and early intervention
- Crisis response
- Comprehensive support for those impacted by suicide

Fostering Resilience in Sailors and their Families

Navy's Operational Stress Control (OSC)[3] program and our integrated structure of health promotion, family readiness, and prevention programs are focused on building resilience, addressing problems early, and creating a healthy and supportive climate.

Navy's OSC program addresses the psychological health of Sailors and their families by encouraging Sailors to seek help for stress reactions before they become stress problems, promoting strong leadership involvement, and increasing awareness of support programs and resources. The first 23 modules of formal OSC curricula have been delivered at key nodes of training throughout the career of the Sailor – "from Accessions to Flag Officer." Specific pre- and post-deployment OSC training is being delivered at all Navy Mobilization Processing Sites and Returning Warrior Workshops. To date, OSC awareness training has been provided to more than 245,000 Sailors. We continue to refine our OSC curricula as we transition from a focus on information and awareness to developing skills to identify and mitigate stress.

In October, we will introduce two mobile training teams based in Norfolk and San Diego to support the expansion of OSC training across the Navy. Parallel family modules have been developed and the basic concepts of OSC have been integrated into a variety of family training forums. Additionally, a six-hour leadership course has been successfully piloted and more than 24 commands have been trained to date with nine more scheduled to complete the course prior to the end of this fiscal year. Leaders receive training in five core areas of responsibility: (1) to

[3]NAVADMIN 332/08 dated 21November 08 established the Navy's Operational Stress Control program.

strengthen Sailors, families, and units; (2) to identify signs of stress response; (3) to mitigate the effects of stress; (4) to treat (and support treatment of) stress injuries, and (5) to reintegrate the Sailor back into the unit and/or society after suicide-related behaviors or other interventions.

We understand that the recognition of stress-related behaviors must be immediately followed by effective action. All of our Sailors receive training in stress first-aid intervention to ensure they are able to recognize when a shipmate is in trouble, break the code of silence and intervene, and connect that shipmate to the next level of leader and caregiver support. The advantage of this integrated approach is that our Sailors are able to look beyond stereotypical warning signs to recognize changes in behavior and initiate helpful actions to save lives, reduce further injury, and promote personal growth.

The Navy Reserve Psychological Health Outreach program was established to improve the psychological health and resiliency of reserve component (RC) Sailors and their families. Teams of psychological health outreach coordinators and outreach team members located at the five regional reserve commands provide psychological health assessments, education, and referrals to mental health specialists. In FY10, these teams conducted mental health assessments for more than 1,300 RC Sailors, made outreach calls to over 4,000 returning RC Sailors, and conducted approximately 176 visits to Navy Operational Support Centers (NOSCs) around the country, providing basic OSC awareness training to more than 21,000 RC Sailors and staff members.

When military parents fulfill occupational duties during wartime, their children and families can face many challenges, such as long separations, changes in family routines, and dealing with concerns about the safety of the parent who is deployed and about the well-being of the parent who remains at home. Our Fleet and Family Support Centers (FFSC) continue to provide comprehensive family and deployment support, life skills training, counseling, and transition support to our Sailors and their families through an array of services.

Project FOCUS (Families Overcoming Under Stress), initiated by the Navy Bureau of Medicine and Surgery (BUMED) in 2008, provides state-of-the-art family resiliency services to military children and families at over 20 Navy and Marine Corps sites and online for those in remote locations. FOCUS promotes a culture of prevention and the reduction of stigma through a family-centered array of programs, such as community briefings, educations workshops, individual and family consultations, and resiliency training. This approach teaches military members and their families to understand their emotional reactions, communicate more clearly, solve problems more effectively, and set and achieve their goals throughout the deployment cycle. As of June 2011, more than 238,000 Sailors, Marines, and their families have used FOCUS services since the program's inception. Feedback on the program has been very positive. Participants report high levels of satisfaction with the services provided, reduced psychological distress, and improved individual and family functioning.

Vigilance and Early Intervention

A basic tenet of our suicide prevention program is to empower shipmates, leaders, family, and community members to recognize early signs of risk and take actions to address concerns at the earliest possible point.

The Coalition of Sailors Against Destructive Decisions (CSADD), a grassroots peer mentoring program led by and for young Sailors, continues to grow with over 200 chapters across the Navy. CSADD focuses on empowering our most junior Sailors with the tools and resources to promote good decision-making processes and leadership development while reinforcing a culture of shipmates helping shipmates. CSADD members promote awareness and discussion among their peers across a range of areas, to include suicide prevention, financial management, and responsible use of alcohol, personal safety, and domestic violence. Examples of CSADD initiatives include the "Stop and Think Campaign," which highlights the potential consequences of poor decisions, an active Facebook page where Sailors can ask questions,

access information and training materials, and share lessons learned, and a semi-annual newsletter to highlight best practices across the Navy.

We recently deployed our fourth Navy Mobile Mental Health Care Team for a six-month mission in Afghanistan. The team consists of two mental health clinicians, a research psychologist, and an enlisted psychiatry technician. They provide psychological first aid to Sailors and administer the Behavioral Health Needs Assessment Survey (BHNAS). The BHNAS provides an overall assessment of real-time force mental health and well-being every six months, and can identify potential areas or sub-groups of concern for leaders. It assesses a wide variety of content areas, including mental health outcomes and the risk and protective factors for those outcomes such as combat exposures, deployment-related stressors, and positive effects of deployment, morale, and unit cohesion.

In addition to data provided by the BHNAS, senior Navy leadership routinely monitors the tone of the force through surveys, monthly reports of suicide-related activities, and weekly updates to the Chief of Naval Operations. We developed a Commander's Toolkit for Suicide Prevention and Response as a ready reference for command leaders and offer "waterfront" briefings around the world on the most current suicide prevention practices and tools. Individual commands can also tailor training to their needs with products such as the "Peer to Peer" training module and "Front Line Supervisor Training."

As of 1 June 2011, every Navy web site was required to include the message "Life is Worth Living" and a link to the National Suicide Prevention Lifeline and Veterans Crisis Line. This is one example of a coordinated and systematic year-round communications strategy that includes leadership messaging, internal media, and educational materials to raise awareness about suicide risk and provide ready access to resources.

Our Medical Home Port Program is a team-based model focused on optimizing the relationship between patients, their providers, and the broader healthcare team. Mental health

providers are embedded within our Medical Home Ports to facilitate regular assessment and early mental health intervention. This model enables Sailors to be treated in the settings in which they feel most comfortable and reduces the stigma associated with the care they receive. Additionally, improving early detection and intervention in the primary care setting reduces the demand for time-intensive intervention in our mental health specialty clinics.

Crisis Response

While the majority of Navy suicide prevention activities focus on resilience building and early intervention, we must also be prepared to intervene at any stage of a crisis. It is not enough to know what to do. We must also know how to do it. Every Navy command is required to maintain a crisis response plan to ensure individuals understand how to quickly and effectively get help to someone in distress or keep someone who is at acute risk safe until they can receive professional care.

Suicide is the last step in a complex chain of events during which an individual may come in contact with key personnel, such as legal professionals, first responders, and chaplains, who have the opportunity to intervene. We are developing targeted training to ensure these individuals can identify potential risk factors and respond appropriately according to their specific roles and responsibilities. Last month, we conducted our first specialized training session for judge advocate generals. We recently filmed a video, currently undergoing editing, as part of a new training program for installation emergency first responders such as Emergency Medical Services (EMS), dispatch, and security personnel that covers safety, de-escalation, and response coordination for behavioral health emergencies and suicide risk situations.

To ensure our mental health providers remain proficient in assessing risk and developing safety and treatment plans, they have the opportunity to participate in Assessment and Management of Suicide Workshops, which focus on developing the core provider competencies identified by the American Association of Suicidology. So far in 2011, 20 of 29 scheduled

workshops at Navy Medical Treatment Facilities around the world have been completed, which provided training to over 700 mental health providers.

We have also expanded leadership briefings and guidance materials to incorporate the reintegration phase. Once someone receives help, it is essential to create an environment that supports their successful return to duty (or in some cases, transition to other duty or civilian life). Successful continuation with a Navy career after receiving help sets a strong, positive example for others in need by demonstrating that positive outcomes are possible if they reach out.

Post-Suicide Support

After a suicide, we believe that timely and compassionate resources and assistance are the first step to mitigating the effects on those impacted by the tragedy of suicide. In late 2010, we completed a training video to assist individuals responsible for providing post-intervention support after a suicide. Navy also formalized a memorandum of understanding with the Tragedy Assistance Program for Survivors (TAPS), enabling them to contact family members to offer support services essential in the long recovery process after a suicide loss. Additionally, Navy Special Psychiatric Rapid Intervention Teams (SPRINT) are on call 24 hours a day, seven days a week for circumstances requiring a higher level of support, and local chaplains and Fleet and Family Support Centers regularly provide command consultation, memorial services, and grief counseling support.

Collaborative Efforts

We are fortunate to have a high degree of collaboration between the services, the Department of Veterans Affairs (VA) and other federal agencies, academia, and community organizations. Navy actively participates in the DoD/VA Suicide Prevention and Risk Reduction Committee. Through conferences, monthly meetings, and other forums, participants leverage shared knowledge and expertise to assess gaps, communicate best practices and lessons learned, and develop joint products for family outreach and public service communications.

The DoD Task Force for Prevention of Suicide Among Members of the Armed Forces conducted a systematic review of prevention efforts and provided 76 recommendations. Navy has already implemented several of the task force recommendations and continues to work to incorporate measures to meet the intent of the Task Force Report. This includes increasing our headquarters level staff devoted to suicide prevention efforts and expanding our resilience initiatives.

Moving forward, our suicide prevention strategy will continue to focus on building resilience, implementing additional skills-based training, expanding the aperture of our efforts to the Selected Reserve and Navy civilians, integrating readiness and prevention activities across the Navy, and breaking down barriers to seeking help.

Conclusion

As a Navy, we ask an incredible amount of our Sailors and their families and in return, we remain committed to providing them with the level of support and care commensurate with the sacrifices they make. On behalf of all the men and women of the United States Navy and their families, thank you for your commitment to this critical issue and of your continued support of our Navy families.

NOT PUBLIC UNTIL RELEASED BY THE
HOUSE ARMED SERVICES COMMITTEE

STATEMENT

OF

LIEUTENANT GENERAL ROBERT E. MILSTEAD, JR.

DEPUTY COMMANDANT FOR MANPOWER & RESERVE AFFAIRS

UNITED STATES MARINE CORPS

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

HOUSE ARMED SERVICES COMMITTEE

CONCERNING

SUICIDE

ON

SEPTEMBER 9, 2011

NOT PUBLIC UNTIL RELEASED BY THE
HOUSE ARMED SERVICES COMMITTEE

Introduction

Chairman Wilson, Ranking Member Davis, and distinguished Members of the Subcommittee, on behalf of your Marine Corps, I would like to thank you for inviting me here today to discuss the issue of suicide. We are grateful for your continued generous and faithful support and attention to this critical issue.

With every suicide, there is a unique life to understand. The loss of a Marine is deeply felt by all those who remain behind. When a Marine dies by suicide, the needless loss of life is a tragedy, and the family members and fellow Marines who are left behind must grapple with the painful questions of why and how.

The Marine Corps believes that one suicide is one too many. Suicides are a loss that we simply cannot accept, and leaders at all levels of the Marine Corps are personally involved in efforts to help address and prevent future tragedies. Our suicide prevention efforts focus on building a resilient force and encouraging Marines to seek help early, before problems worsen to the point of suicide. Taking care of Marines is fundamental to our ethos and serves as the foundation of our resolve to do whatever is necessary to help. As Marines, we pride ourselves in "taking care of our own." It is this commitment to one another that will serve as the foundation of our efforts to learn from these tragedies and guide us in our vital work of suicide prevention.

Understanding the Statistics

Between 2001 and 2007, the number of suicides in the Marine Corps fluctuated between 23 and 34, but between 2007 and 2009 we saw a disturbing increase. From a recent low point of 25 suicides in 2006, the number increased to 33 in 2007, 42 in 2008, and 52 in 2009. Our suicide rate in 2009 was 23.7 suicides per 100,000 Marines, which exceeded the most recent (2007)

national civilian rate of 20.0 per 100,000 when adjusted to match the demographics of the Marine Corps.

During Calendar Year 2010, 37 Marines died by suicide. The 2010 suicide rate was 17.2 suicides per 100,000 Marines, which is a nearly 30 percent decrease from 2009. Thus far this year, from January 1 through July 31, 21 Marines have died by suicide. Through this same time period in 2010, 28 Marines died by suicide.

Attempted suicides have increased from 103 attempts in 2007, to 146 in 2008, to 164 in 2009 and to 172 in 2010. Thus far this year, from January 1 through July 31, 108 Marines have attempted suicide. Through this same time period in 2010, 116 Marines had attempted suicide.

We are hopeful that the reduction in suicides will be part of a downward trend and that we are seeing the rewards of our prevention efforts; however, we will continue our implementation of a wide-range of prevention strategies on several fronts.

Primary Stressors and Risk Factors

Marine suicides and attempts resemble our institutional demographics: Caucasian male, 17-25 years old, and between the ranks of Private and Sergeant (E1-E5). Based on our analysis, we know that the primary stressors and risk factors associated with Marine suicides and attempts are relationship problems, legal or disciplinary problems, behavioral health diagnoses, financial problems, and substance abuse.

Our Marine Corps leaders educate all Marines about the relationship between suicide and stressors, warning signs, and risk factors through annual awareness and prevention training as well as additional training in all formal schools - from recruit training to our Commanders Course. We also teach Marines that it is their duty to seek help for themselves or for a fellow Marine at risk for suicide. Leaders teach Marines the importance of seeking help early, before

problems escalate to the point of suicide risk. Through example, Marines are shown that they need not choose between their military career and getting help for normal reactions to stressful circumstances. While helpful, reacting appropriately to suicide risk and encouraging early help-seeking are not sufficient by themselves.

The Marine Corps is conducting additional analysis to assess the impact that operational deployments may have on suicide rates. To date, our data suggests that, while the continuing stress resulting from a high overall operational tempo may be a factor in our increasing suicide rate, there does not appear to be a direct correlation between an individual Marine's suicide risk and deployment or combat history. Our analyses also suggest that there is no specific time period post deployment that is associated with increased risk of suicide for Marines.

Based on on-going assessments, we are concerned that our current surveillance and investigative procedures may be missing qualitative data from the final 72 hours prior to a Marine's death. Similar to studies conducted on civilian suicides, we are engaged in a forensic psychological autopsy study to more fully understand the detailed processes that lead to a Marine suicide, which we hope will further inform the points at which intervention may prevent another tragedy from occurring. We also continue to stress the critical role of focused and engaged leadership in suicide prevention, especially at the NCO level.

Suicide Reporting

We review and investigate all non-hostile casualty reports daily to track both suicides and suicide attempts and we coordinate weekly with the Armed Forces Institute of Pathology, which is the final arbiter on the manner of death for Marines. When a suspected suicide or attempt is reported, our Suicide Prevention Program Office makes contact with the local command to verify

the report and facilitate their completion of the Department of Defense Suicide Event Report (DoDSER). This surveillance tool is standardized for use by all Services. Along with the other Services, we initiated use of the DoDSER in January 2008 for suicides, and in December 2009, we began using it for suicide attempts as well. We believe that the standard operating procedures put into place for reporting suicide attempts will facilitate a richer dialogue between medical personnel and Marine leadership, will result in better data, and will enhance our suicide prevention efforts.

After each suicide, we conduct an extensive review of the factors that led up to the suicide. This process involves the collection of information from leaders, co-workers, friends, and medical personnel. We do not require information from family members so as not to burden the family at a time of such tragic loss and grief, but include it when available in such a manner that will not compound their loss.

Suicide Prevention Efforts

The Marine Corps has taken a number of actions to improve our overall suicide prevention efforts:

Training

We have learned that peer-to-peer intervention is essential to our prevention efforts. As such, we have further refined our award-winning, peer-led suicide prevention course for Non-Commissioned Officers (NCOs) - "Never Leave a Marine Behind" - and tailored it to address additional Marine Corps audiences. In January 2011, we released this evocative, reality-based training module for our junior Marines, and updated the existing NCO module. In April 2011, we released officer and staff noncommissioned officer modules that give leaders the necessary tools to build resilience and encourage our Marines to engage helping services early.

In addition to our targeted training approaches, we incorporate prevention into our formal education and training at all levels of professional development and throughout a Marine's career - from recruit training to new officer training in The Basic School, to the Sergeants Major Symposium, and the Commanders Course for senior leaders. Training is continuously evaluated and revised to reflect the most up to date information and evidence-based practices. Suicide prevention skills are also taught using warrior metaphors in the Marine Corps Martial Arts Program, in which every Marine participates.

DSTRESS Line Pilot Program

One of our relatively new initiatives, established in 2010, is the DSTRESS Line with TRICARE West. This "By Marines-For Marines" call center is designed to assist Marines with problems at an early stage. The call center is staffed by veteran Marines, providing *anonymous* service to Marines, veteran Marines, attached Sailors, and their families. In the event that a caller in need is struggling with complex issues that are out of the scope of a responder, we have licensed clinical counselors available to provide more in-depth, urgent assistance. We are currently finishing the evaluation of this pilot program and considering Corps-wide expansion.

Combat Operational Stress Control Program

Other suicide prevention initiatives include our Combat and Operational Stress Control Program (COSC) which provides Operational Stress Control and Readiness (OSCAR) team training. OSCAR training creates teams of leaders, Marines, medical and religious ministry personnel within each battalion-sized operational unit who have the skills to help a commander in the prevention of stress injuries and early identification of Marines impacted by stress. By changing social norms and outdated beliefs, OSCAR team members seek to reduce the stigma

associated with behavioral health treatment, which improves referral, rapid case identification and treatment, and contributes to our Marines' overall well-being.

Resiliency Training

We believe improving our Marines' resilience will foster their ability to cope with the widely-varying stressors of life both in combat and garrison, improve their overall sense of well-being, and reduce suicides. We are working aggressively and creatively to build a training continuum that is founded and focused on our core values and recognizes the interconnectedness between physical, social, psychological, and spiritual health. For instance, we know that physical fitness and participation in sports and recreation strengthen resiliency and prevent unhealthy behavior choices. We also know that there is a strong connection between physical health and mental health. We have recently started focusing more strategically on these four pillars - physical, social, psychological, and spiritual - in an effort to build resilience-based concepts and principles into the very fabric of the Corps. This year, we have reorganized many of our existing psychologically-based resiliency programs under a new behavioral health branch. We believe this effort will improve their efficiency and effectiveness while better leveraging other programs across the spectrum of behavioral health. We also believe that connecting these programs will result in increased quality of care provided to Marines, commanders, and communities, and proactively prevent suicide.

In addition to focusing on psychological resilience, we have begun to focus on the social aspects of building resilience. We recognize that individuals who feel "connected" to one another are more engaged at work and home and, therefore, tend to be more resilient. Therefore, over the course of the next year, we will be working to develop and implement a plan that utilizes a more community-based approach to taking care of our Marines and their families.

Connecting our Marines, their units, and their families to the programs and services in the Marine Corps, as well as those in their communities, will encourage them to become more involved and active in their communities, and ultimately build and maintain their overall resiliency.

Partnerships

The complex nature of suicide prevention requires an important balance between immediate action and long-term planning. Partnerships and effective collaboration are necessary to stay abreast of the latest available information within the suicide prevention arena and also to explore future program needs.

We are fully engaged in research efforts with both federal and civilian partners to fill in gaps in our understanding and continue to guide our prevention efforts. In collaboration with the Department of Defense, our sister Services, and federal and civilian agencies, we continually adapt our efforts to reflect the latest public health science and the ever-changing needs of the Marine Corps family. We have an ongoing partnership with the American Association of Suicidology to help guide and inform our work.

In addition, we continue to coordinate our suicide prevention efforts with other experts from across the federal government, civilian organizations, and with international military partners. We actively participate as a member of the DoD Suicide Prevention and Risk Reduction Committee (SPARRC), meeting monthly with our DoD and Department of Veterans Affairs partners to join efforts in reducing suicides.

We are also attentive to the mental health of our warriors and are dedicated to ensuring that all Marines and family members who bear the invisible wounds caused by stress receive the

best help possible. We are partnered with the Navy to address the needs of Marines and their families in the face of the nationwide shortage of qualified mental health care providers, and are committed as a Corps to making sure every Marine struggling with a stress issue gets the support and treatment they need.

Conclusion

Suicides are a loss that we simply cannot accept. Taking care of Marines is fundamental to our ethos and serves as the foundation of our resolve to do whatever it takes to help those in need. We are aggressively increasing our suicide prevention activities and follow-on care. We have taken concrete steps forward and will continue our efforts to build resilience and reduce the stigma of seeking help. Our leaders at all levels are personally involved in efforts to address and prevent future tragedies and will remain actively engaged in this fight.

Thank you again for your concern on this very important issue.

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE SUBCOMMITTEE ON MILITARY PERSONNEL

COMMITTEE ON ARMED SERVICES

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: HEARING TO EXAMINE CURRENT STATUS OF SUICIDE PREVENTION PROGRAMS IN THE AIR FORCE

STATEMENT OF: LIEUTENANT GENERAL DARRELL D. JONES
DEPUTY CHIEF OF STAFF MANPOWER, PERSONNEL
AND SERVICES, UNITED STATES AIR FORCE

SEPTEMBER 9, 2011

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

INTRODUCTION

The Air Force is committed to strengthening the physical, emotional, and mental health of our Airmen. Unfortunately, despite our preventative efforts, some Airmen have chosen to take their own lives. This is a tragedy that strikes at the heart of our Wingman concept, caring for fellow Airmen, and that we must continue to address. We have placed a greater emphasis on resilience to bolster the ability of our Airmen to withstand the pressures of military life. Our Air Force understands we can only be successful when the entire Air Force community, including leaders, Airmen, families, chaplains, and health professionals promote the importance of resilience and early help-seeking by all Airmen in distress.

Since the inception of the Air Force's Suicide Prevention Program in 1997, the Air Force has used a multi-faceted approach to address the needs of Airmen from different backgrounds and different career fields. Our efforts resulted in the Air Force Suicide Prevention Program being recognized by the Substance Abuse and Mental Health Services Administration (SAMSHA) as one of only eight evidence-based strategies for suicide prevention.

Despite our prevention efforts, suicide rates remain a concern. The Air Force continues to work diligently to improve our preventive mechanisms, and we recognize even one suicide is too many.

SHIFT IN MESSAGING

The Air Force is focusing on a strength-based approach, stressing resilience through Comprehensive Airman Fitness (CAF)—that is an Airman that is physically, mentally, socially, and spiritually strong. This represents a change from past suicide prevention training and messaging that may have over-emphasized the term and act of suicide, which some mental health

experts say could inadvertently normalize suicide. Air Force leadership believes using a strength-based approach emphasizing CAF will help Total Force Airmen (Active duty, AF Civilians, Reserve, and Guard) pursue positive options, rather than suicide or other forms of self-destructive behavior.

AIRMAN & FAMILY RESILIENCE

We are committed to building resilient Airmen and families. Our Airmen must be able to withstand, recover, and grow in the face of stressors and changing demands, regardless of time, challenge, or location. Although Airmen cannot control work hours, operational tempo, and other factors, resilient Airmen can withstand stressful life demands.

To heighten the focus on Resilience, the Air Force established a Resilience Division within Headquarters Air Force in June 2010. This division has built a corporate program with two distinct yet integrated focus areas: Airman Resilience and Family Resilience.

The Airman Resilience Program has a tiered-training model, which begins with foundational training beginning at Basic Military Training and officer commissioning sources, and continues throughout an Airman's career with targeted intervention and training at defined points. By targeting education, training, and services at different tiers, resilience is customized to meet the needs of our individual Airmen.

In 2010, the Air Force researched the Resilience and Vulnerabilities of Air Force Families and developed a definition of family resiliency: A sense of community among families along with an awareness of community resources, feeling prepared/supported during all stages of deployment, and an increased sense of unit, family and child/youth support. As a result of this research, the Air Force has reinvigorated our deployment support and reintegration programs,

revamped the Community Action and Information Board process at the Headquarters, Major Commands, and bases, and developed a support program for special needs families.

STATISTICS

So far this year, 56 Total Force Airmen and Civilians have taken their own lives which equates to a suicide rate of 14 suicides per 100,000 Airmen. This is slightly lower than the 63 Air Force suicides in the same period last year, and a rate of 15.5 suicides per 100,000 Airmen.

While no segment of the Air Force is immune to suicide, incidence is higher with some groups. The most common risk factors associated with Air Force suicides are relationship problems, financial troubles, legal issues, and history of mental health diagnosis. Over the past year, 67 percent of suicides have been Airmen under the age of 34.

The Air Force's highest risk career fields continue to be Security Forces and Aircraft Maintenance, which have suicide rates in excess of the Air Force average. Suicide prevention training for frontline supervisors is mandated for these and other at-risk career fields.

While deployments and the demanding military lifestyle can cause additional stress for Airmen, Air Force suicide rates actually show that increased deployments correlate with a reduced suicide risk for Airmen.

STIGMA OF SUICIDE

Air Force medical data shows that more Airmen who died by suicide sought mental health care prior to their death than in previous years. Still, the majority of Airmen who committed suicide did not seek mental health care. Air Force leadership has worked to reduce the stigma associated with seeking and receiving mental health care, however, it still exists. The

2010 Air Force Climate Survey found that more than half of the Airmen surveyed felt there was a stigma associated with seeking help.

To ensure our Airmen have access to care without the perceived negative stigma, the Air Force has added mental health providers in primary care clinics. We also offer care through Military Family Life Consultants (MFLCs), who offer Airmen -- and family members -- the opportunity to see a licensed counselor for short-term counseling on a range of issues without the notification of chain of command, except in cases where counselors are legally required to notify authorities.

POST-SUICIDE CARE

Following a suicide, friends and family are at increased risk for a number of negative outcomes, including suicide. To address this need, the Air Force has developed the Leader's Post-Suicide Checklist designed to assist our leaders with an appropriate response to suicides or suicide attempts. The checklist is supported by research which shows that a proactive response by unit leadership can play a role in the prevention of additional suicides or suicide events. The checklist is continually updated and incorporates lessons learned from leaders who have experienced suicides in their units.

DEPLOYMENT TRANSITION CENTER

In July 2010, the Air Force established the Deployment Transition Center (DTC) at Ramstein Air Base, Germany. Since the Center's inception, approximately 2,000 Airmen have participated in this four-day reintegration and decompression program while enroute to their homes from deployment. Redeployers participate in educational discussions on a variety of

topics, including: how to manage the effects of combat-related stress (cognitive, physical, spiritual, emotional, and behavioral); responsibilities of leadership in reintegration; family reunification; impact of deployments on married and single service members, coworkers, family, spouses and children of different developmental levels, and recommendations for successfully readjusting back to normal life routines. Our internal survey results show that the vast majority of Airmen who have transited through the DTC found the experience worthwhile.

POST TRAUMATIC STRESS DISORDER AND MENTAL HEALTH CARE

We use the Air Force Post-deployment Health Assessment (PDHA) and Post-deployment Health Reassessment (PDHRA) to screen for medical conditions including post-traumatic stress disorder (PTSD). While most Air Force career fields have a very low rate of PTSD, others such as EOD, security forces, medical, and transportation have higher rates of post traumatic stress symptoms. Though the number of PTSD cases are on the rise, part of this increase can be attributed to improved medical care and total force awareness of PTSD causes and symptoms.

The Air Force will increase mental health professional authorizations by 25 percent over fiscal years 2012 through 2016. We expect this increase in manning will improve our ability to detect and treat Airmen with PTSD.

RECENT INITIATIVES

Based on the success of the Air Force's Wingman Day program, the Chief of Staff of the Air Force instituted a minimum of two Wingman Days per year for Airmen. Wingman Day is a "stand-down" day which directs units to participate in activities emphasizing Comprehensive

Airman Fitness, small group discussions, teambuilding, and other activities designed to facilitate unit and Airmen Resiliency.

Additionally, we are in the process of benchmarking a Resilience-based program called Leadership Pathways, which was recently initiated at Dover Air Force Base. This program incentivizes participation in existing classes and programs which enhance an Airman's resilience. Examples of class and program topics include health, nutrition, and financial management.

We are also working with the RAND Corporation on a longitudinal study on families. This study is currently following more than 5,000 active duty families while tracking their resilience across a full deployment cycle, before, during, and after deployment. The information received from this study will be invaluable on how we treat and provide care for Airmen and their families in the future.

CONCLUSION

The Air Force values the service and sacrifice of each Airman and family member, and even more so during times of war. We are keenly aware that our military lifestyle poses unique and sometimes difficult challenges for our Air Force team to overcome. The Air Force must continue to build a more resilient force, identifying our at-risk Airmen, and treating Airmen in need of help. The loss of an Airman to suicide and the consequential impact to the member's family, unit, and community is not acceptable.

DOCUMENTS SUBMITTED FOR THE RECORD

SEPTEMBER 9, 2011

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PTSD cases grow as combat continues for Fort Drum soldiers

By DANIEL WOOLFOLK
TIMES STAFF WRITER
THURSDAY, SEPTEMBER 8, 2011

FORT DRUM — James E. Bonds sat on the back deck of the Captain's Cove Motel overlooking Henderson Harbor and took a break from preparing reflective bait to watch the sea gulls feed.

"Fishing runs in me," the lifelong angler said. "My mom said she was even dreaming of fishing when she had me."

Even when the former soldier was deployed to Iraq in 2005 with the 10th Mountain Division's 2nd Battalion, 22nd Infantry Regiment, he fished.

"I was the only one ... who'd get dressed up in full battle gear to go fishing," he said.

Mr. Bonds survived an improvised explosive device attack. And during a raid, he was shot twice in the chest at close range. The rounds hit his armor, knocking the wind out of him before his fellow soldiers killed the shooter.

Back home after the deployment, Mr. Bonds began having nightmares about being attacked. One night while asleep with his girlfriend beside him, Mr. Bonds had another nightmare and began to choke her.

"After that, I didn't sleep in the bed with her no more," he said. "I couldn't trust myself."

In 2008, a doctor diagnosed Mr. Bonds with post-traumatic stress disorder that he believes came from the countless combat experiences and a traumatic brain injury, which likely came from the IED explosion, he said. To combat the effects of the wars, he makes behavioral health appointments and constantly works to keep the bad dreams and thoughts at bay. He does that mostly by keeping busy. If he's not fishing, he's mowing the lawn or painting.

"The more you harp on it, the worse it gets," he said. "That's why I'm always doing something."

Today, Mr. Bonds, who lives in Georgia, spends summers in the north country helping Capt. John A. Delorme with fishing charters. The two met each other during a fishing trip Mr. Bonds took with Fort Drum's Wounded Warrior unit.

And there is no shortage of wounded warriors in the north country.

Fort Drum's 19,500 soldiers are being deployed constantly to unforgiving combat zones. In the decade since 9/11, thousands of Fort Drum soldiers have served three and even four combat tours. The result has been a huge spike in PTSD cases.

During the past five years in particular, the north country has seen the arrest of soldiers, including some highly decorated for combat heroism, for such crimes as fatal stabbings, random street shootings and armed robberies. Many of the soldiers have cited PTSD as the reason for their behavior.

But Fort Drum and the north country remain underserved by behavioral health specialists. While the post offers round-the-clock emergency psychological services, soldiers seeking regular help can wait weeks for appointments.

More behavioral health professionals were needed when the base grew by 5,321 soldiers from 2003 to 2006 — mostly because of the addition of the 3rd Brigade Combat Team, said Denise K. Young, executive director of the Fort Drum Regional Health Planning Organization, which works with the post and area hospitals to coordinate and expand medical care in the north country.

"When that happened, we needed to expand," she said.

In 2005, the county had 39 credentialed behavioral health providers, she said. Now there are 109.

"That's huge. ... That's more than tripling the providers we have in the region," she said.

Yet those providers are still stretched thin.

"We've been at war a long time and it takes its toll on a soldier," she said. "These soldiers and families are part of our community and we need to take care of them."

A decade ago, Fort Drum had 15 providers and now it has 50, according to Dr. Todd L. Benham, the post's behavioral health chief. But current wait times are about a month, he said, as visits to behavioral health specialists grew from 14,000 in 2001 to 75,000 in 2010. The numbers increased not only from PTSD visits, but from more outreach and an addition of a clinic for traumatic brain injuries, which have grown because of IED attacks.

Off-post providers have a three- to four-month waiting list, Jefferson County Community Services Director Roger J. Ambrose said. A maximum of four to six weeks to see a practitioner would be a good start for him, but the number of specialists still must grow.

"We'd love to have people be able to just walk in and be seeing somebody that day," he said.

The problem is expected to be worse next year. Currently, more than 7,500 soldiers are deployed, but all of them will be back in the north country next year. The Army announced in August that its deployment length will be shortened to nine months from the current 12 months and soldiers can expect two years between deployments. Community leaders project that more home time will mean more families will join their soldiers at Fort Drum.

The increased population will increase demand for behavioral health practitioners, Mr. Ambrose said.

"We can only imagine, I think, that the waiting lists are going to get bigger unless we address the staffing needs of all the clients that we have," he said.

Last month, the post was approved for funding to hire more psychologists and social workers. And the civilian community is responding to the military and civilian behavioral health need, in part, by recruiting locals to become licensed therapists and by educating natives. Jefferson Community College and Keuka College teamed up last fall and introduced a bachelor's degree program in social work. The county has incentive programs to recruit licensed therapists.

Mrs. Young has seen that those therapists who see military cases often learn skills that help civilians.

"I think that we're learning about trauma and about its impact on people," she said.

And it helps if the civilian population is sensitive to the trauma that soldiers and their families are going through,

That includes fireworks, Mr. Bonds said.

"If you've ever been in a firefight and you hear them little rockets they shoot at you, it sounds just like them," he said. "If I know the fireworks are going to go off, it's OK, but if they do it kind of unsuspecting, I still try and find me a hole to climb in."

Instead of climbing into a hole one night when Mr. Bonds heard kids lighting off fireworks in Henderson Harbor, he walked up to them and asked them to stop because he's a combat vet. They did.

The severe psychological scars combat has left on Mr. Bonds will always last and combating the mental effects of war is something the former soldier will always struggle with.

"I learned, since being in the military, 'don't ever quit,' because if you quit that's going to be the end of you," he said. "So I get up regardless ... whether it's a successful day, well, hell, you never know."

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

SEPTEMBER 9, 2011

RESPONSE TO QUESTION SUBMITTED BY MR. JONES

Secretary WOODSON. As indicated in the table below, the numbers of mental health professionals (psychologists, psychiatrists, social workers, and psychiatric nurses) have increased in all occupations over the period covered. These figures include military, contractor, and civilian employees. The number of psychiatric nurses includes nurse practitioners working in the field. [See page 12.]

Occupation	2009	2010	3 Qtr. 2011
	Total	Total	Total
Psychologist	1,520	1,815	1,917
Psychiatrist	652	758	774
Social Worker	1,789	2,082	2,189
Nursing (including NP)	570	580	637
GRAND TOTAL	**4,531**	**5,235**	**5,517**

RESPONSE TO QUESTION SUBMITTED BY MR. COFFMAN

Secretary WOODSON. This is true. There is no requirement that the Warrior Transition Unit (WTU) mandate a Service member's participation in behavioral health treatment. When any Service member self-reports to any behavioral health clinic for the treatment of post-traumatic stress disorder (PTSD) (or any mental health disorder), their behavioral health care provider has the due diligence to conduct a comprehensive mental health evaluation, but cannot mandate treatment unless the Service member is imminently dangerous to themselves or others. There are several guiding policies and standard operating procedures which require both behavioral health providers and their respective units to do everything possible to provide the appropriate level of care for all Service members. In addition, these regulations address the ethical and legal responsibilities of the providers, while ensuring that all possible efforts are made to offer high quality care while preserving the rights of Service members during their time in the military, and prior to any separation from the service. [See page 28.]

RESPONSES TO QUESTIONS SUBMITTED BY MS. TSONGAS

Secretary WOODSON. Suicide is a multi-faceted issue and many factors play a role in whether or not a person decides to take their own life. The 2010 DOD Suicide Event Report is a compilation of over 250 data elements collected on every Active Duty suicide that occurred in Calendar Year 2010. This report indicates that 2.85% of the suicides (a total of eight) had a known history of sexual abuse, which may refer to either a childhood history or an assault as an adult. However, it is not known with any degree of certainty that a specific instance of sexual assault directly contributed to the Service member's decision to end his or her life by suicide. The Department takes the issue of sexual assault very seriously and is committed to establishing a culture free of sexual assault. [See page 17.]

Secretary WOODSON. Through the Department of Defense (DOD) Suicide Event Report program, the Department tracks suicides by gender, as well as many other factors, including age, rank, marital status, location, setting, etc. In Calendar Year (CY) 2010, the last year for which we have complete data, there were 14 female Active Duty Service members who died by suicide. This comprises 4.75% of the total number of suicides in 2010. Looking back through the last decade, the total number of female Service members who have died by suicide has been very small, especially when compared to the percentage of the force comprised of women, which ranges

from approximately 20% in the Air Force, 15% in the Army and Navy, to 6.5% in the Marine Corps. However, women, as a whole, are much more likely to attempt suicide that actually complete suicide. For CY 2010, the Department recorded 863 attempts, 75.67% male and 24.33% female. [See page 18.]

Gender	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Females	4	8	11	9	9	13	11	13	9	14	11	112
Males	156	163	179	186	180	200	212	254	300	281	199	2,310
% Females	2.50	4.68	5.79	4.62	4.76	6.10	4.93	4.87	2.91	4.75	5.24	4.6
Total	160	171	190	195	189	213	223	267	309	295	210	2,422

Source: DOD Mortality Registry, Mortality Surveillance Division, Armed Forces Medical Examiner

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

SEPTEMBER 9, 2011

QUESTIONS SUBMITTED BY MRS. DAVIS

Mrs. DAVIS. Historically, we've heard about the difficulty in hiring behavioral health and related providers within the Services. What are the recruiting and hiring challenges? Are there significant shortfalls within the Services? What are the Services doing to address those shortfalls?

Secretary WOODSON. The recruiting and hiring challenges for DOD mirror the challenges in the private sector. There is a nationwide shortage of behavioral health providers, which means that the Department of Defense (DOD) must compete with the civilian sector for the best qualified professionals. However, the Department has succeeded in significantly increasing the number of behavioral health providers over the past several years. We have increased Uniformed Services, Government Civilian, and contract providers to address the Department's behavioral health concerns. The DOD and the Services have worked closely to develop a yearly consensus on appropriate adjustments to military accession, bonus, and incentive pays. The Department has also recently started implementing the Physician and Dentists Pay Plan, which helps to ensure our ability to provide competitive compensation for Government Service medical professionals.

We defer to the Services for responses regarding Service-specific problems as they implement and fund the program.

Mrs. DAVIS. What are some challenges senior leadership faces regarding efforts to reduce suicide and suicide attempts?

Secretary WOODSON. The Department recognizes that preventing suicide is not simply a problem for the behavioral health care provider or Chaplain; it is a leadership responsibility. One of the biggest challenges senior leaders face is gaining a full understanding of the problem. Two comprehensive reports, the Department of Defense (DOD) Suicide Prevention Task Force Report and RAND Suicide Prevention Report, identify leadership as key in the prevention of suicide. Since suicide is a multi-faceted issue, efforts to prevent it touch virtually every aspect of a Service member's life.

The Department is moving aggressively to enhance protective factors through the various Service resilience programs such as Army's Comprehensive Soldier Fitness and the Marine's Combat Operation Stress Control Program. With this effort comes the challenge of changing the mindset of a force that has been solely focused only on physical fitness to one that embraces psychological fitness as being of equal importance. The Department is making progress enhancing our surveillance methods as well as the fidelity of our data, but there is much work still to do.

Suicide prevention is part of a larger effort dealing with health promotion and risk reduction, a strategy that examines policy, structure, processes and programs to reduce suicides, risk-related deaths, and other negative outcomes of high risk behavior. DOD leadership remains committed to conveying the message to all that seeking help for behavioral health issues is not a symptom of weakness, but a sign of strength. While overcoming the stigma and myths associated with behavioral health care has been a challenge, the Department is making progress on multiple fronts.

Mrs. DAVIS. The DOD Task Force for Prevention of Suicide Among Members of the Armed Forces conducted a systematic review of prevention efforts and provided 76 recommendations. Where is the Services and the Department in implementing any of those recommendations?

Secretary WOODSON. The Department has reviewed and assessed the Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces. The Department sent an initial response to the congressional defense committees in March, 2011 and recently sent a final response on September 21, 2011 in accordance with section 733 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009. This final response contains a synopsis of the Department's implementation plan addressing each of the 76 recommendations contained in the report. After a complete and thorough review, the Department determined that 36 recommendations require new actions to be taken, 34 recommendations have actions planned, underway, or completed, and 6 recommendations do not merit any action. For recommendations requiring action, when the way ahead is

clear and straightforward, those actions will be initiated immediately. In cases where additional clarification or more data are needed, the Department will devote the required time and resources to clarify or assess the extent of the problem so that the Task Force's objective can be properly evaluated and an enduring outcome achieved. The Department will continue to review, implement, and revise its plan to ensure the best possible solutions are identified and implemented promptly.

Mrs. DAVIS. Why did the July 2011 Army numbers spike to an all time high? What is being done to mitigate the spike in July from occurring again?

General BOSTICK. This was a very unexpected and unfortunate outcome for July. After unusually high months in April and May, the Army's Vice Chief of Staff sent an email to every battalion and brigade commander in the Army asking them to "remain vigilant of emerging high-risk and self-harming behavior." Suicide is a very complex issue that is without question the most severe and tragic outcome of a very difficult situation. There are a number of factors that contribute to the decision to commit suicide, and the Army leadership continues to focus highest priority efforts to better understand the causes of Soldier suicides. We are currently reviewing each of these individual cases and looking to identify factors that could explain this unexpected spike.

In an effort to learn as much as possible from every suicide, in March 2009 the VCSA established the monthly VCSA Suicide Senior Review Group (SSRG). The SSRG involves senior commanders from affected commands across the Army who meet and review approximately 15 to 20 suicide cases each month. The cases are discussed to glean lessons learned and identify trends and themes in an effort to help prevent future suicides.

Additionally, since 2009, the Army has had a Health Promotion and Risk Reduction, Task Force to dedicate focused energies and resources to address all aspects of suicide. This Task Force continues to examine the complexity of suicide, taking into account national suicide trends, individual Soldier risk factors and the Army's institutional approach to suicide prevention. The task force has taken a holistic approach to the identification and mitigation of identified risk factors. The focus continues to be on promoting Soldier wellness (physical, mental and spiritual health). This includes investigating ways to promote resiliency, reduce stressors, improve the ability and willingness to identify when someone needs help, and institutionalize and normalize help-seeking behaviors.

Mrs. DAVIS. Historically, we've heard about the difficulty in hiring behavioral health and related providers within the Services. What are the recruiting and hiring challenges? Are there significant shortfalls within the Army? What is the Army doing to address those shortfalls?

General BOSTICK. As of September 2011, the Army has 5,912 Behavioral Health (BH) providers. The current estimated active component Army BH requirement is 6,107 providers, including professional providers and BH technicians, which represents an unmet requirement of 195 supporting the Active Component. Since 2007, the Army has added 2,613 civilian, military and contract BH providers supporting the Active Component. This represents a 92% increase in credentialed BH providers.

BH recruiting and hiring challenges are not due to lack of funding. Recruiting and hiring challenges continue to stem from a national shortage of qualified providers, especially in remote locations, and compensation limitations inherent to government employment.

Given the significant national shortages of qualified providers, the Army has implemented several initiatives to resolve its shortfalls including bonuses, scholarships, and an expansion in training programs. In partnership with Fayetteville State University, the US Army Medical Command (MEDCOM) developed a Masters of Social Work program which graduated 19 in the first class in 2009. The program has a current capacity of 30 candidates. MEDCOM increased the number of Health Professions Scholarship Allocations dedicated to Clinical Psychology and the number of seats available in the Clinical Psychology Internship Program. To enhance recruitment of potential candidates and retention of staff, MEDCOM provided centrally funded reimbursement of recruiting, relocation, and retention bonuses for civilian BH providers.

Mrs. DAVIS. What are some challenges senior leadership faces regarding efforts to reduce suicide and suicide attempts?

General BOSTICK. Senior Army leadership recognizes that the effort to reduce suicide and suicide attempts goes beyond suicide prevention. Suicide prevention is part of a larger effort dealing with health promotion and risk reduction and is nested within a "meta health promotion and risk reduction portfolio management" strategy that examines policy, structure, processes and programs to reduce suicides, risk-related deaths, and other negative outcomes of high risk behavior.

Army leadership understands that a decade of war has unintentionally limited garrison leadership and management requirements by emphasizing combat, technical and tactical training that is focused on reset, readiness cycles, and pre-deployment preparation while in garrison. These activities have tipped the balance from institutional readiness, measured by Soldier/Family wellbeing and good order and discipline in garrison, to combat readiness, as measured by Army force generation of units and tactical skills in theater.

To counter the effects of a decade of war, the Army is institutionalizing Professional Military Education training programs to "re-green" leaders in the lost art of garrison leadership (the art of commanding units, running daily operations, and taking care of Soldiers and Families in peacetime), the importance of enforcing policies and procedures that instill good order and discipline in units, recognizing high risk behavior related to suicide and accidental death, reducing stigma associated with behavioral health and treatment, and increasing resiliency in our Soldiers, DA civilians and Families.

Mrs. DAVIS. What are the Services doing to reduce the stigma in seeking help for mental health issues, especially suicide? Are there confidential reporting mechanisms, and if so, are how do the Services assess their effectiveness?

General BOSTICK. Army leaders have developed and implemented numerous initiatives to address the issue of "stigma" as it relates to seeking mental health services. Policy revisions have been promulgated to discontinue use of the term "mental" when referring to mental health services and replaced it with "behavioral." Additionally, policy guidance has been implemented for leaders and Soldiers regarding stigma, its impact, and their responsibilities. Initiatives were also taken to ensure that the most recent Suicide Prevention and Awareness training videos contain scenarios that model supportive leader behavior and address leader responsibilities relative to promoting health-seeking behavior and the available resources and applicable policies. Strategic communications initiatives have been launched by the Office of the Chief of Public Affairs in conjunction with members of the Army Staff, to utilize various media to promote help-seeking behavior for Soldiers and their Families. These efforts include the use of public service announcements using celebrities as well as Army leaders to include the Army Chief and Vice Chief of Staff and Sergeant Major of the Army. One of the most successful interventions taken by the Army to alleviate stigma is the co-locating of behavioral health and primary healthcare providers (Respect-Mil and Medical Home Model) within medical service facilities. This initiative decreases the differentiation between behavioral health and primary care services and addresses concerns regarding Soldiers being seen by peers as they enter behavioral health treatment facilities. Additionally, this initiative encourages informal communication between the services and improves patient "handoff" from medical service to behavioral health services. The Army continues to explore opportunities to employ confidential behavioral health and related services. A promising program is the Confidential Alcohol Treatment Pilot program. This program is being piloted at six installations and provides eligible Soldiers the opportunity to self-refer to the Army Substance Abuse Program and receive confidential treatment for alcohol abuse issues. Additional support is provided via improved access to behavioral health services through the advent of the TRICARE Assistance Program (TRIAP) and the Tele-Behavioral Healthcare service. These services facilitate private interactions between members and licensed counselors. Eligible beneficiaries can access TRIAP an unlimited number of times, and services are confidential and non-reportable. Confidential services are also offered through the utilization of the Veterans Crisis Line and Military One Source. Both resources, as well as similar services, are heavily promoted through various communications platforms, to include the Army, G–1, Suicide Prevention website. Stigma is measured during several surveys and assessments. The Army has standardized stigma related questions in the Mental Health Assessment Team Survey (administered in theater), Sample Survey Military Personnel (administered at installations), and Periodic Health Assessment Surveys (for not on active duty Reserve Component personnel) to gauge perceptions on the impact of stigma relative to seeking behavioral health assistance, career impact, leadership support and loss of confidence by peers and leaders. The results of these surveys are used to target opportunities to launch additional education and awareness initiatives. The Army is committed to the goal of cultivating a climate in which its members will actively engage in help-seeking behaviors when faced with behavioral health issues and other concerns. A comprehensive Stigma Reduction Campaign Plan is being developed to aggressively address the issue, both institutionally and culturally.

Army has focused efforts to combat stigma:

- Raise awareness and promote self-care by focusing on skill building to reduce known risk factors such as substance abuse and mental health problems. Skill building emphasizes help-seeking behaviors such as teaching service members to refer themselves to behavioral health professionals or chaplains.
- Facilitate access to high-quality care by detecting and reducing barriers such as stigma, educating service members on the benefits of accessing behavioral health care, and ensuring that a sufficient supply of behavioral health care professionals and chaplains is available.
- Provide high-quality care by training providers on state-of-the-art practices for behavioral health and implementing specific interventions focused on suicide.
- Respond appropriately by focusing on how details of the suicide are communicated in the media as well as the dissemination of information to acquaintances of the suicide victim. Commanders should be provided with formal guidance on how to respond to suicides and suicide attempts.

Mrs. DAVIS. Have the Services noticed any differences between Active Duty and Reserve Component suicides? What suicide prevention programs exist in each Service that geographically dispersed members of the Reserves can take advantage of?

General BOSTICK. Several suicide prevention programs provide support to geographically-dispersed Soldiers and Family members to include Army Community Services (ACS) Geographically Dispersed Outreach. This program supplements ACS-centric programs with outreach to Soldiers and Families who are geographically or socially isolated. The ACS programs are delivered either through distance methods or through partnerships with local community-based programs.

Geographically-dispersed members can also take suicide prevention training conducted at the nearest reserve component unit. Some of those programs are Applied Suicide Intervention Skills Training (ASIST), Ask, Care, Escort Suicide Intervention (ACE–SI) Yellow Ribbon Reintegration Program, Strong Bonds, Army Strong Community Centers, the Army Reserve Fort Family hotline, Army Family Team Building training, virtual and real-world Family Readiness Groups, and Army Reserve Child and Youth Services.

Mrs. DAVIS. The DOD Task Force for Prevention of Suicide Among Members of the Armed Forces conducted a systematic review of prevention efforts and provided 76 recommendations. Where is the Services and the Department in implementing any of those recommendations?

General BOSTICK. The Department of Defense has reviewed and assessed the Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces. The Department sent an initial response to the Congressional defense committees in March 2011 and recently sent a final response on September 21, 2011. This final response contains a synopsis of the Department's implementation plan addressing each of the 76 recommendations contained in the report. After a complete and thorough review, the Department determined that 36 recommendations require new actions to be taken, 34 recommendations have actions planned, underway, or completed, and 6 recommendations do not merit any action.

The Army has implemented 11 of the 36 recommendations that DOD has accepted for action. Eight of the 36 do not require any Army action. The Army is working with DOD to address the remaining 17 recommendations.

Mrs. DAVIS. Historically, we've heard about the difficulty in hiring behavioral health and related providers within the Services. What are the recruiting and hiring challenges? Are there significant shortfalls within the Navy? What is the Navy doing to address those shortfalls?

Admiral KURTA. Navy Medicine has increased the size of the mental health workforce to support the readiness and health needs of Sailors and their families throughout the deployment cycle, including at medical treatment facilities, as well as within our Fleet and deployed units by providing embedded mental health support. The Navy is committed to improving the psychological health, resiliency and well-being of our Sailors and their family members and ensuring they have access to the programs and services they need. The military is not immune to the nationwide shortage of qualified mental health professionals. Throughout the country, the demand for behavioral health services remains significant and continues to grow. Within the Navy, mental health professional recruiting and retention remains a top priority for active and reserve component personnel, contractors and civilians, particularly for psychiatrists, clinical psychologists, social workers and mental health nurse practitioners. The Navy is actively using numerous accession and retention bonuses (including educational incentives and special and incentive pays) to attract

and retain uniformed mental health professionals. While not yet fully staffed, the success of these incentive programs is greatly improving our active duty mental health provider staffing.

We have also made progress with our civilian mental health workforce. The use of direct hire authority, pay flexibilities, and centralized recruiting has enabled us to locate and attract the talent that we need. Continued success will depend on the ability of the Federal personnel system to adjust and respond to the associated challenges presented by changes in market conditions. We will continue to carefully assess our efforts to ensure we employ the appropriate tools to recruit and retain our civilian mental health professionals.

Mrs. DAVIS. What are some challenges senior leadership faces regarding efforts to reduce suicide and suicide attempts?

Admiral KURTA. The primary leadership challenge is to foster a climate where Sailors can openly acknowledge when they are under increased personal stress and ask for and receive help when they need it.

Ensuring the perception that seeking help will affect a Sailor's career, lead to the loss of their security clearance, or result in a loss of trust or different treatment from their leaders and peers is removed from the Sailor's decision process in seeking support.

Ensuring logistical barriers to accessing early support resources are fully removed. The Navy continues to embed mental health providers on carriers and within other operational units so early assistance is more readily accessible. Flexible support resources such as Military Onesource, Chaplains, and Fleet and Family Support Centers help expand early access.

Raising the level of understanding of Navy Operational Stress Control among all Sailors in order to mitigate stress effects and encourage taking early actions for themselves or others.

Mrs. DAVIS. What are the Services doing to reduce the stigma in seeking help for mental health issues, especially suicide? Are there confidential reporting mechanisms, and if so, are how do the Services assess their effectiveness?

Admiral KURTA. Navy's suicide prevention strategic communications and program outreach efforts focus on removing barriers to Sailors seeking assistance. These efforts include the dispelling of inaccurate myths, such as a security clearance is not likely to be removed for seeking help, which in turn facilitate stigma reduction.

The Navy continues to embed mental health providers on carriers and within other operational units so early assistance is more readily accessible. Flexible support resources such as Military OneSource, Chaplains, and Fleet and Family Support Centers help expand early access.

The Navy Operational Stress Control program raises the level of understanding among all Sailors regarding stress effects and how to take early actions for oneself or others to avoid or mitigate stress effects.

Despite the above efforts many Sailors continue to believe that seeking help will affect their careers, lead to loss of clearance, or result in the loss of trust or different treatment from their leaders and peers.

A level of confidentiality is available within all care services including Military Medicine, Fleet and Family Services, and Tricare Network care. Sailors can also seek confidential assistance from Military OneSource, Chaplains, and the National Lifeline and Veteran's Crisis Chat Line. Most of these resources have legal limits to confidentiality and each of them will take immediate life saving actions in emergency situations regardless of confidentiality.

It is difficult to evaluate the effectiveness of confidential assistance. However, quarterly medical care utilization surveillance data from the Navy and Marine Corps Public Health Center shows a marked increase in both in-house and Tricare network purchased mental health care utilization by active duty Sailors. These data suggest that an increasing number of people are finding the courage and capacity to seek mental health care.

Mrs. DAVIS. Have the Services noticed any differences between active duty and reserve component suicides? What suicide prevention programs exist in each Service that geographically dispersed members of the reserves can take advantage of?

Admiral KURTA. The relatively small size of the Reserve Component and correspondingly low number of Reserve Sailors lost to Suicide while on Active Duty limits comparability between Active Duty and Reserve Component suicides. However, information suggests that stressors related to economic and job difficulties are more prevalent among the Reserve Component Sailors who have died by suicide.

Geographically dispersed Sailors are accessed through the Reserve Psychological Health Outreach Program, included in their unit suicide prevention program activities, and have access to a variety of resources including the National Lifeline and

Veteran's Chat Line and Military Onesource for immediate counseling or crisis response.

- Navy Reserve units are fully included in Navy suicide prevention program activities including training, surveillance and analysis, and outreach.
- Scenario-based Navy Suicide Prevention Peer to Peer training is conducted throughout the Navy Reserve. Each unit has an assigned Suicide Prevention Coordinator (SPC) who works with the command leadership team to ensure execution of a robust prevention program that engages peers in risk identification and response. Navy includes Operational Stress Control principles in all programs. Bystander intervention curriculum trains peers in identifying risks and effective intervention techniques. Many Navy Reserve units have chapters of the grass roots Coalition of Sailors Against Destructive Decisions (CSADD) program that includes peer to peer support to Navy Reserve Sailors.
- The Navy Reserve Psychological Health Outreach Program provides enhanced training, consultation, and local community outreach for Reserve Component service members. The Navy Psychological Health Outreach Program teams help find, refer to, and follow-up with appropriate military, VA and local community support services for Reservists.
- The Yellow Ribbon initiatives, including the Returning Warrior Workshops, and other pre- and post deployment activities have improved awareness of and access to local community support services.
- Other evidence-based counseling programs are available for those reservists living near military bases, such as Families Over Coming Under Stress (FOCUS).

Mrs. DAVIS. The DOD Task Force for Prevention of Suicide Among Members of the Armed Forces conducted a systematic review of prevention efforts and provided 76 recommendations. Where is the Services and the Department in implementing any of those recommendations?

Admiral KURTA. The Navy has thoroughly reviewed and provided input to Department of Defense on each of the 76 Task Force Recommendations. 35 recommendations require further action and are in work in coordination with USD(P&R), 35 are completed and require no further action and 6 required no action.

We have implemented many of the recommendations including resilience building, building program evaluation into all new suicide prevention initiatives, and resourcing our headquarters level staff. The Navy will work with DOD in continuing to implement other recommendations such as better standardizing the DOD Suicide Event Report (DODSER) process.

Navy will also continue to monitor those initiatives that address the 35 recommendations that were assessed as completed and those areas addressed in the 6 recommendations where no action was directed.

Mrs. DAVIS. In 2009, the Marine Corps documented 172 suicide attempts, that is nearly double the 82 attempts that was documented in 2002. Given the steady increase over the past three years, what efforts has the Marine Corps taken to review the data and determine what efforts should be undertaken to address the increase in attempted suicides? What, if any, lessons can be taken from the fact that as the number of support programs seem to be increasing, attempts at suicide have also increased?

General MILSTEAD. Marine Corps carefully reviews suicide attempt data and continually updates programs and policies in an effort to foster resilience and encourage Marines to engage helping services early, before problems worsen to the point of crisis. There does not appear to be a relationship between the increasing number of support programs and the increasing number of suicide attempts. Increased attempts are due in part to steady improvement over the past few years in suicide attempt surveillance. In addition, improved Marine suicide prevention skill is leading to more suicide attempts being discovered and stopped before completion.

In cooperation with OSD Telehealth and Technology, we analyze quarterly and annually aggregate suicide data, studying close to 100 variables associated with suicide in an effort to identify groups that may be at higher risk. Thus far, no group of Marines appears to be at greater risk than another. The variables most associated with suicide are so common in the general population, that there is little to act upon. In other words, we have not yet figured out how to predict ahead of time WHO will attempt suicide. We are, however, learning more about WHEN a Marine might attempt suicide. We recognize the warning signs of imminent risk that sometimes follow onset of extreme life stressors.

As a result, we use a community approach to suicide prevention, arming ALL Marines with the knowledge to recognize warning signs of suicide, and charging each with the duty to act upon recognizing those signs and to ask the difficult question,

"Are you thinking about killing yourself?" In addition, we continue to study risk and protective factors associated with suicide, through various research projects including the Marine Resiliency Study, the Psychological Autopsy study underway with the American Association of Suicidology, the Penn State study of the effect of suicide on Family Members, and a Blue Ribbon Panel with suicidologists to explore better screening for suicide risk.

Mrs. DAVIS. Historically, we've heard about the difficulty in hiring behavioral health and related providers within the Services. What are the recruiting and hiring challenges? Are there significant shortfalls within the Marine Corps? What is the Marine Corps doing to address those shortfalls?

General MILSTEAD. The military is not immune to the nation-wide shortage of qualified mental health professionals. Throughout the country, the demand for behavioral health services remains significant and continues to grow. Within Navy Medicine, mental health professional recruiting and retention remains a top priority for active and reserve component personnel, contractors and civilians, particularly for psychiatrists, clinical psychologists, social workers, and mental health nurse practitioners. The Navy is actively using numerous accession and retention bonuses (including special and incentive pays) to attract and retain uniformed mental health professionals.

Navy Medicine has increased the size of the mental health work force to support the readiness and health needs of Marines and their families throughout the deployment cycle, including at medical treatment facilities, as well as within our deployed units by providing embedded mental health support. The Marine Corps is committed to improving the psychological health, resiliency, and well-being of our Marines and their family members and ensuring they have access to the programs and services they need.

Mrs. DAVIS. What are some challenges senior leadership faces regarding efforts to reduce suicide and suicide attempts?

General MILSTEAD. Preventing Marine suicide hinges on our leaders' ability to build a resilient Force and encourage Marines to overcome stigma and engage helping services early, before problems worsen to the point of suicide.

The Marine Corps has recently adopted a resiliency model that identifies the interconnectedness between four spheres of resilience (social, physical, psychological, and spiritual) and the key agencies and support programs that deliver services to Marines and families. The end product will result in a resilience approach that draws on strengths of existing programs to infuse resilience content throughout training and programming capabilities. This approach focuses on Marine total 'fitness' as a model that includes not only physical, but also psychological, spiritual and social fitness. Efforts are well underway to inventory current capabilities, assess effectiveness and future operations utility, and identify gaps and redundancies. Identified agencies are collaborating to develop a series of resilience-based training courses that will be offered throughout the course of a Marine's career.

Marines have been ingrained with the ethos that whether in battle or at home, we 'never leave a Marine behind.' By making the language and process of help-seeking consistent with the ethos, Marine Corps leadership is leveraging the culture of the Corps to overcome the stigma against help seeking. According to the Joint Mental Health Assessment Team—7th edition, the Marine Corps has seen a small reduction in the stigma surrounding behavioral health problems and healthcare, but reducing stigma still remains a challenge. Senior leadership messages underscore that seeking help for distress is a duty not an option, and is consistent with Marine Corps culture, ethos, and values.

Mrs. DAVIS. What are the Services doing to reduce the stigma in seeking help for mental health issues, especially suicide? Are there confidential reporting mechanisms, and if so, are how do the Services assess their effectiveness?

General MILSTEAD. Our leaders emphasize to all Marines that psychological and physical fitness are equally important to mission readiness, and that asking for help is a sign of strength. All Marines receive annual suicide prevention education that includes testimonials by Marines who have sought help for stress problems, benefitted from treatment, and continued on to achieve career milestones. Suicide prevention peer trainers discuss their own struggles with stress and their successful use of helping services. Operational Stress Control and Readiness training teaches Marines how to listen to one another and offer trusted referral for more serious issues. Senior leaders are trained to manage command climate in a way that reduces stigma and encourages Marines to engage helping services early, before problems worsen to the point of crisis. Training for senior leaders emphasizes the importance of trust between Marines and their leaders. Training is being modified to include education about behavioral health symptoms, treatment, and treatment effectiveness, a recommended practice for reducing stigma. Due to their nature, anony-

mous and confidential services are challenging to evaluate for effectiveness. Current assessment includes utilization rates and numbers of suicides possibly averted due to emergency response coordinated by the service. Anonymous and confidential services available to Marines include DSTRESS Line counseling service (currently a pilot program in the Western US, scheduled to expand Corps-wide in 2012); Military Family Life Consultants; Military One Source; Veterans Crisis Line; Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Outreach Line; Psychological Health Outreach Program (reserves); Yellow Ribbon Reintegration Events (reserves); and Families Overcoming Under Stress.

Mrs. DAVIS. Have the Services noticed any differences between Active Duty and Reserve Component suicides? What suicide prevention programs exist in each Service that geographically dispersed members of the reserves can take advantage of?

General MILSTEAD. Active duty and selected reserve not on active duty suicides share similar stressors—relationship problems, financial problems, behavioral health diagnosis, legal and occupational problems, and substance abuse.

Marine leaders mitigate the effect of geographic dispersion on selected reserve suicide prevention efforts by reaching out to Marines in non-duty status and encouraging strong relationships between Marines both on and off duty. Currently, the Marine Corps offers several programs to support geographically dispersed Marines. The DSTRESS Line is an anonymous, by-Marine-for-Marine counseling service, currently piloted in the Western US and scheduled to expand Corps-wide in 2012; it is available to all Marines and their loved ones. The Psychological Health Outreach Program assists Marine reservists with screening for behavioral health issues, referring them for appropriate treatment, and assisting with follow up to ensure they are receiving the appropriate behavioral health services. Additionally, our Yellow Ribbon Reintegration Events/Returning Warrior Workshops address suicide prevention and promote resilience in Marine reservists and their families.

External programs available to Marine reservists in non-duty status include Military One Source, Veterans Crisis Line, TRICARE transitional assistance, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Outreach Center, and Department of Veterans Affairs OIF/OEF care management teams.

Mrs. DAVIS. The DOD Task Force for Prevention of Suicide Among Members of the Armed Forces conducted a systematic review of prevention efforts and provided 76 recommendations. Where is the Services and the Department in implementing any of those recommendations?

General MILSTEAD. Marine Corps has implemented half of the 76 targeted recommendations. Our goal is to implement over the next two years the remaining recommendations that have been accepted by the Secretary of Defense.

Mrs. DAVIS. Historically, we've heard about the difficulty in hiring behavioral health and related providers within the Services. What are the recruiting and hiring challenges? Are there significant shortfalls within the Air Force? What is the Air Force doing to address those shortfalls?

General JONES. We have four top challenges for recruiting and retaining all health professions, including those in the behavioral health specialties:

1. Recruiting fully qualified "ready to practice" medical professionals is extremely difficult; available incentives cannot match private sector compensation. Additionally, accession bonuses are not viewed as such since they are offered in lieu of specialty pay.
2. Retention in general is a problem, forcing increased pressure on accessions. Medical professions are extremely lucrative in the private sector and it is difficult to retain people beyond their first commitment even in a sluggish economy.
3. Securing funds and ensuring synchronization of funds for the two portions of the Health Professions Scholarship Program (HPSP) is problematic. Defense Health Program (DHP) and Reserve Personnel Appropriation (RPA) dollars must BOTH be available to start a student in the program.
4. Recruitment of civil service healthcare professionals is challenging due to the lengthy hiring process. Maximizing utilization of available Federal Employee Pay and Compensation Act (FEPCA) incentives is a must to compete with private sector hiring.

We cannot speak for the Army, but shortfalls continue for the Air Force with active duty Licensed Clinical Psychologists. Even with accession and retention bonuses, scholarship and education loan repayment programs, we remain at 85% of our authorized/funded manning (218/257) based on the latest mental health provider

data presented to the Wounded Ill and Injured (WII) Senior Oversight Committee (SOC) for third quarter FY11.

The AFMS uses a three-prong approach to recruiting and retention by promoting education opportunities, enhancing direct compensation packages, and improving quality of life programs. Success with this approach is indicated by improvements to average career length over the last 5 years for each of the Corps. To compensate for shortfalls in specific specialties, the Air Force must continue to rely on contractors and private sector care through the Tricare network.

Due to the critical need for civilian Defense Health Program (DHP) funded behavioral health providers, the Air Force has exempted these positions from the current hiring freeze. The non-DHP Family Advocacy behavioral health providers are also being considered for exclusion from the hiring freeze.

Mrs. DAVIS. What are some challenges senior leadership faces regarding efforts to reduce suicide and suicide attempts?

General JONES. Suicide is one of the most challenging issues senior leaders face. We always want our Airmen to ask for and receive the help they need. Unfortunately, the 2011 Air Force Community Assessment Survey of over 64,000 Airmen suggests interpersonal and individual stigmas continue to represent significant barriers to help-seeking. The Air Force has initiated a number of programs and policies to address the issue of stigma. For example, we recently developed a strategic communication plan to promote help-seeking and dispel myths about the potential career impact from seeking mental health care. Additionally, the Chief of Staff of the Air Force and Chief Master Sergeant of the Air Force released public service announcements encouraging Airmen to ask for help when they need it.

One challenge is to identify Airmen who may have a higher risk factor. The Air Force has a focused curriculum to target suicide prevention training toward high risk career fields such as Security Forces and Aircraft Maintenance. Supervisors in higher-risk career fields also complete the intensive Frontline Supervisors Training, which teaches more advanced peer-to-peer intervention techniques. Perhaps the greatest challenge leaders face is dealing with a suicide that occurs in their unit. Until recently, there was very little information to guide leaders through the process of healing their unit. We know that the time immediately following a suicide is a period of increased risk for friends, family, and co-workers of the deceased. To fill this knowledge gap, the Air Force issued comprehensive post-suicide guidance for leaders. We are hopeful this guidance will help the bereaved in the difficult time following a suicide.

Suicide is a very complex human behavior. Typically, there are a number of factors that contribute to suicidal events. We are working hard to objectively study suicidal behaviors in the Air Force so we can educate senior leadership on the most accurate warning signs and risk factors. To this end, the Air Force is working in concert with the Defense Centers of Excellence Telehealth and Technology to mature and expand the DOD Suicide Event Report (DoDSER). We hope that systematic surveillance and study of Air Force suicides will increase our understanding of how to better prevent suicides in the future.

Mrs. DAVIS. What are the Services doing to reduce the stigma in seeking help for mental health issues, especially suicide? Are there confidential reporting mechanisms, and if so, are how do the Services assess their effectiveness?

General JONES. The Air Force has been working continuously to enhance access to psychological health care and reduce the stigma associated with seeking such care. One of the areas that has seen considerable attention is our Suicide Prevention Program, and the following are some features and improvements. Initial and annual suicide prevention training, Frontline Supervisor Training, and Wingman Day training all now include stigma-reduction messages. The recently published Strategic Communication Plan includes public service announcements, media reporting guidelines, leadership talking points, and post-suicide guidance for commanders. The Air Force's Limited Privilege Suicide Prevention program affords increased confidentiality for Airmen under investigation that are suicidal and seeking mental health care.

There is little objective data which indicates the level of mental health stigma in the Air Force. However, mental health clinic visits have been increasing steadily year by year, suggesting more Airmen are overcoming concerns about stigma. To gain additional objective data, the 2011 Community Assessment Survey contained several questions specifically targeted to mental health stigma. This survey of over 64,000 Airmen began January 2011. Results suggest that interpersonal and individual stigma is more of a barrier to help-seeking than institutional stigma. Another Air Force initiative that targets stigma reduction is Comprehensive Airman Fitness (CAF) that emphasizes a strength-based approach to help withstand stressful life demands. This Air Force-wide initiative includes the widespread implementation of

the Leadership Pathways model that provides incentives to Airmen and family members to take existing psychoeducational classes offered by base helping agencies. The CAF initiative also makes Airmen aware of helping resources and encourages good Wingmanship and responsible help-seeking through semi-annual Wingman Days.

The Behavioral Health Optimization Program (BHOP) is another Air Force effort to enhance access to psychological health care and reduce stigma associated with seeking such care. BHOP places mental health providers in primary care clinics to consult with primary care providers and provide brief psychological interventions to all beneficiaries in a primary care setting. This not only provides mental health services earlier in the treatment process, it facilitates referrals to specialty mental health care for those who need that level of service. NDAA 2010 Section 714's requirement to increase active duty mental health staff by 25 percent will allow a fulltime BHOP at each military treatment facility by Fiscal Year 2016. Non-medical counseling, such as Military OneSource, Military Family Life Consultants, and chaplains, allows Airmen and their families to obtain confidential preventative counseling services before problems rise to a clinical level. Similarly, Mental Health Resiliency Elements at each installation collaborate with key community leaders and helping agencies to provide services that enhance the resilience of Air Force communities and reduce the incidence of unhealthy behaviors. This includes personal visits to base units for outreach and prevention activities.

The Air Force's deployment screening process affords another opportunity for Airmen to access mental health services in a more routine fashion. Airmen now receive a person-to-person assessment with a healthcare provider at four time points: once prior to deployment and three times after a deployment.

Finally, the Air Force Guard and Reserve employ regional, and in many cases installation, psychological health assets to assist Air Reserve Component members and their families to prevent and manage psychological health issues.

Mrs. DAVIS. Have the Services noticed any differences between Active Duty and Reserve Component suicides? What suicide prevention programs exist in each Service that geographically dispersed members of the Reserves can take advantage of?

General JONES. Suicides rates in the Active Duty (AD) Air Force and the Air Reserve Component (ARC) historically are similar from year to year; however, the Total Force (Active Duty, Guard and Reserve) suicide rate this year is slightly lower than the rate for the same period last year. Air Force leadership believes in using a tiered-training approach model that will help all Airmen from both the active duty and reserve components withstand the pressures of military demands. Air Force regulations specifically direct unit commanders and first sergeants to take an outreach approach and proactively contact and provide support for family members of deploying ARC members. The ARC provides education and resources for families on deployment-related conditions through unit leadership. The unit commander also tasks various support agencies, including Airman and Family Readiness, to ensure that families are contacted and their needs are met. The Yellow Ribbon Program offers resources on Post Traumatic Stress Disorder (PTSD) and suicide mitigation and is offered to ARC members and their families pre-deployment, during deployment, and 30 and 60 days post deployment.

The Air National Guard (ANG) assigns an individual to all its wings to provide education on PTSD and suicide prevention through Yellow Ribbon events. This individual is available to answer any questions the ANG member or family member may have related to PTSD, suicide mitigation, or other psychological health-related questions or resource availability. Family Program Managers also work with ANG family members during a spouse's deployment, providing access to information on PTSD and suicide awareness.

The Air Force Reserve Command (AFRC) employs three regional teams to locate resources and provide case facilitation for AFRC members and their families for psychological health issues, including PTSD and suicide. AFRC also has the Wingman Project (www.AFRC.WingmanToolkit.org) that provides education about suicide prevention. The Wingman Toolkit has been targeted and distributed to Air Force Reserve members.

Finally, Military OneSource and the Military Family Life Consultant Program are both available to family members and can provide information and guidance on PTSD and suicide. The unit commander is responsible for educating families about these services.

Mrs. DAVIS. The DOD Task Force for Prevention of Suicide Among Members of the Armed Forces conducted a systematic review of prevention efforts and provided 76 recommendations. Where is the Services and the Department in implementing any of those recommendations?

General JONES. The Air Force (AF) fully believes a multi-faceted strategy designed to reduce risk and increase protective factors will provide a framework to reduce the trend of increasing suicide rates in the military and save lives. The AF helped develop Task Force recommendations that provide a structure to enhance wellness, promote total fitness, and sustain a military force fit in mind, body and spirit while providing the support mechanisms necessary to meet the demands of the high operations tempo required of individuals serving in today's military.

The AF has worked aggressively with the DOD Task Force Response Working Group to analyze the 76 targeted recommendations made in the Task Force report and to address any potential organizational obstacles to implementing the solutions as quickly as possible. In a report to Congress, the AF helped identify 36 recommendations that require new DOD actions to be taken, 34 recommendations that have action planned, underway, or completed and 6 are pending further discussion. For recommendations requiring DOD and Military Service action when the way ahead is clear and straightforward, those actions will be initiated immediately. In cases where additional clarification or more data are needed, the AF will devote the required time and resources to clarify or assess the extent of the problem so the Task Force's objective can be properly evaluated and an enduring outcome achieved. The AF will continue to work closely with the Defense Suicide Prevention Oversight Council to review, implement, and revise its plan to ensure the best possible solutions are identified and implemented within 24 months.

QUESTIONS SUBMITTED BY MR. JONES

Mr. JONES. Here is a clip from the *Watertown Daily Times* of Sept. 8:

"A decade ago, Fort Drum had 15 providers and now it has 50, according to Dr. Todd L. Benham, the post's behavioral health chief. But current wait times are about a month, he said, as visits to behavioral health specialists grew from 14,000 in 2001 to 75,000 in 2010. The numbers increased not only from PTSD visits, but from more outreach and an addition of a clinic for traumatic brain injuries, which have grown because of IED attacks.

"Off-post providers have a three- to four-month waiting list, Jefferson County Community Services Director Roger J. Ambrose said. A maximum of four to six weeks to see a practitioner would be a good start for him, but the number of specialists still must grow." [See page 83 for full article.]

a) How can we begin to address the PTSD issue when service members are waiting weeks, months for appointments?

b) This leads to another question: Are we overmedicating our service members because of the shortage of mental health professionals? I've received many complaints from service members about being overmedicated.

c) I would also be interested to know the correlation between the medications being prescribed and suicide, as I think that perhaps our service members may be overmedicated.

Secretary WOODSON. a) How can we begin to address the PTSD issue when Service members are waiting weeks, months for appointments? In CONUS, military treatment facility (MTF) clinics endeavor to have Active Duty Service members (ADSMs) seen on-post, and within the 7-day intake standard for routine visits. All mental health clinics have triage capabilities that allow acute cases to be seen within a 24-hour standard, and cases that might warrant psychiatric admission or immediate medical intervention are seen emergently, either in the clinic or another medically appropriate venue (for example, when patients with delirium, intoxication, or substance withdrawal present to a mental health clinic, they are often brought to the Emergency Department for stabilization and a safer assessment). In less common cases where ADSMs require subspecialty mental health care, this is provided within a 28-day standard. In these cases, the primary mental health provider is responsible for ongoing management and acute disposition, if necessary. Clinic managers make consultation resources available to generalist practitioners, and the option to defer a patient's treatment to a higher level of care (e.g. a partial hospitalization program or an inpatient facility) is always available.

b) Are we overmedicating our Service members because of the shortage of mental health professionals? The DOD supports the use of psychopharmacological treatments as an important component of mental health care. Scientific evidence over the past several decades shows that appropriately selected and timed medications can limit the severity and duration of mental illness. Medication management is one of several strategies pursued to prevent mental health problems in our troops. Prescribing safeguards include guidelines in clinics that limit the number of pills dispensed to potentially high-risk patients, warning flags that appear in electronic

drug dispensing menus which require physician attention, the MTF prescription restriction program, and real-time monitoring and reconciliation of prescriptions dispensed through MTFs, mail-order, and network pharmacies. We have also increased our reviews of the circumstances of manual overrides of system warning flags by physicians.

c) Is there a correlation between medications being subscribed and suicide? In 2004, the Food and Drug Administration (FDA) issued a black box warning for antidepressants, the most serious type of warning in prescription drug labeling, to inform health care professionals about the increased risk of suicide associated with antidepressant use. The FDA's black box warning states that antidepressants increased the risk of suicidal thinking and behavior in children, adolescents, and young adults (ages 18 to 24), and is most likely to occur early in the course of treatment. The subsequent decrease in antidepressant prescriptions, specifically Selective Serotonin Reuptake Inhibitors in the United States corresponded with the largest year-to-year increase in adolescent suicides 2003 and 2004 (18%). In fact, evidence supports the possibility that antidepressant treatment protects against suicide, by treating one of the causal mental health conditions, depression. A study in 226,866 veterans indeed confirmed that the rates of suicide attempts in patients treated with an antidepressant were roughly one-third of those observed for patients who were not treated with an antidepressant. Therefore, the risk of suicide must be balanced against the benefits of antidepressant treatment, including a reduction in depressive symptoms and improvement in overall functioning.

Mr. JONES. Has there been any analysis of family members of service personnel committing suicide? What support mechanisms to include counseling and therapy have been implemented by DOD to address stress on family members of deployed service personnel?

Secretary WOODSON. There are limits on investigative jurisdiction regarding deaths that do not occur on military installations and many other factors restrict the Department's ability to have a comprehensive picture of family member suicides. The Services have limited authority and ability to investigate family deaths, mandate training, and monitor the stressors faced by family members. Therefore, there is currently no consistent and systematic process to track suicides by family members, despite the Department of Defense (DOD) being highly concerned.

However, despite these limitations, the DOD and the Services provide a comprehensive range of support mechanisms and preventative resources for families, coupled with ongoing assessment of existing efforts:

- The Suicide Prevention and Risk Reduction Committee (SPARRC)—Family Subcommittee focuses on current prevention programs and best practices and supports the development of resources like the ACE (Ask, Care, Escort) card for families.
- There are 104 suicide prevention resources available to Service members and their families across all Services, DOD, Department of Veterans, and several non-profit organizations. There are also many avenues for accessing suicide prevention information, including 23 e-mail addresses, 14 phone numbers, 52 websites, and 44 hand-outs.
- The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) coordinates suicide prevention issues with the National Suicide Prevention Lifeline, Military OneSource, the National Resource Directory, and Service hotlines.
- DCoE has also established an Outreach Center that is open 24-hours per day, seven days per week to provide information and resources regarding psychological health to Service members, veterans, and their family members. It may be accessed via telephone, email or online chat and provides the caller with a live chat feature.
- The DOD has also expanded its efforts to address the needs of the Reserve Components and National Guard. For example, the Navy Reserve Psychological Health Outreach Program was established in 2008 to help affected Reserve family and unit members. In addition, the DOD Yellow Ribbon Program Office is expanding services to include suicide prevention, intervention, and postvention for National Guard, Reserve Components, Service members and their families, and communities.
- The Department is currently working with the Services to establish guidelines for postvention and provide guidance on Service postvention programs, a need that was identified by the DOD Suicide Prevention Task Force.

QUESTIONS SUBMITTED BY MS. TSONGAS

Ms. TSONGAS. Over August I had the opportunity to meet with a group in Massachusetts that was composed of the veterans, counselors, the Massachusetts Department of Veterans Services, and the Department of Public Health that has come together to meet the needs of Massachusetts veterans who have experienced Military Sexual Trauma and post traumatic stress. And one thing that kept coming up over and over were examples of service members who began experiencing mental health problems and were suffering punitive consequences as a result. As all the witnesses mentioned in their testimony, there is still stigma associated with asking for behavioral health treatment.

At this meeting, Colman Nee, the Secretary of Veteran Services for Massachusetts, told the story of an Active Duty service member who, due to a post traumatic stress related issue, hadn't showed up for duty for two days. He was actively afraid he was going to be discharged. Regarding this issue, I have to ask how do we (a) reach these service members for behavioral health treatment before they do something drastic and (b) how do we change military rules so that people who break rules because of their trauma related issues aren't instantly penalized?

Secretary WOODSON. In order to reach these Service members for treatment before their situation escalates, the DOD is currently engaged in a number of stigma reducing efforts with the end state occurring when Service members seeking needed help is considered a sign of strength, and not a weakness. These efforts apply to all behavioral health needs regardless of the root cause of the problem or trauma. Our data show that we are making slow, but steady progress in this area. The Services continue to be engaged in reviewing and evaluating polices that improve access to care and decrease stigma.

In addition to working to show that seeking help is not a weakness and working to reduce the stigma of asking for help, the DOD has collaborated with Service leadership to impress to all Service members the various options for help. Especially how it is possible to seek help and not get in trouble with your chain of command. While working to keep an open door for Service members it is essential for Service members to stay accountable with behavioral standards and proactively address any barriers, regardless of their medical condition, as long as help is available.

Commanders are duty bound to ensure the safety, welfare, and accountability of all of their Soldiers, Sailors, Marines and Airmen. Our Commanders are well-versed about the problems of post-traumatic stress and other related mental health problems and are already taking into consideration their Service members' needs as it relates to these problems.

Ms. TSONGAS. Given that PTSD has a significant effect on families, and that marital and relationship distress, divorce and social support difficulties are key risk factors for suicidal behavior, how are Service Members' families and support networks being engaged in suicide prevention strategies and services (e.g. couples interventions, family support, psycho education of parents and spouses etc)?

General BOSTICK. Our focus is on sustaining healthy relationships. Accordingly, Commanders continue to encourage the Army's Strong Bonds Relationship events to provide skills training and resiliency to Soldiers and specialized events to support Family situations (predeployment, while deployed and post-deployment modules). A Strong Bonds website is available to provide resources and provide a link to available training events. Although the Strong Bonds program is not primarily a suicide program it does contribute significantly to the reduction of distress that can lead to thoughts of suicide, domestic violence and other unhealthy behaviors.

Army Community Services provides voluntary suicide prevention training to Family members. Support networks for Family members, whose Soldier contemplates/attempts/commits suicide include Behavioral Health, Chaplains, TRICARE, Command, Military OneSource, Military Family Life Consultants, Army OneSource, Army Community Service and civilian community resources. Families may also contact the National Suicide Prevention Lifeline at 1–800–273–TALK(8255).

Additionally, the Chaplains Unit Ministry Teams provide a quick pastoral response to crises, conduct programs to help build unit and family cohesion and facilitate opportunities to help Soldiers connect with faith communities.

Ms. TSONGAS. If the family member or dependants are worried that their Service Member is suicidal, what is the process they would take to get help (whether the dependant is co-located with them on base, or a family member from the Service Members home of record)?

General BOSTICK. The first step for a family member is to talk with their Soldier about the family member's concerns. There are several confidential counseling programs that are available at no cost to the Soldier or family member. These programs include Military One Source, Military Family Life Consultants, and the

TRICARE Assistance Program. If the Soldier does not respond to the family members' concerns, the family member may notify the unit chain of command or a chaplain.

Chaplains and Chaplain Assistants form the Unit Ministry Team (UMT) in almost every battalion-sized unit in the Army. They provide a quick pastoral response to crises, conduct programs to help build unit and family cohesion and facilitate opportunities to help Soldiers connect with faith communities. Due to the confidentiality policy, chaplains provide countless interventions to prevent self-destructive behavior.

Ms. TSONGAS. What efforts are being made to educate and engage the civilian community in preventing suicide among returning service members and veterans?

General BOSTICK. The Army uses various venues to inform Family members of suicide prevention material, services, and efforts to promote the psychological health of Soldiers and themselves. A plethora of information is disseminated through websites such as ArmyOnesource and MilitaryOneSource, and through Family Readiness Groups, word of mouth, social networking, installation marquee signage, installation news papers, bulletins, pamphlets, Suicide Prevention Awareness Campaigns, and inserted in Family Program's training curricula, such as Family Advocacy, Army Family Team Building, Mobilization and Deployment, and Financial Readiness. In addition, the National helpline number: 1–800–273–TALK(8255) is included in training material and pamphlets. Finally, the Army has played an integral part in working with the Suicide Prevention and Risk Reduction Committee (SPARRC), Family Sub Working Group (Joint Services) to identify the multiple programs and services available to Family Members to promote psychological health, and to develop a plan for disseminating this information to Family members and other target groups.

Ms. TSONGAS. In Massachusetts, the Massachusetts Department of Veterans Services has found that peer to peer work is key to suicide prevention. What is your branch of the Service doing to further promote peer to peer intervention?

General BOSTICK. Peer-to-peer intervention is promoted through Applied Suicide Intervention Skills Training (ASIST) workshops and Ask, Care, Escort Suicide Intervention (ACE–SI) training. The Army Reserve hosted five LivingWorks ASIST train-the-trainer workshops, certifying over 124 AR personnel as ASIST instructors. Instructors are charged to train first-line leaders as gatekeepers at company size units. Army Reserve has trained 1,800 first-line leaders.

Every Soldier must complete ACE–SI training. ACE–SI is designed to help Soldiers become aware of steps they can take to prevent suicides and encourages Soldiers to ask a fellow Soldier whether he or she is suicidal, care for that Soldier, and escort him/her to the source of professional help.

The Army National Guard (ARNG) considers Peer to Peer (P2P) programs to be a foundational best practice for its Risk Reduction, Resilience and Suicide Prevention Programs. In early 2011 the ARNG reviewed the existing state programs and developed a model P2P program for implementation in all the states. Many states have adopted programs based on this model. States like California, Nebraska, New Hampshire and Illinois have developed unique P2P programs in which they provide extensive training to Soldiers in awareness and response to Soldiers in crisis. Both Oregon (Oregon Partnership) and New Jersey (Vet to Vet) have developed peer based call in centers that have proven to be highly effective. New Jersey's program has gone so far as to train veterans to provide peer support and then pairing them up with Soldiers prior to deployment. Michigan developed a program called Buddy to Buddy in which they train Soldiers and then pay them to call other Soldiers post deployment to check on them and provide peer support and referral. An initiative is being implemented this fall to make the New Jersey Vet to Vet program a national peer based program called Vet to Warrior which will be modeled after the work they have done in New Jersey and at Fort Hood, TX.

Ms. TSONGAS. Given that PTSD has a significant effect on families, and that marital and relationship distress, divorce and social support difficulties are key risk factors for suicidal behavior, how are Service Members' families and support networks being engaged in suicide prevention strategies and services (e.g. couples interventions, family support, psycho education of parents and spouses etc)?

Admiral KURTA. Navy unit level (Command) programs are the primary method of support, outreach and communication with the families of Sailors. They include:

> Command Family Readiness Program. A family readiness program is established at every Navy command to integrate family readiness tools, resources, processes, and procedures into the command's standard operating procedures and culture. Commanders ensure an appropriate, proactive, and accessible family readiness program is maintained and reinforced. This policy prescribes

the base-line level of support that will be provided to Sailors and their families; however, senior leaders, commanders, and commanding officers (COs) may go beyond this guidance to ensure a timely and vital continuum of care and support is provided.

Command Ombudsman. The Ombudsman is a volunteer, appointed by the commanding officer, to serve as an information link between command leadership and Navy families. Ombudsmen are instrumental in providing information and resources to resolve family issues before the issues require extensive command attention. The Command Ombudsman Program is shaped largely by the commanding officer's perceived needs of his/her command. The command ombudsman is appointed by, and works under the guidance of, the commanding officer who determines the priorities of the program, the roles and relationships of those involved, and the type and level of support it will receive. Ombudsmen are trained to disseminate information both up and down the chain of command, including official Department of the Navy and command information, command climate issues, and local quality of life (QOL) improvement opportunities. They also provide resource referrals when needed. Fleet and Family Support Centers provide standardized Ombudsman Basic Training (OBT), which is required for all Command Ombudsmen. During the training module on Crisis Calls and Disasters, suicide prevention training is conducted and includes the actions to take when confronted with suicide behaviors.

Command Family Readiness Group (FRG). An FRG is a private organization, closely-affiliated with the command, comprised of family members, Sailors, and civilians associated with the command and its personnel, who support the flow of information, provide practical tools for adjusting to Navy deployments and separations, and serve as a link between the command and Sailors' families. FRGs help plan, coordinate and conduct informational, care-taking, morale-building and social activities to enhance preparedness, command mission readiness, and increase the resiliency and well-being of Sailors and their families. FRGs are an integral part of a support service network that includes ombudsmen, fleet and family support centers (FFSCs), chaplains, school liaison officers, and child development centers at the command-level, to provide services in support of service members and their families.

Commander Navy Installations Command (CNIC) Deployment Readiness Program supports Navy unit level family support and deployment readiness programs with a wide variety of complementary training and support activities including unit level deployment cycle training, online information and individualized one-on-one counseling. Topics include how to identify possible symptoms of depression, anxiety, and other psychological health issues. These topics are covered through Life Skills education workshops such as Stress Management, Conflict Management, Communication Skills, Anger Management and Parenting. This information is provided on demand and as part of the pre-deployment, during deployment, post-deployment, return, reunion, and reintegration training cycle. Operational Stress Control awareness is incorporated into all deployment support programs and briefings to assist with problem identification, support, and early intervention. Additionally, installation Fleet and Family Support Centers have information available, including brochures and public service-type announcements, on how to identify symptoms of depression, anxiety, and other psychological health issues and where to go to get help. Navy also addresses these issues on our Operational Stress Control blog.

Project FOCUS (Families Overcoming Under Stress), initiated by the Navy Bureau of Medicine and Surgery (BUMED) in 2008, provides state-of-the-art family resiliency services to military children and families at over 20 Navy and Marine Corps sites and online for those in remote locations. FOCUS promotes a culture of prevention and the reduction of stigma through a family-centered array of programs, to include community briefings, educations workshops, individual and family consultations, and resiliency training. This approach teaches military members and their families to understand their emotional reactions, communicate more clearly, solve problems more effectively, and set and achieve their goals throughout the deployment cycle. Feedback on the program has been very positive. Participants report high levels of satisfaction with the services provided, reduced psychological distress, and improved individual and family functioning.

Additionally, as of June 1, 2011, every Navy web site, including those providing information on family support programs, was required to include the message "Life is Worth Living" and a link to the National Suicide Prevention Lifeline and Vet-

erans Crisis Line and Stress Control training, materials, and counseling are available for Sailors and their families at Fleet and Family Support Centers.

Ms. TSONGAS. If the family member or dependants are worried that their Service Member is suicidal, what is the process they would take to get help (whether the dependant is co-located with them on base, or a family member from the Service Members home of record)?

Admiral KURTA. Concerned family members can contact the service member's command. Every Navy command is required to maintain a crisis response plan to ensure command members understand how to quickly and effectively get help to someone in distress or keep someone who is at acute risk safe until they can receive professional care.

Although most Navy commands have a duty office or duty officer available 24/7, some family members may be unsure of how to contact the service member's command. This is why Navy also works closely with the VA to coordinate information and resources with the National Suicide Prevention Lifeline (1–800–273–TALK). This partnership facilitated a modification to the introductory message on the Lifeline, by pressing the number 1, that enables veterans, service members, or callers concerned about a veteran or service member to access a crisis counselor who is knowledgeable about the military and has access to resources designed specifically for this community. Additionally, as of 1 June 2011, every Navy web site was required to include the message "Life is Worth Living" and a link to the National Suicide Prevention Lifeline and Veterans Crisis Line.

Ms. TSONGAS. What efforts are being made to educate and engage the civilian community in preventing suicide among returning service members and veterans?

Admiral KURTA. The Real Warriors Campaign is an initiative launched by the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury to promote the processes of building resilience, facilitating recovery and supporting reintegration of returning service members, veterans and their families. The Real Warriors Campaign presents real world examples of successful use of services to overcome personal crises and psychological health problems. This campaign is progressing steadily.

OSD has representatives working with the Action Alliance Task Force to help develop a Suicide Prevention National Strategic Plan and with the Substance Abuse and Mental Health Administration (SAMHSA) on the Partners in Care pilot projects throughout the country. The Suicide Prevention & Resiliency Resource Inventory (SPRRI) Project is planning a Community Organization Response Effort (CORE) Roundtable with civilian agency representatives and consultants from across the United States to review their experience working with the National Guard and Reserves around suicide prevention in their communities.

Because Navy installation-based Fleet and Family Support Centers provide information and referral services to Service members and their families, they also make contact with appropriate resources in their communities that can provide support. For Reserve personnel, Navy and Marine Forces Reserve Psychological Health Outreach Program (PHOP) teams, located at regionally central Reserve Commands throughout the country, connect and work with local community agencies where Reservists live. Team members educate and engage these community resources concerning the psychological health needs of Reservists and their families.

Project FOCUS (Families Overcoming Under Stress), initiated by the Navy Bureau of Medicine and Surgery (BUMED) in 2008, provides state-of-the-art family resiliency services to military children and families at over 20 Navy and Marine Corps sites, and online for those in remote locations. FOCUS promotes a culture of prevention and the reduction of stigma through a family-centered array of programs, to include community briefings, educations workshops, individual and family consultations, and resiliency training. This approach teaches military members and their families to understand their emotional reactions, communicate more clearly, solve problems more effectively, and set and achieve goals throughout the deployment cycle. Feedback on the program has been very positive. Participants report high levels of satisfaction with the services provided, reduced psychological distress, and improved individual and family functioning. Part of the FOCUS repertoire to is to educate the community in which Service members and their families live on psychological health and increasing resiliency—as part of that education and awareness, suicide prevention and stress detection is included.

Navy fully endorses coordinating communications efforts using science of health communication to engage the civilian community in preventing suicide among returning Service members and veterans, encouraging them choosing to live life fully and use every available resource to be the best professional service members (and family) possible. However, recent experience and research indicates such communications must be carefully crafted to avoid unintentionally re-enforcing negative

stereotypes some civilians may hold about "mentally unbalanced" veterans. Additional research to understand repercussions—the real positive or negative effects of support service utilization—is essential to address barriers and publish myth-busting facts.

DCoE (and the Services) also work closely with the VA to coordinate information and resources with the National Suicide Prevention Lifeline (1–800–273–TALK). This partnership facilitated a modification to the introductory message on the Lifeline, that enables veterans, service members, or callers concerned about a veteran or service member, to access a crisis counselor knowledgeable about the military and who has access to resources designed specifically for this community. Additionally, as of June 1, 2011, every Navy web site was required to include the message "Life is Worth Living" and a link to the National Suicide Prevention Lifeline and Veterans Crisis Line.

Ms. TSONGAS. In Massachusetts, the Massachusetts Department of Veterans Services has found that peer to peer work is key to suicide prevention. What is your branch of the Service doing to further promote peer to peer intervention?

Admiral KURTA. Navy has several training initiatives that promote peer-to-peer, as well as front line supervisor, intervention:

- Peer to Peer Suicide Awareness and Prevention Training—a 60 minute training aimed at junior Sailors that applies information about risk and protective factors, warning signs, and ACT (Ask, Care, Treat) to a scenario and includes video clips, discussion and role play exercises and a music video.
- Video: "Suicide Prevention: A Message from Survivors" augments facilitated training with powerful accounts from Sailors and family members who were impacted by a suicide loss or helped overcome a suicide crisis.
- Front Line Supervisor Training—a 3 to 4 hour facilitator-led interactive training that leads deck plate supervisors that uses role play, case examples, and discussion to learn how to prepare an environment to recognize and engage a member in distress and refer them to appropriate support when needed.

Additionally, the Coalition of Sailors Against Destructive Decisions (CSADD), a grassroots peer mentoring program led by and for young Sailors, continues to grow with over 200 chapters across the Navy. CSADD focuses on empowering our most junior Sailors with the tools and resources to promote good decision-making processes and leadership development while reinforcing a culture of shipmates helping shipmates. CSADD members promote awareness and discussion among their peers across a range of areas, to include suicide prevention, financial management, responsible use of alcohol, personal safety, and domestic violence. Examples of CSADD initiatives include the "Stop and Think Campaign," which highlights the potential consequences of poor decisions, an active Facebook page where Sailors can ask questions, access information and training materials, and share lessons learned, and a semi-annual newsletter to highlight best practices across the Navy.

Ms. TSONGAS. Given that PTSD has a significant effect on families, and that marital and relationship distress, divorce and social support difficulties are key risk factors for suicidal behavior, how are Service Members' families and support networks being engaged in suicide prevention strategies and services (e.g. couples interventions, family support, psycho education of parents and spouses etc)?

General MILSTEAD. An important component of the Marine Corps' suicide prevention strategy involves behavioral health education for parents, spouses, and peers. We offer a wide variety of training programs and classes that build stronger support networks and families, and help them to identify and intervene in those problems that if left unnoticed could develop into a suicide crisis. "LifeSkills" Education and Training Workshops teach communication skills, relationship skills, and conflict resolution for spouses, parents, and children. Family Readiness Officers at the unit level offer deployment cycle training to all Marines and families. This training includes "Marine Operational Stress Training" (MOST) with an emphasis on recognizing both stressors as well as reactions to stress. A new, two-hour training package designed to teach families about combat operational stress control fundamentals and enhanced communication skills is in the final stages of development.

Our Family Readiness Officers routinely provide families with suicide prevention resource information to include the National Suicide Prevention Lifeline and Military One Source. Additionally, we have recently completed the evaluation of our pilot program in the western U.S., "DSTRESS Line". The DSTRESS Line is a 24/7, anonymous, peer-to-peer counseling service following a 'By Marine/For Marine' concept, where veteran Marines, corpsmen, and Marine Corps spouses will answer calls and online chats from our Marines, attached Sailors, and families. For complex issues or crisis calls such as a suicide event that are out of the scope of a peer re-

sponder, onsite licensed clinical counselors take over to provide more in-depth assistance. The pilot program proved a success, and the DSTRESS Line will open Corps-wide during early 2012.

Ms. TSONGAS. If the family member or dependants are worried that their Service Member is suicidal, what is the process they would take to get help (whether the dependant is co-located with them on base, or a family member from the Service Members home of record)?

General MILSTEAD. When concerned for the safety of their Service member, family members and dependents should call 911 to engage emergency response services. Alternately, they may contact anyone in the member's chain of command, who will then ensure the Service member is safe and immediately referred to care. Other resources available to family members and dependants are the Defense Center of Excellence Outreach Call Center, the Veteran's Crisis Line, and Marine Corps Community Services counseling centers.

Additionally, we have recently completed the evaluation of our pilot program in the western U.S., "DSTRESS Line". The DSTRESS Line is a 24/7, anonymous, peer-to-peer counseling service following a 'By Marine/For Marine' concept, where veteran Marines, corpsmen, and Marine Corps spouses will answer calls and online chats from our Marines, attached Sailors, and families. For complex issues or crisis calls such as a suicide event that are out of the scope of a peer responder, onsite licensed clinical counselors take over to provide more in-depth assistance. The pilot program proved a success, and the DSTRESS Line will open Corps-wide during early 2012.

Ms. TSONGAS. What efforts are being made to educate and engage the civilian community in preventing suicide among returning service members and veterans?

General MILSTEAD. The Marine Corps trains its retail and recreational services employees to recognize signs of distress in Marines, engage with Marines, and help Marines in distress find helping services. The Marine Corps is studying the feasibility of creating suicide-specific prevention training for all civilian employees.

Community involvement is equally important to suicide prevention. The Yellow Ribbon Reintegration Program (YRRP), which is a DOD-wide effort mandated in Public Law 110–181, Section 582, calls for informational events and activities for National Guard and Reserve Service members and their families, to facilitate access to services supporting their health and well-being throughout the deployment cycle. Yellow Ribbon Events provide interactive and informative seminars on: communication, stress management, post-military career opportunities, money management, health education, parental skills, suicide prevention, resilience training, and other life-skills training. In addition to these seminars, YRRP provides access or referrals, through our relationships with other Federal and non-federal entities, to support services for issues concerning: mental health and substance abuse disorder; traumatic brain injury; housing stabilization; and family support. YRRP also offers access to employment resources and career counseling to support those Service members facing unemployment/underemployment or who have career concerns after being demobilized/redeployed.

In addition, we recognize that individuals who feel "connected" to one another are more engaged at work and home and, therefore, tend to be more resilient. Over the course of the next year, we will be working to develop and implement a plan that utilizes a more community-based approach to taking care of our Marines and their families. Connecting our Marines, their units, and their families to the programs and services in the Marine Corps, as well as those in their communities, will encourage them to become more involved and active in their communities, and ultimately build and maintain their overall resiliency.

Ms. TSONGAS. In Massachusetts, the Massachusetts Department of Veterans Services has found that peer to peer work is key to suicide prevention. What is your branch of the Service doing to further promote peer to peer intervention?

General MILSTEAD. In 2009, the Marine Corps redesigned its suicide prevention and awareness training with the evocative, award-winning peer-led training—"Never Leave A Marine Behind" for Non-Commissioned Officers. Last year, we released courses for Junior Marines, officers, and staff noncommissioned officers. Marines from the operating forces were included in all stages of course development. The courses contain various degrees of training in personal resilience, peer-to-peer and frontline supervisor intervention, and managing command climate to build resilience and encourage Marines to engage helping services early, before problems escalate to suicide.

In addition, our Combat and Operational Stress Control (COSC) Program provides Operational Stress Control and Readiness (OSCAR) Team Training. OSCAR training creates teams of leaders, Marines, medical and religious ministry personnel within each battalion-sized operational unit with the skills and knowledge to help

the commander in the prevention of stress injuries, and early identification of Marines impacted by stress. By changing social norms and common beliefs, OSCAR Team Members reduce stigma associated with behavioral health treatment, which improves referral, rapid case identification and treatment, and contributes to our Marines' overall well-being.

Lastly, the DSTRESS Line, our pilot program in the western U.S., is based on peer to peer counseling for our Marines, attached Sailors, and families. Callers speak or chat anonymously with 'one of their own'—a veteran Marine, corpsman, or Marine family member who shares our common culture and ethos.

Ms. TSONGAS. Given that PTSD has a significant effect on families, and that marital and relationship distress, divorce and social support difficulties are key risk factors for suicidal behavior, how are Service Members' families and support networks being engaged in suicide prevention strategies and services (e.g. couples interventions, family support, psycho education of parents and spouses etc)?

General JONES. In 2009 the Air Force acknowledged the need for a more robust set of strategies to assist our Air Force Community (Active Duty, Reserve, National Guard, Civilians and families) in coping with the challenges of military lifestyles and stood up the Air Force Resilience office. The mission of the office is to "build and sustain a thriving and resilient Air Force Community that fosters mental, physical, social and spiritual fitness." This is accomplished through a multi-faceted approach which incorporates assessments, education and training programs and support services all under the umbrella of the Comprehensive Airman Fitness (CAF) initiative.

Education and training programs include martial, family and parenting workshops. Additional resources are available to help address PTSD such as Airman and Family Readiness Centers, Chaplains, Mental Health facilities, Military Family Life Consultants and Health and Wellness Centers are available to all members of our AF Community. The Yellow Ribbon Program also offers resources on Post Traumatic Stress Disorder (PTSD) and suicide mitigation and is offered to ARC members and their families pre-deployment, during deployment, and 30 and 60 days post deployment.

Finally, we are developing larger initiatives to promote personal growth. Leadership Pathways is a new initiative which incentivizes participation in resilience building events, activities and classes. There is also a plan to employ Master Resilience Trainers (MRTs) at each Air Force base to conduct needs assessments, perform program evaluation and design custom-tailored, resilience-based training.

In sum, CAF is designed to promote a resilient AF community by employing a number of education and training programs and support services. The end goal is to equip the Air Force community with the tools they need to manage the rigors of military life.

Ms. TSONGAS. If the family member or dependants are worried that their Service Member is suicidal, what is the process they would take to get help (whether the dependant is co-located with them on base, or a family member from the Service Members home of record)?

General JONES. The Air Force has a number of services in place to support family members. The frontline of support for families is always the unit leadership. If a family member is concerned about the wellbeing of an Airman they should immediately reach out to the Squadron Commander, First Sergeant or supervisor. Additionally, chaplains, mental health providers and primary care physicians are standing ready to assist family members who are concerned that their service member is suicidal. If a family member believes that the service member poses an imminent risk to themselves or others they should call 911 or local law enforcement, who can engage emergency services right away.

Outside of the military a number of more confidential resources exist to support family members. The Department of Veterans Affairs offers both a 24-hour suicide prevention crisis line and online chat. Military OneSource also offers confidential counseling and referral options to military dependents.

Ms. TSONGAS. What efforts are being made to educate and engage the civilian community in preventing suicide among returning service members and veterans?

General JONES. The primary forum for suicide prevention collaboration and community engagement at the Department of Defense level is the Suicide Prevention and Risk Reduction Committee (SPARRC). The SPARRC provides a forum for the Department of Defense and the Department of Veterans Affairs (VA) to partner and coordinate suicide prevention and risk reduction efforts with civilian organizations like Substance Abuse and Mental Health Services Administration (SAMSHA) and Tragedy Assistance Program for Survivors (TAPS). This committee is chaired by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

(DCoE). Members include suicide prevention program managers from each of the services and representatives from the National Guard Bureau, Office of the Assistant Secretary of Defense Reserve Affairs, VA, Office of Armed Forces Medical Examiner, National Center for Telehealth and Technology, SAMSAH and others. Information is disseminated by committee members to their respective stakeholders, including service members, families, health care providers and the field of psychological health research.

At the local level, the Air Force uses the Community Action and Information Board (CAIB) to integrate installation and community helping resources. The Air Force Reserve Component installations employ Directors of Psychological Health and Psychological Health Advocacy Program managers to collaborate with local resources to support service members and prevent suicide.

Ms. TSONGAS. In Massachusetts, the Massachusetts Department of Veterans Services has found that peer to peer work is key to suicide prevention. What is your branch of the Service doing to further promote peer to peer intervention?

General JONES. Peer-to-peer intervention is a center piece of the Air Force Suicide Prevention Program. All Airmen receive annual suicide prevention training based on the Ask, Care, Escort (ACE) peer-to-peer model of suicide prevention. The peer-to-peer concept is also reinforced at semi-annual Wingman Days, which emphasize responsible help-seeking and unit cohesion. Supervisors in higher-risk career fields also complete the intensive Frontline Supervisors Training, which teaches more advanced peer-to-peer intervention techniques.

The Air Force is also working on training and placing four Master Resiliency Trainers (MRT) at each installation. These MRTs will function as peer mentors to Airmen and advise on ways to manage stress and improve coping so Airmen are able to deal with adversity and avoid crises. Finally, Applied Suicide Intervention Skills Training (ASIST) and Safe Talk are chaplain-sponsored programs for teaching skills to uncover thoughts of suicide and bring a person with thoughts of suicide to a more experienced caregiver.

QUESTIONS SUBMITTED BY MS. BORDALLO

Ms. BORDALLO. DOD noted in its response to Congress that it agreed that there was a need for an OSD suicide prevention office, when can Congress expect to see that office stood up? Can OSD share a copy of an implementation plan? Who will be the Executive Director of the office? Will this office be adequately staffed to address suicide issues for the Services' Total Workforce (AC, RC, Civilians and their family members)?

Secretary WOODSON. While the effort to meet the full intent of the Task Force's recommendation to establish an office has been challenging in this fiscal environment, the USD P&R has given direction and provided initial funding to establish the baseline manning for a suicide prevention team. This team will conduct day-to-day activities and provide direct support to the Defense Suicide Prevention Oversight Council (DSPOC) which will continue to be the primary entity to provide strategic direction, oversight, and policy standardization of DOD suicide prevention efforts and programs.

This team will be supported by five government subject matter experts, to include a clinical psychologist. Additional contract support will be added to provide specific expertise and support as required. Resources are also being budgeted in FY13 and beyond to further support this effort without duplicating programs being executed at the Service level. As this is a lengthy process, the exact manpower requirements and specific personnel to fill the billets are still being determined.

It is the intent of the USD P&R that this effort will be focused on addressing suicide prevention issues not just for the active duty force, but for the Reserve Component as well.

Ms. BORDALLO. How will DOD improve its tracking and data on suicides among members of the Armed Forces? How will it go about tracking suicides among family members?

Secretary WOODSON. The Department currently has an excellent surveillance process to collect data on fatal and non-fatal suicide events for active duty service members. The Department is working to further refine these procedures based on the recommendations of the Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces. For example, the Department is working more closely with the Department of Veterans Affairs, the National Center for Telehealth and Technology, and the Office of the Armed Forces Medical Examiner to coordinate and develop a joint database to gather and report suicide prevention surveillance data, analyze data, and help translate findings into

policy updates and program strategy in a dynamic manner. Also, the Principal Deputy Under Secretary of Defense for Personnel and Readiness signed a memorandum directing the Department to adopt a standardized system of nomenclature for clinical events related to suicide. This will allow the Department to more accurately classify these events and bring the Department into alignment with the Centers for Disease Control and Prevention and the Department of Veterans Affairs. Furthermore, the Department is currently working to issue a DOD instruction to codify the process for publishing and using the DOD Suicide Event Report. This will enhance the fidelity and accuracy of suicide event data and improve the process of dissemination.

The Department is concerned about any suicide that occurs in the military community, to include suicides among family members, and is committed to meeting the needs of the survivors and providing the necessary support. While we have reliable methods of collecting data on suicides for service members, we have no such method for family members, as the Department is sensitive to their federally protected rights to privacy.

Ms. BORDALLO. How will DOD go about identifying key areas for additional research into suicide? How will research be translated into best practices at the clinical level and among line commanders?

Secretary WOODSON. The Department has already identified key areas for additional research. For example, the Department has awarded a $17 million federal grant to Florida State University and the Denver Veterans' Affairs Medical Center to establish the Department of Defense (DOD) Military Suicide Research Consortium (MSRC). The consortium is the first of its kind to integrate DOD and civilian efforts in implementing a multidisciplinary research approach to suicide prevention.

In addition and in response to the Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, the Department will review and evaluate all organizations within the Department (and those organizations outside of the Department that receive funds from DOD) that are involved in suicide prevention research. This review is for the purposes of identifying overlap, duplication of effort, and identifying gaps; make recommendations to create a unified, strategic, and comprehensive plan for research in military suicide prevention. After review, the report the findings will be submitted to the Defense Suicide Prevention Oversight Council for further action.

In order to promote the translation of mental health related research into action, the VA/DOD Integrated Mental Health Strategy, Translation of Mental Health Research Work Group, will promote innovative action, programs, and policies for service members. Specifically, this Work Group is tasked to facilitate the rapid translation of research findings into innovations in mental health care. They are monitoring on-going research, making recommendations for adoption of models and practices to promote translation, and creating standardized operating procedures to ensure collaboration and communication between the Department of Defense and the Department of Veterans Affairs and throughout their respective Departments.

Ms. BORDALLO. What will DOD do to improve support and services to survivors of suicide (for the Total Force) among unit members and next of kin?

Secretary WOODSON. The Department has taken several actions to support unit members and family members in the aftermath of a suicide. Each Service has traumatic response teams and mental health providers available to meet the emotional needs of unit and family members. Each Service has disseminated guidance for commanders and first sergeants to assist in their response to suicides and non-fatal suicide attempts. Normally, the unit commander will conduct an installation or unit memorial service following the death of a Service member, to include a death by suicide. For eligible relatives, it is Department policy to provide funds for authorized travel and transportation expenses for one round-trip to the installation or unit memorial service. In addition, each Service has an officer or senior non-commissioned officer who has been trained and assigned to support the family in the event of a Service member's death.

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