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[H.A.S.C. No. 111–90]

PSYCHOLOGICAL STRESS IN THE MILITARY: WHAT STEPS ARE LEADERS TAKING?

HEARING

BEFORE THE

MILITARY PERSONNEL SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

HEARING HELD
JULY 29, 2009

U.S. GOVERNMENT PRINTING OFFICE

56–936 WASHINGTON : 2010

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

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PSYCHOLOGICAL STRESS IN THE MILITARY: WHAT STEPS ARE LEADERS TAKING?

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
Washington, DC, Wednesday, July 29, 2009.

The subcommittee met, pursuant to call, at 2:07 p.m., in room HVC–210, Capitol Visitor Center, Hon. Susan A. Davis (chairwoman of the subcommittee) presiding.

OPENING STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, CHAIRWOMAN, MILITARY PERSONNEL SUBCOMMITTEE

Mrs. DAVIS. The meeting will now come to order. Thank you all for being here, and welcome to our new digs. We are obviously refurbishing the House Armed Services room in Rayburn, and so we are using this room today. We hope that everybody is going to be comfortable here.

The mental health status and needs of servicemembers, their families, retirees and their families relate to most, if not all, hearings held by this subcommittee. Whether we are discussing post-traumatic stress disorder (PTSD), family support programs, frequency of deployment, access to health care, missing in action (MIAs), prisoners of war (POWs), or the aftermath of a sexual assault, the importance of mental well-being is always involved. We also dedicate one hearing a year solely to mental health issues.

This year's hearing on mental health was originally intended to examine the increased incidence of suicide in the military and to review what actions the Office of the Secretary of Defense (OSD) and the military services were taking to address this troubling trend. However, we know that suicide is not a discrete occurrence or problem. It is the final step an individual takes when they can no longer deal with the stressors in their lives. And, therefore, in order to determine why the suicide rate has increased, the entire spectrum of stressors must be considered.

Further, there is zero-sum-gain aspect to mental health. Neither the Department of Defense (DOD) nor the country in general have enough mental health providers. Any resources directed towards suicide prevention will have to be directed away from your current allocation. So it is important to examine what is going to be short-changed in order to resource any new suicide prevention program and to consider if this will have any negative unintended consequences.

For today's hearing we will have two panels. In the first we are fortunate to have the four vice chiefs of the services here to talk

about what they are doing to deal with the psychological stress on their soldiers, sailors, marines and airmen. We have the Vice Chief of Staff of the Army, General Peter Chiarelli; the Vice Chief of Staff of Naval Operations, Admiral Patrick Walsh; the Assistant Commandant of the Marine Corps, General James Amos; and the Vice Chief of Staff of the Air Force, General William Fraser.

Gentlemen, we look forward to your testimony and hope to leave this hearing with a clear understanding of how each of your services is addressing the issue. It is important for the headquarters of each military department to acknowledge and to address this issue, and it is also just as important for individual commanders to understand the problem and take positive actions at their level.

For our second panel, then, we have chosen to highlight the positive actions taken by commanders of their own accord to address the psychological stress experienced by their command. We have Lieutenant General Rick Lynch of the Army, Commanding General of III Corps and Fort Hood, to participate in our hearing. General Lynch has used his command authority to make fundamental changes to the way his installation is run with the goal of providing soldiers and, just as importantly, their families stability and predictability in their schedules.

From Marine Corps we have Major General Paul Lefebvre, Deputy Commanding General of II Marine Expeditionary Force. General Lefebvre created the Office of Suicide Prevention Training Program and the Operational Stress Control and Readiness Extender Program.

The problems that we are discussing today cannot be solved today. We wish they could, but we know that is not possible. But we must continue to understand and confront the psychological stress that our servicemembers and families have to deal with every single day. We must continually evaluate actions taken, gauge their effectiveness, and then press to determine what must be done.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 53.]

Mrs. DAVIS. Mr. Wilson, I turn it over to you for your comments.

STATEMENT OF HON. JOE WILSON, A REPRESENTATIVE FROM SOUTH CAROLINA, RANKING MEMBER, MILITARY PERSONNEL SUBCOMMITTEE

Mr. WILSON. Thank the Chairwoman Davis. And thank you for holding this hearing today.

Today's hearing continues our commitment to work with the Department of Defense to find ways to address the psychological stress that our servicemembers are struggling to overcome and to continue to improve mental health services for our military personnel and their families. I am encouraged by the direction that the Department and the military services are taking to recognize and alleviate psychological stress experienced by our troops, particularly our combat veterans.

From my own service as a veteran in the National Guard and Reserves, with four sons currently serving in the military, I understand the responsibility for finding the right answers to this problem does not lie solely with the military medical departments. This

is also a leadership challenge, and I commend the military service for making the mental health of our military and their families a leadership priority.

With that said, as the former president of the Mid-Carolina Mental Health Association, I remain concerned that the programs that each of the services are implementing to address psychological stress are disjointed and are not well coordinated or communicated. I am anxious to hear from our military senior leaders on our two panels what steps have been taken to develop a comprehensive multidiscipline approach to addressing psychological stress.

I would like to welcome our witnesses, thank them for their services, and I am particularly grateful to see persons who have served at Fort Jackson Marine Air Station/Beaufort, at Parris Island/Beaufort Navy Hospital that I have the privilege of representing. And I want to thank you for participating in the hearing today. I appreciate your providing young people the extraordinary opportunity of military service which protects American families. I look forward to your testimony.

Mrs. DAVIS. Thank you very much.

[The prepared statement of Mr. Wilson can be found in the Appendix on page 55.]

Mrs. DAVIS. And we will begin, General, please.

STATEMENT OF GEN. PETER W. CHIARELLI, USA, VICE CHIEF OF STAFF, U.S. ARMY

General CHIARELLI. Madam Chairwoman, Ranking Member Wilson, distinguished members of the subcommittee, I thank you for the opportunity to appear before you today to provide a status on the United States Army's efforts to reduce the number of suicides across our force. This is my first occasion to appear before this esteemed subcommittee, and I pledge to always provide an honest and forthright assessment. I submitted a statement for the record, and I look forward to answering your questions at the conclusion of opening remarks.

As all of you know, it has been a busy time for our Nation's military. We are at war. We have been at war for nearly eight years. That has undeniably put a strain on our people and our equipment. Unfortunately, in a growing segment of the Army's population, we have seen increased stress and anxiety manifest itself through high-risk behaviors, including acts of violence, excess use of alcohol, drug abuse and reckless driving. The consequence in the most extreme cases has been an increased incidence of suicide.

Earlier this year I visited six posts in eight days in order to conduct sensing sessions, collect data and evaluate suicide-prevention efforts and programs. It became clear to me after leaving the third installation that our mission extended far beyond suicide. Simply stated, we must find a way and ways to improve the behavioral wellness of soldiers and their families after repeated deployments in the context of eight years of war. And that is why Secretary of the Army Pete Geren and our Chief, General George Casey, consciously made the decision to expand our efforts to improving the overall behavioral health and well-being of the force.

Ultimately we want to get left of this very serious problem, and to do so we must improve the resiliency of our soldiers and their

family members. In the past the Army's approach was primarily reactive. That has changed today. It is, in fact, proactive, to identify or assess and mitigate issues early on before it becomes significant concerns; to educate soldiers in order to ensure they are aware and have access to resources and support programs that can provide them with the most benefit; and to assist and treat individuals who are struggling and may need help. We are confident by doing so, by improving the overall resiliency, behavioral health and well-being of soldiers and their families, we will also ultimately reduce the number of suicides across our Army.

Our approach is based on two big ideas: the Comprehensive Soldier Fitness program, which is really the big idea that moves us to the left, and a campaign plan for health promotion, risk reduction and suicide prevention. We are also taking steps to eliminate the stigma that has frequently kept soldiers from seeking and receiving help.

The reality is in all cases there is no simple solution, and we must resist any attempt to generalize or oversimplify the challenges we are facing. Improving the overall health and well-being of our force will require a multidimensional approach to identify effective programs and mitigation strategies. And it will take a total team effort across all Army components, jurisdictions and commands, as well as in cooperation with the Department of Health, Congress, National Institute of Mental Health (NIMH) and other willing civilian health-care providers, research institutes and care facilities. I can assure you, the members of this subcommittee, that this challenge remains a top priority for the United States Army.

Madam Chairwoman, members of the subcommittee, I thank you for your continued and generous support and demonstrated commitment to the outstanding men and women of the United States Army and their families. I look forward to your questions.

Mrs. DAVIS. Thank you very much.

[The prepared statement of General Chiarelli can be found in the Appendix on page 56.]

Mrs. DAVIS. Admiral Walsh.

STATEMENT OF ADM. PATRICK M. WALSH, USN, VICE CHIEF OF NAVAL OPERATIONS, U.S. NAVY

Admiral WALSH. Madam Chairwoman, Congressman Wilson, distinguished members of the subcommittee, thank you for the opportunity to testify about the organizational and command-level efforts to prevent suicides in the Navy. Suicide ranks as the third leading cause of death in the Navy. It is a loss that destroys families, devastates communities and unravels the cohesive social fabric and morale inside our commands.

While the symptoms of those who contemplate suicide are unique to each person, a common thread to all victims is a sense of psychological emptiness that leaves individuals impaired and unable to resolve problems. Therefore, the steps that leaders take to find solutions to this tragedy must address the underlying causes that affect the ability of an individual to recover from change or misfortune and regain their physical and emotional stamina. So the target of our policy and practice is the resilience of individual sailors and their families. This means that leaders must look for and con-

nect to those individuals challenged by seemingly intractable troubles with relationships and work, financial and legal matters, deteriorating fiscal health, as well as mental health issues and depression.

We must eliminate the perceived stigma, shame and dishonor of asking for help. This is not simply an issue isolated to the medical community to recognize and resolve. Commands have a critical role to play in setting a supportive climate for those who need to admit their struggle and seek assistance.

Some of the more noteworthy policy and programmatic actions that leaders have taken include the Chief of Naval Operations (CNO) directed establishment of a preparedness alliance, which is a consortium led by our Chief of Naval Personnel, our Chief of Naval Reserves, Bureau of Medicine and our Commander of Installations Command, to address a continuum of care that covers all aspects of individual medical, physical, psychological and family readiness issues across the Navy.

Additionally, the CNO instituted an Operational Stress Control Program, which is a comprehensive approach designed to address the psychological health needs of sailors and their families. It is a program led by operational leadership, supported by the naval medical community, and provides practical decision-making tools for sailors, leaders and families so they can identify stress responses and problematic tension.

By addressing problems early, individuals can mitigate the effects of personal turmoil and get the necessary help when professional counseling or treatment warrant. Through training, intervention, response and reporting, the Navy executes prevention programs for all sailors that focus on operational commands to take ownership of suicide training initiatives and tailor them to their unique command cultures.

Feedback is an important element of policy development. The Navy polls extensively and tracks statistics on personal and family-related indicators such as stress, financial health, command climate, as well as sailor and family support. We use this data to monitor the trends in the force and make recommendations for adjustments in deployment practices, as well as track all suicidal acts and gestures.

In conclusion, on behalf of the men and women of the United States Navy, I thank you for your attention and commitment to the critical issue of suicide prevention. By teaching sailors better problem-solving skills and coping mechanisms for stress, the Navy will make our force more resilient. We will do everything possible to support our sailors so that in their eyes their lives are valued and are truly worth living.

Thank you.

Mrs. DAVIS. Thank you.

[The prepared statement of Admiral Walsh can be found in the Appendix on page 67.]

Mrs. DAVIS. General Amos.

STATEMENT OF GEN. JAMES F. AMOS, USMC, ASSISTANT COMMANDANT, U.S. MARINE CORPS

General AMOS. Thank you, Chairwoman Davis, Ranking Member Wilson and distinguished members of this subcommittee, for the opportunity to report on the Marine Corps suicide and psychological stress prevention efforts. On behalf of the more than 242,000 active and Reserve marines and their families, I would like to extend my appreciation for the sustained support Congress has faithfully given to its corps.

As we begin this hearing, I would like to highlight a few points from our written statement. The tragic loss of a single marine to suicide is deeply felt by all of us who remain behind. We lost 42 marines to suicide in 2008, up from 33 in 2007 and up from 25 in 2006. This is unacceptable, and we are taking action to turn this trend around. The Commandant cares deeply about this and is committed to work with the leadership of the Marine Corps to fix it.

The data shows that the marine most likely to die by suicide corresponds to the Marine Corps' institutional demographics. He is a Caucasian male. He is 18 to 24 years old, between the ranks of private and sergeant E–1 through E–5. The most prevalent common thread is a failed relationship. Male marines are significantly at greater risk of suicide than female marines. The most common methods of suicide within the Marine Corps are gunshot or hanging, similar to our civilian counterparts.

Suicide prevention is required training for recruits in boot camp and for all our new officers at The Basic School. It is part of the curriculum at our staff non-commissioned officer (NCO) academies, our commanders courses, and at other professional military education venues. Simply put, suicide prevention training is incorporated into our formal education and training at all levels of professional development and throughout a marine's entire career.

Regretfully, there is no single solution that will likely turn this trend around. Rather, we believe it will be a combination of efforts whose consistent themes are value-based training, behavior modification and leadership. At a planning session this past November, some of our Corps' very brightest and best young non-commissioned officers asked us to provide them with the additional training so that they could take ownership of suicide prevention for their peers and for their marines.

Our NCOs have the day-to-day contact with these marines, and as such have the best opportunity to see changes in behavior and other problems that can mark marines in need of help. As a result, we have developed a high-impact leadership training program focused on our non-commissioned officers and our corpsmen. It is designed to provide them with additional tools to identify and assist marines at risk for suicide.

Additionally, I directed the Marine Corps Combat Development Command to take an independent look at our suicide-prevention training throughout the Marine Corps. A special task force began their work earlier this month on how we are specifically training our marines. It will explore how we can modify training at all levels to improve resilience, decrease stigma and reinforce the themes that marines thrive in hardship, that marines persevere through

the strength of our fellow marines, and that marines don't quit when the going gets tough. In other words, we want to get to the left of the suicide.

To rapidly raise the level of awareness across the Marine Corps, 100 percent of all marines received additional training in suicide prevention during the month of March this year. The training package was delivered by Marine leaders and educated all marines on warning signs, engagement with their buddies, and how to access the variety of local and national support resources. With support from the Navy, we are increasing the number of our mental-health professionals, embedding more of them in our deploying units where they can develop close relationships with our marines all in an attempt to reduce the stigma of seeking help and to identify potentially affected individuals earlier.

While there is no single answer that will solve this crisis of rising suicides, we are committed to exploring every possible solution and using every resource we have available. I promise this committee that I will not rest until this is turned around. I thank each and every one of you for your faithfulness to our Nation and your confidence in the leadership and commitment of our Corps.

Mrs. DAVIS. Thank you, General.

[The prepared statement of General Amos can be found in the Appendix on page 79.]

Mrs. DAVIS. General Fraser.

STATEMENT OF GEN. WILLIAM M. FRASER III, USAF, VICE CHIEF OF STAFF, U.S. AIR FORCE

General FRASER. Chairwoman Davis, Representative Wilson, distinguished members of this committee, I want to thank you for the opportunity to appear before you today. It is a privilege to join with the other vice chiefs of our sister services in addressing this very important issue. I want to echo their sentiments and believe we must continue to develop and implement programs to maintain the psychological health of our servicemembers.

Your Air Force is heavily engaged in worldwide operations. The demands of frequent deployments and increased workloads at home station, compounded by other external factors such as economic pressures, continue to place a heavy burden on our airmen and their families. Under these conditions the Air Force does not take a business-as-usual approach to monitoring the physical and the psychological well-being of our force. The Air Force Suicide Prevention Program requires the personal attention of every airman. Secretary Donley and General Schwartz, our Chief of Staff, have led the charge in making it clear that whether you are on active duty, Guard, Reserve or civilian, leaders across our force must deal with this problem head on.

Through a total force approach, we are strengthening our focus on the suicide preventions. We are working diligently to heighten awareness and reduce the stigma of seeking help. Our goal is to ensure that every airman is as mentally prepared for deployments and redeployments as they are physically and professionally.

We continue to institutionalize our Air Force Suicide Prevention Program, focusing heavily on 11 program elements that enhance the psychological and health treatment and management programs.

Recognizing the importance of collaboration in this effort, we are bringing together key representatives from across the Air Force in working groups to ensure that we anticipate, identify and then treat the psychological health issues that are before us.

We are also working closely with our joint teammates to capitalize on best practices as seen in the other services. While there is some comfort in the impact these programs are having, even a single suicide is one too many. Individually and collectively, the Air Force is committed to taking care of our most valuable asset, that is our airmen.

I want to thank you for your continued support of America's airmen. I look forward to your questions and further discussion on how we can best serve those that serve our Nation.

Thank you.

Mrs. DAVIS. Thank you.

[The prepared statement of General Fraser can be found in the Appendix on page 90.]

Mrs. DAVIS. I want to thank all of you. And I know from your statements that you have submitted, as well as your comments today, that you take this very seriously, and we certainly appreciate that. I wonder if you could just expand on your statements a little bit and share with us what has been the most frustrating part of trying to deal with these issues? What would you like us to know as you have had to deal with this?

General Chiarelli.

General CHIARELLI. Well, the most frustrating thing is trying to find the cause. And that is why we have asked the help of the National Institute of Mental Health to do a study. And we feel that this could be huge, huge for the Army, Department of Defense and, quite frankly, for America, because I think many of the lessons that are going to be learned in this study, where we have combined the resources of the Department of Defense, Harvard, Columbia, University of Michigan and put together a world-class team, that it is going to have the Army and the Marine Corps to use, to gather the data that I think are really going to unlock some of the mysteries of why this happens with some individuals. And I think it will get us out of the speculation of someone who spent 36 years with troops trying to figure out and look at statistics and determine a cause, it will get me out of that business and into the business of finding out what the real cause is, what works and what does doesn't work, so that we can provide for our commanders that which I think will help them in helping to prevent suicide.

Mrs. DAVIS. Have they shared how you might make real-time use of that data as they are developing their study? Is that something that you have been able to move forward on?

General CHIARELLI. They realize this is not business as usual, as General Fraser said. We are into this, and we are not going to wait for the results of a study or anything else. And the National Institute of Mental Health understands that. And we rolled out the study team a week ago, and we already have calendared their first comeback to us of initial study results in early November of this year. They will do that every single quarter. So we will learn as they are collecting the data and analyzing the data, and that is exciting.

I think the other thing that is frustrating to me is I really think the thing that will give us a leg up on this that will help us out so much is to increase the amount of dwell time that our soldiers have at home. There is no doubt in my mind that this reduced dwell time, turning it around in rotations every 12 to 15 months, is causing a tremendous amount of stress on the force, on soldiers, families, and I have to believe that the National Institute of Mental Health will identify that early as one of the stressors that is affecting us.

Mrs. DAVIS. Thank you.

Admiral Walsh, did you want to comment?

Admiral WALSH. It is actually hard to organize our thoughts when it comes to that question because there is so many different ways to approach this at so many different levels. So on a very personal note, I would like to play a constructive, impactful role. And in this particular area, because you are dealing with so many unknowns and variables that are very hard to even describe and grasp, it is hard to come forward asking for more resources and programmatic solutions to something that requires a connection to take place between people.

And so that is why we try and take a balanced approach to this that really pulls on the command and operational sorts of roles that need to be played in trying to carve out time and space to look at people and see what people need. And what I have heard across the panel here is absolute consensus on a climate that allows for that kind of dialogue and feedback; absolute consensus on we will leave no good idea on the table; shared best practices between the services in terms of how they will adapt initiatives to their particular culture and domain.

What is frustrating for us is not to find the correlative data that we are looking for. In one sense you would think that more deployments would be indicative of those that would be more inclined to go down this path, and that has not been the case for Navy. In fact, what this conversation provokes is really an inward look inside our own cultures to see where are the checks and balances, where is the accountability, where are the authorities, and how do we look after people. And what we find is that we have built our culture on our deployment model, and that while there may be some exceptions, the problems that we find in the case of suicide is that our folks, while they are deployed, generally do okay. We have some vulnerable pockets within the general population of sailors.

But the area that we really need to focus on is when all those checks and balances and that sort of cocoon that they live in on deployment is now taken away, and they come back off the deployment. And so the first six months for those who return from deployment are those who are in the area that is most vulnerable, as well as those who have never deployed. And so what that does is it sort of strikes in the face of what many in the general population think, is that we are handcuffed off to deployment, and that we have to do this, and therefore, it is more stressful for us.

The reality of it is the target for this needs to be the assimilation of those who have served back into the general population dealing with the day to day, whether it is families, their kids, their education, their bills and the relationship stressors associated with it.

Mrs. DAVIS. Thank you.

General Amos and General Fraser, if the panel doesn't mind, if Members don't mind, we are going to go ahead and finish our panel. Thank you.

General AMOS. I share my colleagues' exact sentiments here. It is interesting because the Marine Corps, like all of us, have been deployed in some pretty tough conditions for the last seven years and have done quite well. And when you visit, and I know probably all the committee members have visited them forward-deployed in combat, they are a happy lot. Even though they are full of stress, and there is an awful lot going on, it is very dangerous, they are a happy lot. And when they come home, that is typically when we have issues.

The Marine Corps is unique in that 70 percent of the marines, actually about 71 percent of our 204,000 marines we have on active duty today are on their first enlistment. So we are the youngest of all the services. We have got 42 percent of our marines are lance corporal and below; 24 percent of that 204,000 aren't even of drinking age yet. So this is a very, very young population that we have.

The frustrating part for us in the Marine Corps, and I know it is shared by my brothers here, is trying to find those common threads that you can actually put your fingerprints on and try to do something about. I mentioned in my opening comments that one of the typical threads is a failed relationship. That seems to—that seems to be for the marines, the young men, that 18 to 24 that are taking their lives, seems to be a common thread, but it is never the thing that seems to push it over the edge.

There are a pile of stressors that in many cases, if taken by themselves, and you could carve them out and set them aside, they can deal with them quite nicely. And the fact of the matter is most marines do deal with them. But it is the compilation of those stressors and all of us trying to figure out, okay, how do we identify those ahead of time, and how do we do something about it to kind of stop this chain of events that finally leads somebody to take their lives. That is the frustrating part, Chairwoman. And we are working very hard, but we have only found a couple of things that seem to be common.

Mrs. DAVIS. General Fraser.

General FRASER. Thank you. And I, too, would echo the comments that have already been made. But let me just say that most frustrating is the fact that there is no one single answer. But even above that, I would say it is more frustrating, for everything that we provide, given the resources that we have in the programs that are in place, is when an individual does reach out and they seek help, and we are seeing that happen. Actually our numbers are going up where I think we are seeing that the stigmatism is—we are getting past that, that people are reaching out for help. And so you begin to provide that help. And then it gets very frustrating when all of a sudden they go along a path, and then they are successful in executing suicide.

To me that is very frustrating because you have provided programs, you have provided mental health care providers or chaplains or whatever else it may be that they were reaching out for,

but for some reason it wasn't enough, and to me that is the most frustrating.

And we do have some rather small numbers from 2003 to this time period here. About 25 percent of those have actually been receiving care of some sort, but yet something wasn't good enough, and that is disappointing. And so we go back and we take a hard look at that, but I would say that is the most frustrating is when you provide things, and then still it is just not enough. And you never, ever really know what else could I have done or could we have done to help them to not lose hope and despair and then commit that fateful act.

Mrs. DAVIS. Thank you. Thank you all for responding.

Mr. Wilson.

Mr. WILSON. Thank you very much.

And again, thank you for your participation today.

General Amos, I want to particularly thank you for pointing out the morale of our troops who are serving overseas. I have had the privilege of visiting 10 times in Iraq, 8 times in Afghanistan. Actually I visited with my former National Guard unit in Afghanistan. And I have had two sons serve in Iraq. They are proud of their service. And we go over to actually encourage them. Every time I go, I come back inspired by the young people serving our country.

For all of you today, each of you have described a broad spectrum of programs that cut across many disciplines within your respective service aimed at preventing, recognizing and treating psychological stress in military personnel. How do you identify which services are most appropriate for a particular servicemember and then coordinate the use of those services between the servicemember, the command and the multiple organizations that offer the services?

In addition, when I look at the continuing incidence of suicide, even with the number of mental health programs each service has available, I can't help but wonder if your programs are working. What are your thoughts and how effective are your programs for reducing psychological stress and suicide, and how are you measuring whether your programs are effective? And this is for each one of the panel, and beginning with General Chiarelli.

General CHIARELLI. Sir, last year the Army Science Board did a study for us as they looked into the increasing number of suicides in the Army, and they found 14 pages of programs. So a young commander going to look at what he needed to do to work this issue would be faced with 14 pages of programs. And it is clear to all of us that this is not a problem of having too many programs, it is not knowing which ones are the ones that actually have an effect.

We feel that we were very successful in getting the focus on this problem with the stand-down we conducted in the March-April time period where we used the Beyond the Front video followed up by a chain teach. But we know the National Institute of Mental Health is going to help us to identify which programs in that 14 pages work. And we also feel that the Comprehensive Soldier Fitness will move us to the left of this problem as today we have young non-commissioned officers who are taking training at the University of Pennsylvania in resiliency training that will go back to their units and begin to work with soldiers from the time they

enter the Army until the time they leave the Army. And we hold great hope that that is going to move us to the left.

Admiral WALSH. Sir, I would put it in the category of mental welfare and the programs associated with that. For Navy we really focus our energy around a concept of operations here that involve line leadership. We feel that we cannot just develop something in the medical community and have it stand in isolation, which may or may not actually connect to people.

So the focus of our effort that is now under way today, that is too early to assess but instinctively and intuitively tells us we are on the right path, is our Operational Stress Control Program. The way we are going to track this is really relying heavily on assessments and feedback. And the question that that then promotes is what do you do with that feedback once you get it.

We have learned over the course of this war that we have to have the ability to get mental-health professionals on site, and we have direct examples of this, where we have looked at detainee operations, for example, in Afghanistan, where we were looking at the rotation rates, the dwell time, and just the amount of effort that it took for sailors to take on that duty and responsibility. When we had the flyaway team get boots on ground and actually take a look at it, the feedback that we got, the surveys that we used to target that particular population, then influence, then policy changes in terms of who we identify for those types of billets, how long they have those billets, the dwell time that they need to have after having a job like that, and then whether or not they are good candidates for returning to the area of responsibility (AOR).

So in response to your question, whatever program that we come up with has to have an understanding that unless we are able to assess it and measure it, then we have no idea whether or not it is taking any traction. And that is the spirit in which we are unveiling the Operational Stress Control Program this fall.

Mr. WILSON. Thank you.

General AMOS. Sir, I think the programs that we have had in the past, if you go back and look at history, the Department of Defense hasn't kept, didn't start keeping accurate records on suicides until post-Vietnam. That was probably sometime in the 1980s. But I remember looking at a chart. In 1996, the Department of Defense began to focus on suicides, and across the services you saw a drop. So I think the fact that this subcommittee, our Secretary of Defense, our service secretaries and our service chiefs are putting this much attention to it is going to have an effect.

It is too soon to tell. Certainly if you ask me today, how are you doing today, I will tell you we are doing abysmal, we are not doing well. But the programs that we have had have worked up, I think, until probably just the last couple of years. It has—this generation, this—where we are in kind of the state of the Marine Corps with the consistent persistent deployments and, I think, the young men and women we are bringing in, which are the best we have ever seen by far, requires a different approach. It requires an approach that is more meaningful to them. And we are going back to what the basics of the Marine Corps is, which is leadership; not just a platitude, not a plaque, but fundamental leadership. Leadership, the same leadership we had while we are deployed in Iraq. And we

watch them, and we know everything that goes on in their brains when we are together on the ground, and yet we come home, and we don't have a lot of time at home, and we are not spending that detailed leadership and attention to detail and attentiveness to those young men and women back home.

We are changing that. We are instituting the NCO leadership panel or training period, which I was telling you about in my opening statement.

And then this final thing that I think is going to take root, and it may have the most significant effect, and that is to go into entry-level training, to Parris Island, South Carolina, and to Marine Corps Recruit Depot in San Diego, and with those senior drill instructors and those other two junior drill instructors, and they look at those young men and women, and they are making them marines in 12 weeks, they change their behavior for life. We are working right now to figure out what those precise messages are so that when that senior drill instructor who they will never forget tells them that marines endure hardship well, we don't take the easy way out.

That is where we are going, sir. So it is too soon to tell, but we are working fervently on this thing right now.

General FRASER. Sir, one of the things that we are doing and continue to do is build upon the program that we instituted back in the 1997 time period as far as our Air Force Suicide Prevention Program goes. It has 11 different elements within it, and we take a holistic look across all of our programs all the time. And this integrated delivery system that we have brings together different elements from different organizations, from the medical community, from the chaplaincy I mentioned earlier. We have also got Office of Special Investigations (OSI) for investigations. We also have the Judge Advocate General (JAG) Corps that is a part of that, and also our personnel, and we have recently integrated safety as a part of this. And what we do with this type of holistic approach is look across all of our programs at the wing, the numbered Air Force, the Major Command (MAJCOM) and even at the headquarters level. And so we are able to look across all of our programs and see what can we do better.

We are also participating in the Suicide Prevention Awareness Risk Reduction Committee that is now a part of OSD across all the services. And I think that goes to the point that you were trying to make is how are we reaching out and getting best lessons from others, best practices, so that we can integrate them in. And so not only at the wing, Numbered Air Force (NAF), MAJCOM and headquarters level, but even across the services we are trying to take this approach to see what can we do better.

We have learned some things. In March of this year, I instituted a Suicide Prevention Working Group. And just in the short time that they had been meeting every single week, just recently they outbriefed me with 33 different initiatives that we are going to be looking into that go across training, policies and other types of programs that we can actually institute. So we are seeing some positive things come about to ensure that we are maximizing everything that is available to us and to our troops.

Mr. WILSON. We look forward to receiving your updated reports. Thank you very much.

Mrs. DAVIS. Thank you.

Mr. Jones.

Mr. JONES. Madam Chairman, thank you very much. And I sit here listening very carefully. And thank you, gentlemen. You have got one tough damn job, truthfully, because of the war in Iraq and Afghanistan. And I am looking at an article in *Marine Times,* and, General Amos, this is not a criticism, this is praise really. At least seven marines are believed to have killed themselves so far in July, officials said, putting the Corps on a record pace despite broad-based efforts introduced to reduce suicides.

I think you and those who work with you got an impossible situation, but I want to thank you for accepting it not as impossible.

I guess you know when you really want to look at this, this Nation continues to wear out and break the military. And no matter how tough that marine is or that soldier, airman, seaman, whatever, a tough human being is a human being. And I guess my question, if I have one, I want to know, these seven marines, and it could have been seven soldiers, when you get the report that Sergeant X or Private X has committed suicide, where does that report go? Does it come all the way up the chain?

My point of what I am trying to ask is what I would love to know, just one tragedy, the history of that one soldier or that one marine, and wanting to know that if he or she had been there—let us say that it is because of frequent deployments. You said sometimes it is not, and I understood, and I agree with that. It could be family situation, it could be financial situation. But I really would like to have a briefing from the Army or the Marine Corps or the Navy just taking one soldier or one marine and give me a classified briefing of what was his life like, what signs did you see or not see; and I don't mean you individually, but that lieutenant or that captain or that major. Did they see any signs? Because I truthfully—I don't think you all could be doing any more than you are doing, and that is my own personal feelings. But I have sat here, and I want to thank the Chairlady and the Ranking Member. We have had numerous hearings, and I have sat here, and I think you all are doing the very best job you can do. And I commend not only you, but the organization, the service that you work with. But I don't know if we can get a handle on, unless we had several classified briefings about it, Chairman, and let you give us a soldier or five soldiers or five marines or five seamen or airmen to tell us what was that person's life like, why was it not—why was it missed? I am not sure that would help us give you any better direction, to be honest with you, but I think it would better help us understand.

Does that make any sense to you that we could be briefed individually if not as a committee to try to understand?

General AMOS. If I could take that. I think it makes complete sense. And you need to know, and the committee needs to know, that in our organization we have a thing, and it is not a fancy term and it is a heartbreaker, but it is called a death debrief. And you go to visit General Hejlick down at Camp Lejeune, and General Hejlick gets a brief. It doesn't matter whether it is an airplane acci-

dent, or whether it is a marine who takes his life, or we have an accident out there and a kid has a single-vehicle accident and loses his life. That thing is dissected at the lowest level, the Lieutenant Colonel command level, all those people in his chain of command or her chain of command, sergeant major right down to platoon sergeant right down to the squad leader. Everybody comes into General Hejlick's office, to include all the generals in between, and he will sit down for probably about a 2½- to 3-hour debrief to include pictures, to include family history, all the things that you had mentioned. All that is peeled back at General Hejlick's.

That happens across the Marine Corps for the very reasons—and parts of that comes to me within eight days. That is the Assistant Commandant. It comes up. I get to see it, I see the pictures, I get the preliminary reports. And for the very reasons that you were asking, Congressman Jones, is because we just—I don't ever want it to be just another statistic. I want it to be a face, a name. He belongs to somebody. Some mother and father loaned him to the Marine Corps, or her.

And so we can do that. We would be happy to do that.

[The information referred to can be found in the Appendix on page 109.]

General CHIARELLI. Sir, I sat in a video teleconference this morning with commanders from all over the United States where 11 suicide cases were briefed to me. Those cases took place between February and March of this year. Every single suicide is briefed to me this year. And we go through them in great detail; 11 cases in about 2 hours and 15 minutes. We learn. And that is what this is all about. It is learning. And as a commander briefs, another commander in another part of the United States, Iraq, Afghanistan, Hawaii or Japan is on that video teleconference being able to apply the lessons learned from each individual case to situations that he might find himself in with the smaller population that he commands. And we could very easily provide you with that information.

Mr. JONES. Yes, sir.

Admiral WALSH. Typically I will see the information either the day of or the night after in terms of the summary of what happened, which then will prompt a series of questions, because we know where our pockets of vulnerability are typically with our individual augmentees who are serving apart from deployed units on their own in support of the ground fight. While our statistical evidence suggests that we have not had a problem in that area, that is one of the first areas we start looking for. Then we look for deployment history. That briefing will go up to the Chief of Naval Operations so that everyone is aware.

I am happy to provide you that information. It is unsatisfying because it will leave you with more questions than answers. The approach that we take today, the questions that we ask, the emphasis and the focus that we place on leadership, beginning with the question of why didn't you know, you should have known, actually are not our words. Those words were written in 1995 by Mike Boorda months before he committed suicide.

So we are a service that has lived with these lingering questions and no answers for many years, and this is something that we can't put enough focus and emphasis on.

Mr. JONES. Madam Chairman, I guess my time is about up. I want again to say I don't really want to see the reports. I know you are doing your job. And I guess I want to bring that point up just to say I think you are doing everything that you can possibly do in a situation that is just unbelievable, because these young men and women are being stressed beyond belief. And you cannot—again, in closing, you cannot be—I don't care how strong you are, there comes a time that the body just says, I cannot do much more. And this country needs to face this. This is not your problem. This is the problem of this Administration as it was the past Administration, and we need to face the facts that we are in a bad situation.

Thank you.

Mrs. DAVIS. Thank you, Mr. Jones.

And we have been a little loose with the time today because I know that it takes a while sometimes to even express how some of these programs and concerns are moving along. And so I appreciate taking a little more time.

I wanted to just ask unanimous consent for Mr. Coffman to be able to participate and ask questions. Hearing none, I move on to Mr. Murphy.

Mr. MURPHY. Thanks for that, Madam Chairwoman.

Gentlemen, thank you for your candor and tact on such a difficult issue with suicides in our military and the psychological stress that our heroes are going under during these times.

General Chiarelli, I appreciated your comments regarding being more proactive than reactive of a change in philosophy, and we do appreciate that; and also your partnership with the University of Pennsylvania, that resiliency training classes that your folks are going through.

General Amos, I appreciate your comments, too. As far as we all know, in the Army this is the year of the non-commissioned officer and your leadership program with the NCOs and making sure that they break through those barriers, and that leadership, I think, is very much welcome as well.

I know today we also talked about as far as the stress on deployments and the stress going home. I know when I was in Iraq 6 years ago, 1 of our 19 paratroopers committed suicide over in Baghdad, and that weighs on my heart. And I know my colleague that I served with over there, Captain John Soltz, he talked about when he came home the hardest thing about deploying was coming home and that stress there.

I represent the Eighth District of Pennsylvania, and I can tell you that we have had three young heroes in the past seven months this year alone, three young heroes who came home from either Iraq or Afghanistan that committed suicide, and that has been really tough, that has been really tough. In each of these cases we heard similar stories from their families. They knew that their loved ones were having problems, but they just didn't know how to help or where to turn.

So my question, I think, are—you know, I know the earlier testimony about there was 14 different programs and making sure that we are syncing this up and getting it straight. But how are the services working with the families before, during and after their loved one's deployment so they can spot the signs of either post-traumatic stress disorder, traumatic brain injury or depression and know how to take action? If you can comment about that, I would be very much appreciative.

General AMOS. Sir, two years ago the Commandant got ahold of our family team—what we call our family team-building or family readiness focus and said, let us put this on a wartime footing, when it became apparent that we are going to be at this for some time. Not that money is an indication of focus, but it does give you a sense of prioritization for our Commandant. And it is $400 million in 2008, $400 million 2009, and just about that, in fact a little bit more than that, in 2010. And the whole purpose is to build those, of all those awareness programs, all the predeployment efforts, the briefings, bringing in the health advisors, bringing in all the folks that pull a family together as a unit, to prepare them for their deployment.

Now, there is a host of things that the young marine goes through, all the combat training, as you know. I am talking about the family readiness part. I am talking about getting the spouse prepared for the deployment, what is it like, what can you expect, how is it as you get closer, and what it is like when you are in the middle of it; and then what is it going to be like, as you said, sir, when you come home, what is that like? I mean, that is a different set of dynamics.

We have looked at all three of those periods of time, and without getting into just huge details, we have put a lot of effort in there to include communications tools, to include staying plugged into them with volunteers and paid workers to help us stay plugged into those families. In there are all the different ways. You can bring your children and get them help if they are in school and they are struggling with it. We worked very hard at that, sir. And it is all begins six months before the deployment and comes back when they come back home.

Mr. MURPHY. Thank you, General Amos.

General Chiarelli, could you comment.

General CHIARELLI. The most successful program we have seen in recent years is the military family life counselors. They have been absolutely fantastic, and we are pushing them down to battalion level. Prior to having that asset that you could use, the only thing you found down at the battalion level, that formation of anywhere between 500 and 800 individuals, was the chaplain. We have always had one chaplain, but, you know, in today's world, after eight years of war, we need two chaplains, I would argue, down at those battalion headquarters along with the military family life counselors.

Substance abuse counselors. What I found when I went to visit seven installations in eight days was that we still had the same authorizations for substance abuse counselors in 2009 that we had in 2001. And there is no doubt in my mind that the incidence of substance abuse has increased in the United States Army, and it is

part and parcel to the deployments we are under. So we are today hiring as quickly as we can to provide the additional substance abuse counselors we need.

And you all know the problem with mental health counselors in trying to get enough. We are looking for new and innovative ways. And we really believe that being able to provide mental health counseling on line, and one day, I hope by November or December, an individual will be able to do that at his or her home. We made available to all families as well as soldiers in the privacy of their own home, and we think that this is one way we can get around a national shortage we have by being able to bring them together in an on-line capability that will service all the Department of Defense.

Mr. MURPHY. Thank you.

Gentlemen, I think my time is up. I don't want to get reprimanded by the Chairwoman, but I would appreciate the next round we can further discuss. Thank you.

Mrs. DAVIS. Thank you.

Dr. Snyder.

We actually have some votes coming up. I think we can probably work for at least another Member asking questions and maybe a second.

Dr. Snyder.

Dr. SNYDER. Thank you, Madam Chair.

General Amos, when you were talking about Marine Corps Recruit Depot (MCRD) in both the east and west coast, it is 42 years next month I began, and I don't remember much in terms of the teddy bear counseling quality of my drill instructors. On the other hand, I think I remember everything they ever said, so I think your point is probably a good one.

I wanted to direct my questions to you, General Chiarelli, if I might, since you have the study going on by the National Institute of Mental Health, and more in the spirit of just open questions. We are focused here today on suicide rates. That may or may not be the thing that we need to be measuring or looking at. I don't know what is under the water out there. I think of all those soldiers that you have right now who are in misery and their family is in misery and perhaps children who witness a lot of this are in misery, and yet because they don't ever actually take the act of some violence towards himself, we may not know about it. And I don't know what that is for every completed suicide. Is it 5 families, is it 20 families, is it 200 families? But I think that is—you know, what do we measure, and what do we look at? And I think that your study from the National Institute of Mental Health may point to what we look at. Do we measure the suicide rates of spouses or the suicide rates of children of military members?

General CHIARELLI. We collect as much of that data as we possibly can, and we track it. It is the most difficult of all the data gathered not when it takes place on a military installation, but when it takes place off of a military installation. But we do our best to collect as much of that data as we can.

And, sir, I think you are 100 percent right. Suicide is a the extreme indicator. And by the time I hit the third installation, I realized that this wasn't about suicide prevention, this is about the

mental wellness of soldiers and families. That is what this is about. And what our programs have to be directed at is that mental wellness, not at the extreme. And if we get at that, I really think we are going to see the incidence go——

Dr. SNYDER. I think that is right. When you talk about the factors, failed relationships, I think, was one that you specifically mentioned. Again, the causation is what you are looking for; what is causing this out there along the chain? I was surprised that a diagnosis of depression was not one of the factors. Where does that fit into this?

General CHIARELLI. Depression is an indicator, but when I talked to spouses on that tour, what I found from them was their spouse was coming back off of a deployment going through that first 30-day period where everything is wonderful, but then getting down into that training period as he is getting ready to go out or she is getting ready to go out in 9 to 11 months. And the whole process of reintegration, if you have ever tried to do that, spouses were telling me their husbands were not reintegrating with the family. They just realized that that was too hard to do in the short period of time they had, and they would back off from the family, which creates the relationship problem, which you know spirals out of effect.

Dr. SNYDER. Is there—you all—I think all of you talked about the fact that we haven't talked about this for some years now, that I think we are doing a better job both in our American civil culture, but also the military culture, of acknowledging that seeking mental health counseling should not be stigmatized. In your Army culture what about couples who seek help for marital problems? Is there a stigma to acknowledge as a couple that they are having problems, or do you think that that is also recognized as better accepted, that it is okay to go ahead and acknowledge to your folks that you are having difficulty?

General CHIARELLI. I think marriage counseling is better accepted, if there is such a way to put it, than the stigma of seeking mental health help. And one of the focuses of what we are trying to do is to do everything possible to get rid of that stigma. That is one of the reasons why I am so excited about being able to deliver mental health counseling on line. It has been done in Australia. They have had tremendous success. The people are more willing to open up on line. And that gets the geographically separated people who don't have the cocoon of a military post to fall under.

Dr. SNYDER. Are there any duty assignments that a person can't hold for a while, such as flying or air traffic controller, if they are placed on an antidepressant or a medicine for depression or a mental health illness?

General CHIARELLI. There are, and flying is one for sure.

Dr. SNYDER. So that can be a factor in how we deal with some of these signs.

General CHIARELLI. It can. But I worry about something other than that. I worry that we are overprescribing. I worry that we are having such a rough time determining the causal effect of this that in many instances I fear that our own doctors, at least I will state Army doctors, at times are throwing prescriptions at soldiers because they are either overworked or just don't know what to do,

and there is enough evidence-based information to indicate that in some instances drugs do——

Dr. SNYDER. Do you track allegations or confirmed episodes of child abuse in military families, in Army families.

General CHIARELLI. We do and those numbers are available also.

Dr. SNYDER. Do you know what the trend is in that?

General CHIARELLI. I believe last year we were down.

Dr. SNYDER. I think my time is up, Madam Chair. Thank you. Thank you all for your service.

Mrs. DAVIS. Thank you. We are going to go vote and then come back. We are certainly hopeful that you all will be able to stay, and I certainly hope that the members will all come back, because this is a very important hearing and we would like to have everybody's input.

So can I count on members to come back, hopefully? Thank you.

[Recess.]

Mrs. DAVIS. We want to thank everybody for your patience. It always takes longer than we think it will. I want to turn to the next member, Mr. Loebsack.

Mr. LOEBSACK. Well, thank you, Madam Chair. Speaking of chairs, I will allow everyone to get in their chairs.

I really appreciate your being here, all of you. Thank you so much for your service and for what you are doing on this particular issue. I guess I might just mention a couple of things at the outset here before I ask specific questions.

The whole issue of stigma, I am glad that that was brought up. You know, obviously whether it is mental health in the civilian sector or the military sector, I think stigma is probably maybe the most important factor in all of this and doing all we can to overcome the stigma of mental health.

I have some personal connection to this. My mother as I was growing up and throughout my whole adult life, as long as I can remember, there has been a struggle with mental health and stigma was a huge issue. And we had Rosalyn Carter speak before the Education and Labor Committee on Mental Health Parity and a number of folks, including her, focused on that particular issue. And never having served in the military, but I can only imagine that that issue may be even more significant in the culture of the military, and you can correct me if I am wrong, if I am wrong about that. As I said, I have never served.

Also the issue of multiple deployments, I think that just seems to be coming up over and over again. And clearly that is just an important issue with not a lot of dwell time in between. I know we are trying to improve on that in all the services. And I really hope that we can continue to do so.

I want to also maybe focus on or drill down a little bit more on the families and the children. It was mentioned, I think General Amos is the one who mentioned that predeployment there is a lot of work done with the families. Obviously postdeployment. This is a very important issue. There was a National Public Radio story recently about children of the Guard, Reserve Components. We do not have a lot of big bases, we have none in fact in Iowa, but we have a lot of National Guard folks. I like to mention that every hearing I possibly can. And clearly I think it is just absolutely crit-

ical we do everything we can for the families, not just of the active service folks, but also those Reserve Components. And I am just wondering if you folks, one or all of you, whatever number would like to could speak to the Reserve Components, especially those Guard folks and their families, those folks who have had these multiple deployments. And everyone is trying to balance a lot of different things when they are deployed and when they come back, but those Guard folks in particular. Whoever wants to start, please do.

General CHIARELLI. Well, sir, that is definitely a focus of ours. It is how you can take a disbursed population. When you take a look at the United States Army today, we have 710,000 folks on active duty, they are active duty soldiers, Title 10 soldiers. With about 400,000 who were in the Reserve Components. Their total numbers are greater, but 200,000 of them, close to 200,000 of them are on active duty. When they come off of a 12- or 15-month deployment within 3 or 4 days they are back in their community. And that community won't have the support base of a Fort Hood or a Fort Bragg. And that is why we are so excited about being able to provide mental health care on-line, because we will be able to move into remote areas and provide Reserve Component soldiers who are part of the TRICARE, who join TRICARE, and they can do that today with TRICARE Reserve Plus. They and their families will have access to that on-line mental health care counseling. And I think you all know the tremendous impact the Yellow Ribbon Program has made on Reserve Component soldiers in bringing them back and giving them the opportunity to go through some reintegration training at different periods after they return home from deployment.

So definitely a focus and concern of the Army, one of the toughest things we have to try to get at.

Admiral WALSH. If I could speak to the multiple deployments, we don't have correlative data that with more deployments we have more suicides, but intuitively, instinctively, I think what we have learned in the course of these discussions is that what multiple deployments do, often time under voluntary conditions where the member elects to go back, sometimes sooner than required, is it puts off the family integration challenge, and it just allows this to take more time and to fester in some cases. This is personal opinion. This is sort of an insight that comes with time, trying to dissect what the data is really telling us.

On the family and the children issue, I think I can offer an example here where our collaboration with the Marine Corps has provided insights that now apply across the Navy in the case of needs addressed in Pendleton about trying to target families who have gone through multiple deployments and specifically the needs of children.

The Marines, with Navy Medicine, piloted a program and worked with local universities to come up with a program called FOCUS, which is really a program for families that are under constant stress from continuing deployments. Took that idea, Naval Special Warfare saw that, liked it and piggybacked on it, and now we use that Navy-wide.

What it does is it is another set of antenna that get us out inside our own population to understand what the stressors are and what people's needs are. We know that the stress is more now than it has been before. We know that there are a number of factors that contribute to it. To look at the service culture and isolation is not fair to the problem, nor is it accurate.

So our reintegration efforts with folks who return from deployment who empirically we know are at risk need to take into account these factors of trying to plug people back with their families and help them assimilate into problem solving for their families, because that is really an issue.

And then finally on the Guard component, for us it is the Reserves, you have given me an opportunity to highlight. We couldn't be where we are without the help of Reserves. The Reserves have been a tremendous force multiplier for us in terms of the skills they offer and the patriotism they bring to the mission.

The challenge that we have in this particular area is not so much those who affiliate, it is those who then choose not to affiliate after they have served and then we lose track of them.

Typically the way things work in the service culture is that if we have got our eyes on it, we will fix it, we will work with it, we will support and we will find ways to help. But if we are not looking so then we don't see it. So this is an area of concern for us.

General AMOS. Sir, we get to the children through the parents. That is how we touch our children, both on active duty and on our bases and stations where we have DOD schools, like Lejeune and Pendleton, and overseas where the children live on the base. That is actually the easiest of how we get to them. In fact most of those, if not all of those DOD schools, they have added counselors, because of deployments. The teachers are seeing the results of the deployments on the behavior of the children in the school.

So it is not quite as easy outside in the public school systems, which is clearly where the majority of 100,000 children reside. But to the Reserves—we don't have Guard in the Marine Corps, we have Reserves, and they have been very, very effective. We have deployed the socks off them in the last four or five years. Every unit has deployed at least twice, and so we are resetting many of those units right now.

Eighty plus percent of our Reserves are in what we would call whole cloth units; In other words, an infantry battalion, Marine wing support squadron. And when they go what has happened with the Reserve side is we have mirrored all the family readiness programs, all the things I talked to Congressman Murphy about. We have mirrored all that for those units that are in the Reserve. So they had the benefit of all the training, everything. The ones that are troublesome are the individual log meds, what we call the IRR, the Individual Ready Reserve that kind of goes out onesie, twosie. They come out of your state, they come out of my home state. They deploy and they come back. That is what Chiarelli was talking about, this Yellow Ribbon Program, this reunion effort which is fantastic. So the focus effort that came out of University of California Los Angeles (UCLA) that was just talked about, Web-based opportunities. We call now every single one of the families. We are doing our best to stay plugged into them. Through them the par-

ents we can get to the children, but there are programs available for our children and our families that are out there, even if you are an individual log med. It is just the level, degree of difficulty of that is significantly higher.

General FRASER. Sir, we look at it from a total force perspective and so all the programs that we have for the active duty are certainly available for our Guard and the Reserve. We have a very active Yellow Ribbon Program in every state and territories now, and it is funded and we are actively engaged in that.

We do also have some new positions with respect to the Guard, there is psychological director that has been established, a directorate, and is being manned. There is also seven regional teams that are able to reach out and work with the folks in and the families.

The other things that we have also made sure that we do for the non-collocated locations where there may not be active duty, or other types of care, or programs provided is how to reach out to them, and what can we do. If somebody has a need, has a requirement for some mental health care, then we make sure that we get that to them or we will bring them to a location where they can receive health care.

The other thing that we have done is utilizing our Preventive Health Assessments, PHAs, before they deploy. That then gives us a baseline. We then do a post deployment health assessment. Then there is another mandatory one after that, 90 to 180 days after the deployment for a reassessment. Then that gives three looks at the individual so that we can see are there any other indicators so that we can be proactive. Where they may not be coming forward but we see something through these assessments, that allows us then to reach out to the individuals or to the families if we are seeing things, too. So that has been very hopeful.

Mr. LOEBSACK. Madam Chair, I would like to submit a question or two for the record to our witnesses because I am going to have to go to another meeting.

Mrs. DAVIS. If you can submit those, that would be fine, Mr. Loebsack.

Mr. Kline.

Mr. KLINE. Thank you, Madam Chair. Thank you, gentlemen, for being here and for your outstanding service.

Looking at the testimony of all of you and the numbers, I think it is interesting to note that while both the Army and the Marine Corps have suicide rates in the 19 to 20 per thousand and the Navy and the Air Force about 11 per—per 100,000, I am sorry—per 100,000, that puts you at or near the national average or just barely above half of the national average. And so one could say you could potentially say well, we are really okay, we are doing as well as the country as a whole or we are doing a little better than the country as a whole, but you are not saying that. You are not satisfied at any suicide rate and you are digging in, and we all ought to be grateful to you and your leadership and the service for digging into that because we share your concern that it is not okay. But I think it is also important to recognize that this isn't an extraordinary suicide rate. This is very much in keeping, sadly, with what is going on in the Nation as a whole.

I would like to address questions to all of you, but I am not going to do that. I am always tempted to go directly to General Amos for the Marine Corps tie, but I am not going to do that.

General Chiarelli, I want to chat with you for just a minute and pick up on some of the conversation we have had here. We have been active in a Yellow Ribbon Reintegration Program in Minnesota for the National Guard, and the Marine Reserves there have been actively participating in that. We think it is working very well. Part of the program is to bring those soldiers back on a regular schedule, 30 days, 60 days and 90 days, so that they can get some marriage counseling, there is a marriage retreat program in Minnesota. You can go to up with of the finest hotels in the Twin Cities, quite a nice event. There is counseling and a chance to reunite, and so forth. So I think that has been a great program. I am glad that it is expanding and the states are picking it up, and it seems to be working for the Reserve Component.

The question is when you look at the active component, I think that for a long time we have sort of made the assumption that because you are back with the family, if you will, you are back on a big post or station, you have got medical facilities, you have got resources there, that we don't have to worry about that periodic checking. And I am just wondering particular for the Army, and perhaps the others could take it for the record, are you looking at that set period, we are going to look at these soldiers, the active soldiers on purpose at 30 days or 45 days or some time and again at 60 and again at 90, specifically looking at the how are you doing, you know, are there signs of undue stress?

General CHIARELLI. Well, if I am not mistaken sir, Minnesota led with the Yellow Ribbon Program, it is true.

Mr. KLINE. Thank you, I didn't plant that question, but thank you very much.

General CHIARELLI. And it was always a frustration to me that we brought active component soldiers home and made them go to 14 consecutive days of reintegration training, we brought mobilized soldiers home and got them demobilized in two days and that was success. It never made any sense. That is exactly in my opinion the right template to use, to bring them back.

The Army force generation model has provided us a brigade centric force. We don't deploy divisions anymore, all we deploy is brigades. There are some second and third order effects that our task force is finding. One of them is we normally change out commands and leaders at the 30- to 60-day mark upon return from a deployment. And when you do that, you break down that leadership knowledge where you knew that Private Chiarelli had a rough time in that last deployment, and if you don't have a handover to someone who is taking over the platoon or battalion where you tell Chiarelli's story, he can very easily get lost in now a desire to get ready to go on the next deployment as quickly as you possibly can, with the new leadership team that is totally focused on not only what you have done, but what you are getting ready to do. So this is something that we are going to have to work very, very hard to make sure we are bringing soldiers back at the 90- and 100-day period, that leaders are passing off good continuity books to ensure that they know who had problems and who didn't.

I know for a fact that one of the biggest issues I have got is I don't have the number of mental health care providers I need. I send a psychologist on rotation, he comes back within 30 days, he comes back to the military treatment facility where his practice is and we leave a unit without someone who was with the unit doing those kinds of things.

So you are spot on.

Mr. KLINE. Thank you, General. My time is about to expire. I very much appreciate the answer, and I hope that all core services are looking at that issue, because there is leadership turnover, there is personnel turnover. And we need some continuity, which ironically we now have the Reserve Component, Guard and Reserve, that I am afraid we may not have in the active component.

Again thank you very much. I yield back.

Mrs. DAVIS. Thank you. Ms. Tsongas.

Ms. TSONGAS. Thank you all for being here today to talk with us about this most difficult issue. I was recently in Iraq and Afghanistan with Congressman Wilson where a young soldier had been lost to suicide, and I know how hard the commanders took it. So this is not a simple issue by any means.

I have a question more directed to what happens after somebody has chosen to take their life and you learn of it, what is in place? Are there protocols in place to deal with family members? And also how do you deal with it within the unit of the military, because all you have to do is look, for example, when a young high school student is lost to violence or whatever and the way in which schools come together to provide counseling and understanding and try to move people forward. Is there any attempt to address the unit after something like this happens? And also do you track data to see can it become viral, can the issue of suicide and the existence of suicide become viral so it travels within the unit once it takes place, unfortunately takes place?

I direct that to all of you. I don't know who wants to begin.

General AMOS. Ma'am, if we lose a Marine through a suicide, that family member is treated just as if that Marine fell in the battlefield in Iraq or Afghanistan. That great sense of dignity and care of the family is precisely what happens. The casualty assistance officer is assigned, the whole unit from that unit all the way up to Headquarters Marine Corps turns its spotlight on that family to provide all those things that family members have happen to them after the loss of a loved one.

So there is zero stigma, it is not a matter of we are not going to take care of you because you did something that—you know, it is precisely with the same dignity we would do with the fallen Marine. So I want you to know that all the way from the family members all the way to the burial, and the staying reconnection typically between that unit and that family member. So I want you to feel good about that.

Ms. TSONGAS. Is there an effort to identify that it may be different for a family member in the instance of suicide and something different might be required to be supportive?

General AMOS. I don't know. I suspect probably our there are cases where that might be. But I would also opt just about every time a door is knocked on at 2 o'clock in the morning and the cas-

ualty assistance officer is there or the notification, each family, each one of those situations are always different. We have the way we do it, but each one of them has probably 20 percent of the entire effort is different because family members are different. So I would say that if there are differences and things that had to be handled as a result of a suicide instead of a Marine that was lost in combat, they would do that. They would know how to do that.

The issue within units by all means. What typically happens, we lost a Marine last week. The report I got was the unit stood down. We brought all the leadership to the unit, it was an infantry battalion, brought all the leadership of the unit together, to include the entire unit in pieces and companies as a battalion, and they sat down and talked about it. In other words, the last thing we want to do is hide it. We want the Marines to know about it and we want them to understand there is an obligation that they have to the family if they are close to that family, and that we talked about it. We bring the chaplains in, and that is where it begins. And then from that point if there are issues, like best friend kind of issues, then we are sensitive to that and we will route that young man or young woman to the right help that we do. We pay very close attention to that.

The final thing I would tell you is that I am always nervous about when a unit has a suicide it might then make somebody else think that this is an option. And I worry about that. I can't tell you that I have seen that, but I will tell you I am always concerned about that.

Ms. TSONGAS. So there is no actual data around that?

General AMOS. We actually have data, we can certainly tell because we have tracked all the suicides since the early 90s, so we can tell precisely what unit and where they are.

Ms. TSONGAS. I would be curious to see that from all the services if that was possible.

General AMOS. Okay.

[The information referred to can be found in the Appendix beginning on page 109.]

General CHIARELLI. I have some pretty strong feelings about that. The literature that I have read indicates that there is not a tendency for suicides to multiply through a unit or an organization because of a single or a second suicide. And I think sometimes out of frustration people want to go there. And I think it is exactly the wrong place to go. I totally agree with Jim, in the requirement to sit down and talk about this from every single incident.

As far as the stigma, I would like to say we are as good as our Marine brethren, but I fear we are not, because stigma still exists in the United States Army. I know that for a fact. We are making great strides at trying as hard as we can to change that, but stigma not only resides in the United States Army, it resides in the civilian world. And I would hope that some day the family and parents of suicide victims would be treated exactly the same. We will do everything we can from the Headquarters Department of the Army (DA) level to be able to do that, but I fear that it is not the same across the board in every single unit in the United States Army.

Mrs. DAVIS. Ms. Tsongas, I am going to move on because we have a few people who have not had an opportunity yet. I also want to ask unanimous consent for Mr. Kennedy to be able to participate and ask questions. Hearing no objection, thank you.

Next we move to Ms. Bordallo.

Ms. BORDALLO. Thank you very much, Madam Chairman, and thank you to all our witnesses here today. General Amos, a special hello to you, and I hope that all things are still a go with the Marines coming to Guam and that the community on Guam will receive the full and uncompromised support of the Commandant and the Marine Forces Pacific as we go forward with the realignment and the buildup. Thank you.

I am very concerned about the mental well-being of the men and women in the Army and Air National Guard, since we have such large numbers of guardsmen and reservists, the highest number per capita of any State in the Union. Given their increased assignments over the past six years, we have seen a significant stress on their force from equipment availability, to training, as well as psychologically on the servicemembers themselves.

There was an article in the *Pacific Daily News* of Guam recently, our local newspaper, that reported on the psychological stress on our National Guard force. And Madam Chairman, I will ask that these articles be entered into the record.

Mrs. DAVIS. Yes.

[The information referred to can be found in the Appendix on page 101.]

Ms. BORDALLO. In the article one woman soldier stated, "There is incidences where my daughter would say something to me and I would snap. And she'd come back and say, mom, we are not the enemy, you are at home now." And this woman soldier goes on to say, how do I adjust? How do I adapt to the changes that I am bringing home?

So my question is for General Chiarelli and General Fraser, what are the Army and Air Force doing to ensure that our guardsmen and women have access to appropriate mental care when they return from deployment? Now I am particularly interested to hear your perspective on how you are working to ensure a home station mobilization and demobilization for the National Guard. I believe that the home station demobilization, known to some of us as the Yellow Ribbon Program, and that was referred to earlier here, helps in identifying these symptoms early, but additionally after demobilization what specific steps are being taken to watch for any symptoms that may develop over time? And is there a program in place to monitor this type of activity? And is there any follow-up with individual soldiers beyond the 30-, the 60-, the 90-day checkup periods after demobilization?

General FRASER. Yes, ma'am. With all of our Reserve Component, and more specifically with the Guard, we do the same thing with them as all of our programs for the active duty. And so they have access to all of those programs. They have also, as you mentioned there, the Yellow Ribbon Program, we have that and we are very much in favor of it. We see a lot of positive things coming out of it, and so we have ensured that that program continues to be viable.

And the other thing that we do is our surveys, that we do before individuals deploy, give us a baseline. That is the Preventive Health Assessment. And so now they complete those.

And to go to your point about follow-up afterwards, that is the reassessment that is done between the 90 to 180-day. And so you are able to take a look at predeployment, postdeployment before they return home, and then another reassessment to see if there has been any change, which allows us then to be proactive in providing them any help that they may need. And that is an indicator.

The family members are all briefed, too. And so they know the programs that are available. So we continue to reach out to all the family members to make sure they are aware of the various programs that are available.

For those that are non-collocated though, we still have work to do. And that is the hardest one that we are trying to make sure that we accomplish now, because they don't have everything that is available to them. So we keep working it as hard as we can, we are not perfect yet, but we will stay at it.

Ms. BORDALLO. Thank you.

General Chiarelli.

General CHIARELLI. Initially counseling happens as a soldier returns from deployment and the demobilization time period. Then I have indicated to you that we are very excited about being able to provide mental health care on-line. That will be kicked off in a test program in three States that I know of in the National Guard armories, where soldiers will be able to go to the armory and go on-line and get that kind of care. And then Military One Source also offers the opportunity for up to 10 appointments to an individual feeling that he needs to see a mental health care professional in person.

Ms. BORDALLO. Thank you.

Mrs. DAVIS. We are going to have another vote. What I would like to do, we have three individuals, three members who want to ask questions. If we can get through those three in the time before voting, and then we are delighted that some of you may be able to stay. We would love it if you could all stay for the second panel in case there are some additional questions, and we will return after the votes. They are the last votes. So we wouldn't be interrupted again.

So if I could go on to Ms. Shea-Porter and then we will have Mr. Coffman and Mr. Kennedy. If you could all try to keep your questions really brief so they can respond in the time, that would be helpful.

Ms. SHEA-PORTER. Thank you. And General Chiarelli, thank you for your comments. Your comments were wonderful. I have a question though. I wondered if you know what percentage of your suicide victims had drug or alcohol problems.

General CHIARELLI. I can't give you that number off the top of my head right now. I know it is lower than one might think, but definitely an issue that we are really working hard at right now, because we know that drug abuse and alcohol abuse has increased since the start of the war. There is no doubt about it. I will get that number to you.

[The information referred to can be found in the Appendix on page 109.]

Ms. SHEA-PORTER. Thank you. Because I know a lot will self-medicate to ease some of the pain. So first of all, what is the process for discovering that someone has drug and alcohol problems and how do you treat them?

And I am going to say it all at once so you will be able to answer it in one question. Can you describe the treatment you do after diagnosis, do you have intervention, and what is the length of your treatment, and do you work with the family as well?

General CHIARELLI. The length of the treatment depends on the soldier. There are two major ways. There used to be only one. We were very reactive before. We waited until an incident occurred, and you were command referred either because you came up hot on a urinalysis for some kind of drug abuse or you did something like get picked up for driving while intoxicated. It kicked off a pilot program at three installations, only at one right now, where we are allowing soldiers to command refer themselves, to literally self-refer themselves, self-refer themselves for drug and alcohol counseling, and their command is not informed. So you can go in, we have set up special hours that are after duty hours on Saturdays and Sundays where these appointments can be made where a soldier who self-refers can go in, get the care and the counseling he needs, and hopefully head off a problem before we end up in the reactive mode.

Ms. SHEA-PORTER. I think self-referral and being able to keep their privacy is absolutely critical for soldiers to step forward for treatment. But again, if you recognize them—the length of time that they are in treatment is critical. A lot of the programs that fail in the general population, like three days inpatient and then they don't have the support around them when they are discharged. So if you find somebody and you recognize that they do have to be hospitalized and treated for this, what is the range of the program, is it available to all?

General CHIARELLI. My problem is counselors right now. I don't have enough counselors. We are really focused on hiring as many as we can. But it is up to the individual counselor to determine the severity of the case and make a determination on whether it can be handled as an outpatient or whether inpatient care is required. If inpatient care is required, we have a number of facilities we use throughout the United States where we will send individuals for the requisite amount of time to handle the substance abuse problem that they have.

Ms. SHEA-PORTER. And do they have to wait for the referral because of your backlog?

General CHIARELLI. That is exactly the problem I have got. When you don't have enough substance abuse counselors and you get a series of command referrals, what I found with the recidivism rate that I had, where the number of soldiers who had come up hot on a urinalysis for drugs, the time it was taking to get them referred and get them seen by a counselor was so long because of a higher incidence rate and not enough counselors. So that is an issue that we have had to attack and we are attacking it as hard as we can. I couldn't kick off the pilot program because it wouldn't do anybody

any good to self-refer yourself for an alcohol problem to be told well, come back in eight weeks and we will take care of you.

Ms. SHEA-PORTER. And sadly the same problem exists in the general population.

Thank you, I yield back.

Mrs. DAVIS. Thank you.

Mr. Coffman.

Mr. COFFMAN. Thank you, Madam Chairman. First of all, I want to compliment you on something you are doing and encourage you maybe to enhance that or certainly stress that, and there are two things that I think are very effective. One is I guess the postdeployment briefs prior to leaving the theater of operations. I found during the Gulf War, in leaving Iraq in 2006 of the United States Marine Corps, that those briefings, those postdeployment briefings were extremely helpful in readjusting, in my case, back to civilian life. So I want to obviously I was an individual augmentee and I think that certainly the Marine Corps was covering everybody, and I want to encourage everybody that that is extremely helpful.

And the second thing that is being done that I want to certainly stress that you continue doing, if not enhance, and that is the decompression period, particularly for the Guard and Reserve, that they come back somewhere and that there is a period of time where maybe they are processing out, but it is extended a little bit prior to sending them back out to civilian life. I think that is another important feature that you all do.

Last is a question that I have in terms of a preventative tool. I was in Army in between a Marine Corps infantry, combat training and combat is tough stuff. It requires people that are physically and mentally tough. And you can't sugarcoat that. That is just the way it is. And what tools have you developed, or are you looking at, or I would hope that you would look at, that when you are looking at that intake, when you are looking at that potential recruit, people have varying thresholds to stress. And there are people that by the nature of their makeup are going to break a lot earlier than other people. Are you being able to look at those recruits, potential recruits, and develop tools to say, you know, this person just isn't going to make it, they are going to fall apart, and this person has the characteristics to be successful. I think that is absolutely important to try to address this problem preemptively instead of dealing with it after the fact.

So if you all could address that, I would appreciate that.

General CHIARELLI. Well, that is why I am so excited about comprehensive soldier fitness, because it has such a robust assessment tool on the front end. It will not only be used when a soldier comes into the Army but will be used throughout his career to evaluate his resiliency and his ability to do exactly what you are talking about. So from the Army's standpoint, that is our big idea and what we are looking at to get at the exact problem you are talking about, sir.

Mr. COFFMAN. Are you doing it in terms of looking at potentially saying, you know, you meet all the standards, but we think that given there are some behavioral characteristics here, based on as-

sessment tools, that maybe you are not meant for the United States Army, certainly you are not meant for ground combat?

General CHIARELLI. That is an excellent question. We can do the assessment. I have asked the same question. Once we get this totally in place, there will be some legal issues that we will have to, I know, maneuver our way through to show that the assessment tool has that degree of accuracy that we could make that kind of call.

Admiral WALSH. From the Naval perspective, we have sailors serving on the ground. The assessment tools that we have rely on the judgment of leaders, and that is where we see this warrior ethos passed from one generation to the next. We see it in the training pipeline for Naval Aviation, we see it in the Recruit Training Command, we see it in Special Warfare Command. The way we have been able to tailor our training command pipeline so that we do put stress on folks to see how they react and respond under stressful conditions, however artificially induced, gives us a preview of how they will react over time in the duress of combat, not perfected.

Mr. COFFMAN. Thank you.

General AMOS. Sir, at recruit training, in the next session we will have maybe General Lefebvre up here sitting in this spot and he commanded the recruit depot at Parris Island, so he will be able to give you precisely. But we specifically and very purposely put an enormous amount of stress at boot camp for a 24-hour period of time. And what we want to do is find out those young men and women that can't handle it. This isn't machoism, it is just a function of the unit, you know, what the Marine Corps is. And after 24 hours they get what they call the moment of truth, that is where the drill instructor takes his hat off and says, okay, it is now time, those of you that have now figured out that you're in the wrong spot, no harm, no foul. You can leave the depot, and of course we do that. So that is how it happens entry, in the early entry. We rely on those drill instructors, and as you know, they are pretty doggone good.

A little bit farther down the pipeline for bona fide card-carrying Marines, we have immersion training that we put them in, where the sights, the smells, the sound, the fear, the noise builds their level of stress while they are doing their training up to the point where the guys that are combat vets, if they have any issues in some cases that comes out during this immersion training. So we give that. We have a combat fitness program now that the Commandant started about a year ago which actually gets us in shape to do the kinds of things we find in Iraq, and then we finally rely on small unit leadership, those NCOs and those staff NCOs and those young officers paying very close attention.

Mr. COFFMAN. Thank you.

General FRASER. Some of the exact same processes are used as far as our troops go too. Early on using some of the tools that are available to us to ensure they get into the right career fields. As they are stressed in their comprehensive training program, some are actually dismissed and possibly then retrained in other areas because they still want to continue to serve. Part of going into theater though, it is a comprehensive, realistic training environment

to stress them as best we can and then relying on those leaders to make that assessment if they are ready to go.

Mr. COFFMAN. Thank you, Madam Chairman.

Mrs. DAVIS. Thank you.

Mr. Kennedy.

Mr. KENNEDY. Thank you, Madam Chair. Thank you for the honor of able to participate with this panel. I appreciate my colleagues agreeing to let me speak.

I first want to thank all those members of the armed services who are here for their service to their country. It is an enormous sacrifice. You are not in it for the money, that is for sure. You are in it for your service to our country, and for that on behalf of my constituents I want to thank you for your service, especially at this time while we are at war. You never know when you serve, when you will be serving, whether it is at peacetime or wartime, or where you will be serving and whether you will be in a place where you might be called upon to put your life at risk. And all of us want to say thank you for your service to our country and to say thank you to your families as well for the sacrifice they make on behalf of our country.

It is really in that regard that I wanted to ask all of our panel what they think of the opportunity for us to get treatment for and really for our soldiers by helping support our family members, because really the family is our first line of defense in helping those returning servicemen and women when coming back. And we found with the Veterans Committee the benefits all go to the veteran, but it might be good if we kind of broaden the definition of beneficiary to include the spouse and the kids in terms of reimbursement for services, because, you know, they are suffering from secondary post-traumatic stress disorder when they see their family member overseas and in harm's way, and of course they are away from their family member for so long that is a stressor. But when their family member comes home, would you not agree that if it were up to us, it would be good to get them ready to know how to identify and be ready for and support their loved one so that they can help them reacclimate to family life, and don't you think we need to be kind of helping to reimburse for whatever services that may be needed for those family members?

Can we start with you General Chiarelli.

General CHIARELLI. Well sir, the military family life counselors I think has been a huge, huge improvement in the last few years to provide that kind of a service and care for families down to that battalion level. They are working inside the battalion. But I am very proud of the fact that all family programs that we have put so much into these last years, they have all been put into the base budget in everything from child care to all the services available to families are there and available throughout the deployment and once soldiers come back home. So I really think the emphasis has been placed on this has been emphasis well placed, and it has had a huge impact on the United States Army.

Mr. KENNEDY. If I could follow up, I know my previous colleagues, Representatives Coffman and Carol Shea-Porter, both asked about how to screen soldiers before they come in to make sure that they are adequately prepared for the stresses of combat

and military life and then how to best treat a soldier who might be suffering from substance abuse disorders and the like.

I have introduced, along with Walter Jones, the SUPPORT Act, Supporting Uniform Personnel By Providing Oversight and Relevant Treatment, SUPPORT in short, and that is to oversee basically all of the substance abuse and treatment programs that are out there within DOD to assess what are working and what aren't and bring some coordination and see to it that we are using the best practices in our treatment efforts.

And in regards to making sure our servicemen and women can be prepared for any situation, I wish we didn't have to have a stigma, because when I was first elected to Congress I was asked to go down to the John F. Kennedy Special Warfare Center, and there our elite Green Berets have available to them psychiatrists 24 hours a day, 7 days a week. And you might ask why would the elite of the elite have psychiatrists available to them. Well, it was believed by the commanders that it made them better at what they do to have a clear head and a healthy state of mind when they were called into combat duty.

Now if that was the thinking for our elite forces, why isn't it the thinking with the rest of our forces if they are now being called in to all kinds of dangerous situations to have a healthy state of mind? Why do we look at this as a weakness? Why don't we look at this as proactive, as my colleague Representative Coffman said, and think of this as a strengthening tool rather than as a reactionary tool to only treat people who may be looking as though they are falling apart? We look at this as strengthening. They can better be resilient, and they can better make decisions under combat in stressful situations, and they can be better soldiers in the process.

So what would all of you like to say about that?

Admiral WALSH. We have mental health specialists that deploy with our services, with our units, with our carrier strike groups. So it is viewed as an asset that helps to sustain the force. So the capability is there no matter what happens, under what conditions, to help servicemen, regardless of their rank or their rate or gender or background, whatever help that they need. And so we see it as the embedded concept works at sea and helps sustain the force.

Mr. KENNEDY. What troubles me is that with the Marines having just in 2006 put the suicide prevention program in place, I mean, this is many years after the war started and then the funding for suicide preventions remain relatively stagnant in spite of the fact that suicide has gone up. Am I right or did I not get the testimony correct?

General AMOS. Sir, the funding is not an issue. We have never had an issue with funding, both from the perspective of if we ever asked for it we can get it. Quite honestly, the Services are more than willing to realign programs to get the money to do it. So funding is not an issue.

Honestly, I think this has been an evolutionary process. Prior to stepping across the border in March of 2003, we had a military that hadn't been to combat since the Gulf War, for all intents and purposes. So now we spent probably the first two or three years not in denial, but this effort of combat stress, the issue of what is this doing to our force, because quite honestly I think everybody

thought well, this war will be over, we will be able to come back and reset, and we are going to be okay.

Now we are coming at this from my perspective probably a little bit late within the last three years I would say, certainly in my service the last three years, have been huge efforts put towards this thing. I will tell you there is not enough mental health folks right now. What you have described with the special forces is exactly what we would like to have happen. We have got 24 mental health folks in Afghanistan with our 10,600 Marines right now. We want more, we want to get them there. In a perfect world you would want to have as many of those kinds of folks as you possibly could get and higher down with those units for the very reason you have talked about. Quite frankly, they are not there.

Mrs. DAVIS. Thank you, Mr. Kennedy. We are going to have to close.

What I would ask you to do, I think, is you have spoken about the need. Is it necessarily money? It is obviously trained people who would be available and either in the service or in some cases, whether it is TRICARE or family care, help for our children. It is through the health programs that their families are engaged with. Thinking about what would it look like if we actually were covering these issues at a better level, what would that mean? How many personnel are we really looking for and what areas particularly might they be, the full spectrum in terms of our servicemembers and their families. I think trying to maybe see ideally where we ought to be, that might help us. If we think in terms of strategically where we need to be, we wouldn't want to even think out five years, maybe even three years for that matter. Because I think looking at the mental health work that is being done, the research, trying to follow up, go through the data and understand it better, we know that that is in the future a little bit before we have all of that information.

You have great information. I think you all are doing what needs to be done, and it may be that some of the concerns that we have had over the years haven't necessarily been met because it has been hard to figure out what you really need. And now we have an opportunity to perhaps see that clear. And we would certainly hope that with those budget requests that we were able to at least understand the extent to which we are able to meet the most critical needs. And if we can help with that, we would certainly like to know what does that picture really look like.

Mr. KENNEDY. Madam Chair, there was an article in the *Washington Post* I would like to submit for the record about the crime rate on base at the 4th Infantry Division in Fort Carson being 114 times higher than the surrounding Colorado Springs community, and the issue here is how are we going to deal with the servicemen and women dealing with their stress and getting caught up in the criminal justice system and even the court-martial system.

Are we going to make special allowances to the fact that much of this is due to their post-traumatic stress? How is the military going to deal with this? Are we going to end up locking up all of our soldiers because of the crisis they are facing emotionally as a result of their service?

[The information referred to can be found in the Appendix on page 105.]

Mrs. DAVIS. Thank you, Mr. Kennedy. Thank you all so much for being here. If you can stay a while for the second panel we would certainly be grateful for that. We will return after several votes, and then there will be no more interruptions. And we really do look forward to hearing the second panel.

Thank you so much.

[Recess.]

Mrs. DAVIS. Thank you. We are pleased to start with our second panel. And we are delighted to have you here. Lieutenant General Rick Lynch and Major General Paul Lefebvre. Thank you. Please.

STATEMENT OF LT. GEN. RICK LYNCH, USA, COMMANDING GENERAL, III ARMORED CORPS AND FORT HOOD, U.S. ARMY

General LYNCH. Thank you, ma'am. Chairwoman Davis and Ranking Member Wilson, thank you for this opportunity to talk about what has happened in III Corps and Fort Hood, but candidly, more important, thank you for your continued support for our soldiers and their families and your demonstrated commitment. Just having the opportunity to watch the engagement with the service vices shows me how dedicated you are to truly helping us take care of our soldiers and their families.

I am privileged to command III Corps in Fort Hood. That is 63,000 soldiers, over 10 percent of the Army, and one-third of the Corps is currently deployed fighting and winning our Nation's wars, one-third of the Corps just recently returned from a deployment, and one-third of the Corps is preparing to deploy. That is the new normal in an operational force here and one facet of the Army Force Generation (ARFORGEN) model.

I am personally responsible for the lives and well-being of 125,000 family members and 200,000 retirees in the central Texas area, and I take that responsibility very personal. I believe that engaged leaders love their soldiers and their families like they love their own children, and indeed that is the approach we take at III Corps and Ford Hood.

I don't spend a lot of time at Fort Hood talking about suicide prevention, but I spend all my time talking about stress reduction. Because I am convinced that the stress of the force can indeed be reduced by positive affirmative actions. And if you don't mind I would like to highlight four of those things for you now and then take whatever questions you would like towards the end.

The first thing is we have declared III Corps and Fort Hood as the family first Corps. If you are assigned to III Corps, you are home for dinner every night by 6:00 because that is where the family unit forms and functions. If you are assigned to III Corps, you leave Thursdays at 3:00 in the afternoon. That allows you more time with your families, that allows you to be home when the kids get home from school, that allows you to have some additional family activities. And if you are assigned to III Corps in Fort Hood, you don't work on weekends without my personal approval.

Because the only thing you cannot do once you deploy is spend time with your family. So what we have to do is mandate quality family time. It was only three days in the command of the Corps,

this is now over a year ago, when a family member came and said, General, you all are lying to us. I said, ma'am, what? She said, you say that you brought our husbands home in this thing called dwell time but we never see our husbands. He comes home after the kids go to bed, he is working on weekends, you take him off to the national training center, and she looked me in the eye and said, you might as well just keep him because we are not seeing him anyway. That is why we are the family first Corps. And that has indeed had great effect in reducing the stress on the families.

As part of that what we have done is emphasized the maintain balance and have fun. What I found when I returned to the Corps is we lost the ability as an Army to have fun. So what I have done is implemented a lot of things that allow folks to have fun. We have reopened the club systems, we have rejuvenated family programs because I want the youngsters and their families to enjoy life at Fort Hood.

The second thing we did is we took an entire city block at Fort Hood, Texas and made it the resiliency campus. See, I believe we spend too much time addressing issues with soldiers and their families after we broke them and not enough time keeping them from breaking, and I think that is the essence of resiliency. So at the resiliency campus we took a chapel, which happened to be the chapel my wife and I were married in 27 years earlier. We took this chapel and turned it into a spiritual fitness center. It is manned 24/7 by chaplains and counselors, so if a youngster or a family member has a problem late at night and they need someplace to go and somebody to talk to they can go to the spiritual fitness center. They can go there to pause and reflect, they can go there to meditate, they can talk to people with shared experiences, they can indeed grow spiritually. It is not about religion, it is about a spiritual foundation from which to turn to.

We turned a gym into the wellness center, and it is not about how much push-ups you can do but how truly well you are. So we do diagnosis of the individual, of the soldier and their family, we determine their level of wellness and then we take them into the wellness center and improve their wellness.

The primary issues with suicide in a III Corps perspective, we have had four completed suicides since the first of the year. It is about strained relationships, and it is about financial issues. So on the resiliency campus we put our military family life consultants that General Chiarelli was talking about so you have immediate access to counselors, and we have a national assistance center which allows us to improve the financial readiness of our soldiers, which reduces the stress on the family, so so very important.

So this resiliency campus indeed found a life of its own, and people come there not because they got a problem, but because they want to avoid having a problem. It is all about getting in front of the problem and not reacting afterwards.

We are all concerned at the stigma related to mental health issues. So the way we approach this at Fort Hood is every Friday—correction, every Wednesday at 3:00 I personally greet every new arrival to the great place. And normally that is about 300 to 400 new soldiers and their families. And I explain to them how important they are, their self-worth, how important they are to their

families, to our organization, and make it a point to tell them how important they are. And then I tell the group that I have cried more in the last three years than I have cried my entire adult life. One hundred fifty-three soldiers died on the place in the battlefield that I placed them as I was commander of the task force as part of the surge, and I got to live with that the rest of my life. And I am personally responsible for 882 gold star families, these families who have paid the ultimate sacrifice, and that has an emotional drain. But I share with the larger audience that I am indeed affected and I am getting help, so if they got a problem raise your hand, so we can get you the right kind of help to reduce the stigma. The stigma is still out there, but it is something we approach on a daily basis.

And the last thing, it is all about engaged leadership. I personally chair a suicide prevention review board once a month where every commander and command sergeant major and I review all the suicidal trends across the Corps from the previous month. I thank God and I thank engaged leadership we have only had four completed suicides. But three times a day my phone rings with a youngster who has got a suicidal gesture, an ideation or an attempt. And what we do as a group of leaders is we dissect each case and try to learn from those cases. We empower our leaders with information on how to deal with suicidal ideations. And we find ourselves in a situation now when a youngster who has a problem he feels free to tell his battle buddy or his leader that I got a problem, that I need some help. That has significantly driven down the completed suicides at least at Fort Hood, Texas.

So again I think it is all about reducing stress, and we continue to take action at Fort Hood to reduce stress. And ma'am, with that I am happy to answer any questions.

Mrs. DAVIS. Thank you very much. We will go on and come back to questions. Thank you.

General Lefebvre.

STATEMENT OF MAJ. GEN. PAUL E. LEFEBVRE, USMC, DEPUTY COMMANDING GENERAL, II MARINE EXPEDITIONARY FORCE, U.S. MARINE CORPS

General LEFEBVRE. Thank you, ma'am, Chairwoman Davis, Ranking Member Wilson, distinguished members of the committee. On behalf of all marines and sailors and the II Marine Expeditionary Force (MEF), I would like to thank you for having us here today to let us talk a little bit about what we are doing down in the Carolina Marine Air-Ground Task Force (MAGTF).

Just by way of reference, as the Commandant of the Marine Corps said, I was Commanding General at Parris Island for two years. So I had recruiting duty east of the Mississippi, and I also had recruit training. And for the last year I was the Deputy Commander for the 18th Airborne Corps, largely an Army unit in Iraq, and I chaired their Suicide Prevention Board. And I am currently serving as the Deputy for II MEF, and I am headed to a Marine Special Operations Command shortly.

I also have personal knowledge of the General's command and leadership philosophy as it was exhibited in Iraq, and I can tell you that it doesn't get any better than what the General does in terms

of leadership. You can have all the programs you want, but it is the commander and what he does to make all those things happen that are important. And his impact in Iraq was felt long after he left on many, many soldiers across the theater.

In reference to II MEF as a combat unit supporting both Iraqi Freedom and Enduring Freedom, we very deeply feel the death of every marine and sailor, whether combat loss, accidental fatality, or suicide. I would reinforce General Amos' statement when he said that when a marine or sailor dies by suicide the needless loss of life is a tragedy. We take every opportunity to ensure our marines and sailors know how important they are to the Nation and to the institution.

II Marine Expeditionary Force is grateful for your support, that of OSD and from our service in dealing with this issue. In our analysis of factors affecting suicide we have identified trends that may contribute to a tragic suicide; however, the majority of our suicides this year appear to be impulsive responses to a short-term issue, often a troubled relationship. We are trying to determine how cohesion is affected in certain units that continually regenerate for combat.

As marines we seek to build a strong sense of commitment within our platoons, companies, battalions, and squadrons to foster the feeling of an extended family so our warriors know they will always have someone to turn to immediately when confronted with problems. It is imperative that in an era of instant communication where personal issues boil quickly that we are there to intervene and to mitigate. This task has proven to be challenging given the increased and extended operational tempo resulting from the war.

Whether deployed or at home station, the day-to-day activities to either conduct or support requisite training keep our leaders at full steam and almost in perpetual motion. The challenge for our leaders is to balance the preparations and execution of war with team building, mentorship and the development of a war ethos for their subordinates while maintaining their own families and personal relationships.

It is the sense of team among peers, unit esprit, and the approachability of leaders that provide the safety net when the individual marine lacks the resiliency to handle a flash point personal issue or extended period of stress. Our operational tempo has stretched the safety net on a number of occasions.

Our Commandant acknowledged the effect of operational stress when he gained congressional approval to increase the size of the Marine Corps from 182,000 to 202,000. We had a 5-year period in which we had hoped to do that, and we actually accomplished it in 2½ years, and this year we hope to see the benefit of that buffer so to speak that we have established here now with the force. His intent was to break this 7 months deployed, 7 months home cycle—and as you know it is not really home, it is preparation for the next deployment—and to put a 14-month buffer in there which allows the concerned leadership that we require at the individual level to identify these flash point issues that often lead to a negative consequence.

We believe a key issue in this suicide rests with smart young leadership. I would tell you that—I would emphasize what General

Amos said in that we have put all our marbles, so to speak, in the NCO basket because they are closest to this particular problem. And they are young themselves, as General Amos talked about, probably the youngest of all the force. So how does a young corporal who succeeds in combat, how do we give him the skills to both understand the issue and to be able to deal with it. So that is our focus of effort as we speak today.

My boss, Lieutenant General Denny Hejlik, the Commanding General of MEF, recently addressed all lieutenants and captains who had been very focused on the operational aspects of this in order to enhance the concerned leaderships required by junior officers, in particular to understand what the signs are here within operational stress both in the families as well as within their marines. And our Sergeant Major has done the same with all our staff NCOs in the force. We will continue to create and maintain an environment where marines and sailors are cared for even though we maintain the tempo that I have talked of.

Our marines and sailors must know that they are integral to the success of the Marine Corps and to the expeditionary force, and sometimes we forget that. In the heat of the moment as we prepare for the next training piece or the next deployment it is important to remind them from a resiliency standpoint what we have accomplished and what role they play in it from a self-worth perspective.

Most importantly, we want our young marines and sailors to have the confidence that they can reach out and embrace the support they need from the leadership without any stigma attached. Our way forward is to continue integration of service level programs with local initiatives that meet our circumstances.

The NCO program that I talked about is extremely hard hitting. It starts with a 30-minute video. And this video takes you through a marine from combat that starts to experience the stress of the post-stress environment, to include the financial piece, marital issues, and marines can see for themselves what it is to witness this as it occurs even when it has not happened in their own lives. This video also takes a marine corporal who attempted suicide and talks to nine of his supervisors that intervened in the suicide and talks to what they saw. And significantly, it includes one of our Navy Cross winners who actually attempted suicide also, and it talks to how he got to that point from a relationship standpoint, and it walks you back to where he started to and then how he got there and concludes with three family members that have experienced suicide.

And then the Socratic method is used by NCOs with NCOs to talk about the video in terms of the vignette as to what the lessons learned. And we think this will enhance the skills at the NCO level. As a matter of fact, this past Friday General Hejlik with all the general officers in the MEF, all the leaders and the staff NCOs, witnessed the instruction for the purposes of making sure that we understood we had the best NCOs in here to be the best teachers for this as we really focus down at that particular level.

Additionally, we are implementing the operational stress control and readiness. We talked a little bit about that in the previous session. What that does, it provides mental health professionals provide instruction to our doctors and our chaplains and our leaders

at the battalion level to give a connecting thought to these NCOs that we are training. So we are pushing down the capability down to the battalion, down actually down into the company level. That training is going on now and will be implemented here within the next 90 days. So greater awareness, as well as greater response capability.

Lastly, I would like to conclude by saying that we are not accepting this. You have acknowledged our great effort. There is still tremendous work to be done. I very much appreciate the efforts of this committee to look at this and to help us. Also very much appreciate the sharing of ideas with our sister services here on this because no one has the answers.

Again, thank you very much for the opportunity to express my thoughts today. Thank you.

Mrs. DAVIS. Thank you very much. It is good to have you.

General Lynch, if I could just start by asking a few questions. How has your new program, if we call it, been received, and do you find that there is work that is not getting done because of the schedule? Have the exercises of time management sunk in and are people utilizing them? People must be watching what you are doing and wondering what is going on.

General LYNCH. You know, I went so far as to bring in the Franklin Covey Institute for Time Management to give classes to all my leaders, because what I found is we are indeed wasting time during the course of the day which caused them to have to work late at night which caused them to be away from their families. So I just took away that option. If you got to be home for dinner by 6:00, you got to manage your time better. And I gave them the skill sets so they could manage their time better.

It is well received across the installation. It is embarrassing to me the number of family members who come to me to tell me thank you. When I ask what are you thanking me for, they say we are thanking you because you gave us our husbands back. They should never have to do that. That is something we should do all the time.

So it really is a function of effective time management, take away the options to work late at night, work on weekends and we are as prepared for war now as we were when we found ourselves working seven days a week.

Mrs. DAVIS. And are you able to evaluate that? Is there something in particular that you are looking for in that evaluation that would be helpful for others to know?

General LYNCH. Yes, ma'am. We continue to work all of our training regiment in preparation for combat operations. That is indeed what we are trying to accomplish. Number one is prepare for and win our Nation's wars. So there has been no degradation in our capability. And since I have been the corps commander we have deployed multiple units, and in the deployment they are doing extremely well. So I know we didn't lose anything there.

And I do know now the stress on the families has been reduced because when the husband is home or the wife is home they are truly home. And I am seeing all indicators go down; domestic violence go down, substance abuse go down, suicide ideations, gestures, attempts go down as a result of reducing the stress.

Mrs. DAVIS. One of my colleagues, and I think it was Dr. Snyder who mentioned earlier that we are not just focusing on those who actually commit suicide, but people that are in pain, that are hurting in a whole host of ways. And I am wondering if you have a sense that—you mentioned that things are looking better.

What about acting out? What about people getting into trouble in town? We know that there are a number of problems that a number of our military men and women are experiencing that may really be of great concern as we look at the numbers soon. What are you seeing? Are people not getting into trouble as much? I like the fact that you took everybody on a motorcycle run. I saw that.

General LYNCH. Yes ma'am. What we found is——

Mrs. DAVIS. Are you tracking that, are you tracking those numbers.

General LYNCH. Yes, ma'am, we are. I get briefed routinely, as all commanders do, on statistical trends. And one of the things I am working and looking at is crime rate on the installation and off the installation, and it has been significantly reduced over the course of the last year, to the point of about, I think it was half of what it was this time last year. So the kids are indeed, the kids being my soldiers, I refer to them as my kids because I love them like I love my children, the kids are indeed as a result of having reduced some stress and emphasizing to having fun—I mean, you talked about my motorcycle run. I happen to be a Harley Davidson aficionado. So we take these runs, but it is all about reducing stress. And the result of them being less stressed they are less likely to hurt themselves, hurt somebody else and do something bad, and we are seeing those trends.

Mrs. DAVIS. General Lefebvre, you had mentioned working with the commanders and really trying to educate them as well. And I am just wondering if you have had much pushback? You know do—are you seeing that people are saying, well, you know, I am not a psychologist, you know, what do I need to know this stuff for. Or did you start out with those kind of conversations that have changed and trended, and what could you tell us about that?

General LEFEBVRE. Yes, ma'am. First of all, because suicide is pervasive and it is not to a specific unit, military occupational specialty (MOS) or element in the MAGTF, everyone has experienced it. So there is no question or problem at any level of leadership inside the Marine Corps as to how big an issue this is. And I think the traditional pieces of let's just be a little more concerned about this, those ideas went out the window a long time ago. Now it is how, as you asked your question earlier about frustration, how do we actually figure out where the causative factors are and what do we actually put our arms around. And commanders are asking those questions and they are looking for help.

So you can proliferate programs, and yes, you are right about the fact that some of them may not be coordinated, but right now they are very interested in every asset they can put their hands on in order to get at aspects of the program until we get our arms around the larger piece.

So there is no bad idea, so to speak. So when we come forward to them with a new way of looking at this, and especially when we emphasize at the NCO level what we are going to do, it is part and

parcel to our leadership style and it fits our culture perfectly in terms of where we are going to go.

So I think the commanders are absolutely on board with that, and I think the forum probably is more to get a give and take with the commanders on better practices and ideas than it is to sell a particular idea to them.

Mrs. DAVIS. What part of the culture though makes this difficult?

General LEFEBVRE. The part of the culture is that we are all tough guys. But I think we are by that. And I will use how we approach boot camp. One of the members today was talking about the fact that he went to boot camp and he remembers what his drill instructor said but he doesn't remember the soft side of things. Well, I wouldn't exactly say it is the soft side of things. What I would say is that we have embraced this idea of values-based training.

So now you have 80 hours where a drill instructor stacks up a couple of locker boxes and he gets in front of his platoon and they talk about sexual assault. I mean, it is not a lecture, it is a back and forth on what is this, it is a back and forth about stress, it is a back and forth about, for instance, the power of prayer and what part that plays inside the development of a marine.

So it is not just about the mental and the physical. The moral aspect of it is now a big piece of recruit training. And you cause kind of some—you cause kind of a new area. So out in the fleet sometimes when we start to talk about these things people are, what are you doing in boot camp now, why are you having these sessions where you are talking about these issues. And the bottom line is that is how you recognize whose resiliency locker, so to speak, is low or high and who you have to focus on in the boot camp stressful environment in order to put some tools in that particular marine's bag in order to allow him to be successful as he moves out.

So those have been very, very positive developments, but they have not necessarily been part of who we have been in the past, but clearly where our Commandant wants us to go.

Mrs. DAVIS. Thank you. Mr. Wilson.

Mr. WILSON. Thank you, Madam Chairwoman, and thank both of you for your heartfelt explanations and pointing out of something that I believe, and that is the military service of the servicemembers, their families, veterans. It is like extended family. And I particularly—General Lynch, I appreciate your past service at Fort Stewart. I spent 25 summers with the Army National Guard at Fort Stewart, so I know the capable people who are there. And then also very significant, my oldest son was trained there for his deployment to Iraq for a year and returned to Fort Stewart before he resumed his legal career.

Also, General Lefebvre, thank you so much for your service as commanding general at Parris Island. I am very grateful. That is part of the district that I represent. It has already been identified that all males east of the Mississippi River are trained at Parris Island. I am also very grateful all female marines in the world are trained at Parris Island. And I have been there to see the training, I have been there for the graduations to see the bearing of these young people. It just makes you feel so good to know how they have

faith in themselves and know what they are doing. But it is also even better to see the families, to see the moms, dads, the grandparents, the siblings, the other relatives who are present, and there is not a dry eye in the house. Everybody is just so proud of their military.

And so thank both of you for providing the opportunities you do.

General Lefebvre, as we consider this issue could you tell about the Marine Corps programs that are specifically focused on reducing stress on the personnel most affected by suicide? How do you plan to measure the success of these programs? In your estimation, what other resources are needed to address psychological stress in the Marines?

General LEFEBVRE. The measurement piece, sir, as expressed in the last panel is one of the causative factors and how do we put a capability against it and then wait to see how we are being successful.

The two programs that probably have the most benefit, one is the NCO program I just talked about. The other one is this, is the OSCAR program, this Operational Stress Control and Readiness program that we are developing with the Navy, where we are adding mental health professionals at the higher levels of command and providing mental health professionals at the regimental level, which we have already done in combat. And because there is a shortage of those we have taken mental health professionals and we are now going to train battalion commanders and normal doctors, medical doctors, and chaplains in a couple of areas.

One is in this issue of resiliency that we talked about here today. And I think resiliency, mentioned by every member of the panel, is one of the keys, but a tough thing to define and a tough thing to measure in the individual servicemember. But for sure when resiliency is low they are prone to suicide.

So the key is how will they measure what is in the tool bag so to speak to include what we are doing at boot camp, how we sustain that through their training and how do we refresh that in the fleet.

But the OSCAR extender program that we call it will give us capability down into the battalions, actually down into the company level as a peer kind of a capability with specialized training. The goal in the long term is to provide the health professionals at that level, but that will take time and we don't have time.

So I think, ma'am, in particular your question to the previous panel about what the ideal is, that is apropos and one that we can really get our arms around because we have been looking at that in terms of numbers of professionals. I think when we made this decision to go to 202,000 and as we studied family readiness the Commandant did a couple of other things also. He put a family readiness officer in each one of our battalions. We had a family readiness program for an awful long time, but it was volunteer. And we asked our families, the senior wives in particular, to handle a lot of those responsibilities at the expense of a lot of other personal issues. As a matter of fact, the kinds of issues you deal with today are so complex that a volunteer wife would have difficulty being smart on those issues.

So this family readiness officer who is now with the reserve units, as well as with the active duty units, is a one-stop shopping as a resource into the number of programs that are there. As a matter of fact once referred there or once there they can sort out the programs for you, whether that is a family program or an individual program, has proven to be hugely successful to this point for units that are getting ready to deploy, and they remain at home station with the families while we are gone.

So, sir, those are the programs. The measurement of those I think, given the NCO program, the combat operational stress program, as well as what we are doing in family readiness, I think over the course of the next year, as well as we have achieved this, about to achieve this 14-month buffer because of our increase in our forces, are going to pay dividends for us in our ability to spend more time from a leadership perspective around those who are most at risk.

Mr. WILSON. Thank you very much.

General LEFEBVRE. Thank you, sir.

Mrs. DAVIS. Thank you. We appreciate that. You are talking about the family readiness counselors, and I know having met with key volunteers and the ombudsman how critical they are. When I first came into Congress and started working with HASC, and even though I had obviously been living in San Diego for many, many years I wasn't aware of the role that they played. And I was also aware that they were all volunteers and they handled such complex issues 24 hours a day. And I really wondered how they do that. And without any recognition.

We tried to change some of that, but I know that we have moved from that role for a number of individuals. And I was going to ask you whether you felt that in order to deal with the shortage that we have in mental health providers if there are individuals that we could or should be training, utilizing, that are in the services today that perhaps are doing very important jobs but could be doing even something more critical to the mission. And if you thought about that and where you might want to go to think about bringing more of those individuals, whether they are—we think of them in terms of practitioners at a physician assistance level or how we might do that in the future.

General Lynch.

General LYNCH. You had asked the question to the earlier panel what is the biggest source of frustration. My biggest source of frustration is indeed the lack of behavioral health professionals. That is the biggest frustration. I am short about 44 of what I am convinced I need at Fort Hood that I just don't have. And that includes reaching out to the community to see what the community can do to help. But candidly, what I found is the Nation is short these behavioral health specialists, not just the military. So when we try to bring somebody on the installation we are taking away from the community which expands the problem.

So what General Chiarelli talked about earlier, we are very excited about, this idea of on-line counseling. Because if the youngsters or their families can go on a computer, which is what they do most of the time anyway, and can access a behavioral health specialist and have individual counseling, that would be powerful.

It wouldn't rob from the community but it would be a nationwide asset to allow us to be able to access. And what I understand from the Army's perspective we will be able to do that in the fall. That is very important.

What we have found is the number one issue with suicidal ideations is failed relationships, and these failed relationships are a lot of the function of deployments around, it just is. I mean you can't continue to go away, come back, go away, come back without strain in a relationship. It can't happen. You have got to focus on those family counselors.

So when General Chiarelli talked about these military family life consultants, that is so very important. These are licensed professional counselors with at least a Master's Degree of education in counseling that are now embedded in our units at the battalion level that allow soldiers and family members to say hey, I need some help, and they can have that in a confidential forum.

We also take those military family life counselors and take them off the installation in a program we call Operation Store Front. So if somebody wants to go get help but doesn't want to do it on the installation, they can do it off the installation.

Many of the local hospitals have reached out as well with their licensed professional counselors to give my soldiers and their families access.

So, ma'am, we are doing all we can do there trying to make sure we get the right professionals helping us address the problem. We try to empower our leaders with how do you deal with grief, tragedy and loss. We try to empower our leaders in how do you identify suicide or ideations and what do you do about it, but you really need to be able to turn to those professionals.

Mrs. DAVIS. Are you finding that families who have experienced a suicide in the family—in most cases they would be leaving the base fairly within a year's time, is that correct, or how does—what happens after a period of time?

General LYNCH. We treat our fallen heroes who fell as a result of suicide with the same dignity and respect that we do those soldiers who fell on the field of battle, to include their families. So we do everything we can do to ensure the families are helped through these difficult times.

I talked about the 882 gold star families that we deal with in central Texas. Many of those are gold star families from suicides. So we make sure that those families know about it. They stay on the installation as long as they need to up to six months, and they can extend that if they need to. We make sure they are given the same kind of resources and access to resources that those soldiers who fell in combat do.

Mrs. DAVIS. And you are saying that it is six months but it can be extended if that would be in the best interest of the family?

General LYNCH. Yes, ma'am. It is all about concerned, caring, compassionate leadership. And what we try to do is handle each case on a case-by-case basis and look at the situation to see what is appropriate.

Mrs. DAVIS. Thank you. I certainly appreciate that. And just in terms of waiting times to get help and assistance, are you aware of whether it takes a family several weeks to have a child in, for

example, to see somebody as opposed to the servicemember who may be seeking help? What do those wait times look like to you?

General LEFEBVRE. At Camp Lejeune, ma'am, we have five family counselors with a full docket. But to get in there for an additional appointment for assessment is actually pretty quick. It is based on how deep is the problem and what is it going to take. So we don't think four is enough. We think the number is probably about 10 to handle just the families and the children.

The FOCUS program that we talked about a little while ago with the help of UCLA is the program that we developed, and it has been very, very successful. What we don't know based on the stigma that you have talked about is how many people would not come to this.

But again I would go back to the 14 months now between deployments. I think commanders will be more aware of what, for a fingertip feel, what their issues are. They are embracing the counseling pieces that are required, and I think you will see more advocacy of that as we turn more attention to those pieces.

But we suffer from the shortage that we have talked about. But we also have worked very closely with the Navy to increase our clinicians. They are kind of a bridge. They are not behavioral psychologists, but they know enough to help our leaders to point them in the right direction for help. That is the bridge to about 2011 before we start to see an increase from the Navy.

The issue that we do see that is significant with post-traumatic stress disorder (PTSD) and others is continuity care. Once a young marine establishes a relationship, when that psychologist or psychiatrist transfers to the theater, which happens often because they are on rotations, it is like we talked about before just a little while ago about changing commanders after 90 days. You lose visibility, you lose confidence. So continuity care is as important as the numbers of doctors that we have to address this issue.

Mrs. DAVIS. Thank you. Mr. Wilson, did you have any other questions?

Mr. WILSON. Yes, thank you. General Lynch, you have identified some programs that are unique to Fort Hood that are specifically aimed at reducing the stress on your troops. Can you please tell us more about these programs, such as the Warrior Combat Stress Reset Program?

I would also like to understand why you felt it necessary to initiate at Fort Hood unique programs in light of there are so many DOD and Army programs already in place for mental health stress issues.

General LYNCH. Thank you, sir. We indeed approach the problem from all aspects. So we established what we call the Combat Warrior Reset Program, which allows my soldiers who indeed have difficult times, either PTSD or mild traumatic brain injury (MTBI), to be seen over a three-week process by dedicated professionals. And we use every approach to their treatment that we can, to include acupuncture and Reiki and massage therapy. And indeed everybody that goes into that program and comes out the other end benefits from the program. Those are the kinds of things we look at.

But candidly, sir, what I am trying to do is spend more time addressing the problem before it becomes a problem. I don't need to

get them into the Combat Warrior Reset Center if I can indeed make them more resilient. Now, not every soldier who deploys to combat, and your sons can attest to this, not every soldier who deploys to combat comes back with PTSD. Not all of them, they do not. Some of them found it to be an enriching experience. They were confronted with a difficult situation, they thrived in that situation, and they grew as an individual.

So what we are trying to do in line with the Chief of Staff of the Army's Comprehensive Soldier Fitness Program, which really is all about resiliency, emotional, physical, spiritual, family, and social resiliency, is have the programs on Fort Hood that I described on our resiliency campus. Because I want the families who are experiencing times, and they all are, they all are—you know, Sara and I have been married 27 years. I have been away from her four of the last six years. That is hard. It is hard on a marriage, on an established marriage. Can you imagine the strain or the difficulties with a newly married couple and these deployments? So have programs like Marriage to Street Retreats and a Strong Bonds Program, which allow families who are developing their relationships to become more strong and as a result of that more resilient prior to deployment.

Mr. WILSON. I want to thank both of you, because the family support activities, I spent many years working on pre-mobilization legal counseling. And I have seen advances through Judge Advocate General (JAG) officers, through the family support organizations, and the Yellow Ribbon Campaign. All of these are just so helpful to families. And I appreciate you pointing out, too, that so many of our young people who have served, this will be a hallmark of their lives in terms of an uplifting experience to look back to and to let their families know about it in the future.

And so again thank both of you for what you are doing. And Madam Chairwoman, thank you so much for this hearing today.

Mrs. DAVIS. Thank you, Mr. Wilson.

One follow-up. I just wanted to ask about the families where the soldier, airman have been wounded, marine, have been wounded and whether we are providing additional kind of support to them over and above what you would hope to be provided for those at Fort Hood.

General LYNCH. Yes, ma'am. Engaged leaders know their subordinates and their families. And what we do is we identify those families that could indeed be high risk. And they could be high risk as a result of a wound that was incurred in combat, or they could be high risk because of strained relationships or financial problems. And what we do is ensure that we zoom in on those individuals and lead them to the right kind of resources so they can be taken care of.

Candidly, ma'am, what I found is you can have the resources, but if they don't know about them they are not going to access the resource. So engaged leaders lead their subordinates to those resources, those programs that we have.

Mrs. DAVIS. Thank you. We certainly have many families that are supporting their warrior in untold ways, and I think we do need to provide that support to them. They are extremely resilient

in many cases, but we can't take that for granted because they are working so hard to be supportive.

Thank you so much. We really appreciate you being here. We are grateful for what you are doing, and we look forward to continuing feedback. And we hope that perhaps some of the examples that we have heard about here today will be followed in other places. Thank you very much.

[Whereupon, at 5:57 p.m., the subcommittee was adjourned.]

A P P E N D I X

JULY 29, 2009

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

JULY 29, 2009

Opening Statement of the Chair
Hearing on
"Psychological Stress in the Military: What Steps Are Leaders Taking?"
July 29, 2009

The mental health status and needs of service members, their families, retirees, and their families relate to most, if not all, hearings held by this subcommittee. Whether we are discussing PTSD, family support programs, frequency of deployment, access to health care, MIAs/POWs, or the aftermath of a sexual assault, the importance of mental well-being is involved. We also dedicate one hearing a year solely to mental health issues.

This year's hearing on mental health was originally intended to examine the increased incidence of suicide in the military, and to review what actions the Office of the Secretary of Defense and the military services were taking to address this troubling trend. However, suicide is not a discrete occurrence or problem: it is the final step an individual takes when they can no longer deal with the stressors in their life. Therefore, in order to determine why the suicide rate has increased, the entire spectrum of stressors must be considered.

Further, there is a zero-sum game aspect to mental health. Neither the Department of Defense nor the country in general have enough mental health providers. Any resources directed towards suicide prevention will have to be directed away from their current allocation. It is important to examine what is going to be shortchanged in order to resource any new suicide prevention programs, and to consider if this will have any negative unintended consequences.

For today's hearing we will have two panels. In the first, we are fortunate to have the four vice chiefs of the services here to talk about what they are doing to deal with the psychological stress on their

soldiers, sailors, Marines, and airmen. We have the Vice Chief of Staff of the Army, General Peter Chiarelli, the Vice Chief of Naval Operations, Admiral Patrick Walsh, the Assistant Commandant of the Marine Corps, General James Amos, and the Vice Chief of Staff of the Air Force, General William Fraser. Gentlemen, we look forward to your testimony, and hope to leave this hearing with a clear understanding of how each of your services is addressing the issue.

It is important for the headquarters of each military department to acknowledge and address this issue. It is also just as important for individual commanders to understand the problem and take positive actions at their level. For our second panel, we have chosen to highlight the positive actions taken by commanders of their own accord to address the psychological stress experienced by their commands. We have Lieutenant General Rick Lynch of the Army, Commanding General of III Corps and Fort Hood, to participate in our hearing. General Lynch has used his command authority to make fundamental changes to the way his installation is run, with the goal of providing soldiers, and just as importantly their families, stability and predictability in their schedules.

From the Marine Corps, we have Major General Paul Lefebvre, Deputy Commanding General of II Marine Expeditionary Force. General Lefebvre created the Officer Suicide Prevention Training Program and the Operational Stress Control and Readiness Extender Program.

The problems we will discuss today cannot be solved today. But we must continue to understand and confront the psychological stress that our service members and families have to deal with every day. We must continually evaluate actions taken, gauge their effectiveness, and then press to determine what must be done less.

Opening Remarks – Congressman Wilson
Military Personnel Subcommittee Hearing
Psychological Stress in the Military: What Steps Are Leaders Taking?
July 29, 2009

Thank you Chairwoman Davis and thank you for holding this hearing. Today's hearing continues our commitment to work with the Department of Defense to find ways to address the psychological stress that our service members are struggling to overcome and to continue to improve mental health services for our military personnel and their families.

I am encouraged by the direction that the Department and the military Services are taking to recognize and alleviate psychological stress experienced by our troops, particularly our combat veterans. From my own service in the National Guard and reserves, I understand that the responsibility for finding the right answers to this problem does not lie solely with the military medical departments. This is also a leadership challenge and I commend the military Services for making the mental health of our military and their families a leadership priority.

With that said, I remain concerned that the programs that each of the Services are implementing to address psychological stress are disjointed and neither well coordinated nor communicated. I am anxious to hear from the military senior leaders on our two panels what steps they have taken to develop a comprehensive, multi-discipline approach to addressing psychological stress.

I would like to welcome our witnesses and thank them for their service and for participating in the hearing today. I look forward to your testimony.

RECORD VERSION

STATEMENT BY

GENERAL PETER W. CHIARELLI
VICE CHIEF OF STAFF
UNITED STATES ARMY

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON MILITARY PERSONNEL
UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 111TH CONGRESS

ON PSYCHOLOGICAL STRESS IN THE MILITARY: WHAT STEPS ARE LEADERS TAKING?

JULY 29, 2009

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

STATEMENT BY
GENERAL PETER W. CHIARELLI
VICE CHIEF OF STAFF
UNITED STATES ARMY

Chairwoman Davis, Ranking Member Wilson, 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 efforts to reduce the number of suicides across our Force. This is my first occasion to appear before this esteemed subcommittee, and I pledge to always provide an honest and forthright assessment.

On behalf of our Secretary, the Honorable Pete Geren and our Chief of Staff, General George Casey, I want to take this opportunity to thank you for your continued, strong support and demonstrated commitment to our Soldiers, Army Civilians, and Family members.

As all of you know, it has been a busy time for our Nation's military. We are at war; we have been at war for nearly eight years. That has undeniably put a strain on our people and equipment. In spite of this, I continue to be amazed by the resiliency of the Force. The men and women serving in the Army today are well-trained, highly-motivated, deeply patriotic, and are doing an outstanding job on behalf of the Nation.

As leaders, we have a responsibility to look out for the physical and mental well-being of our people. The culture of the Army is that of a team; and, in everything that we do – how we train, how we fight – we are guided by the Warrior Ethos, *"No Soldier left behind."* I assure the members of this subcommittee that we are addressing the issue of suicides across the Army with that same attitude.

The Overall Health and Well-Being of the Force

I must address up front what I've learned. Since being given the mission by Secretary Geren and General Casey in January to develop a plan to significantly reduce the high number of suicides across the Army, I have talked

with Soldiers, Non-Commissioned Officers, Spouses, Parents, Commanders, and Chaplains at installations across the Army. I have conducted video-teleconferences with health care providers, therapists, and Commanders of Soldiers who committed suicide. I have met with researchers, scientists, doctors, and practitioners. I have studied the data and analysis that is available on the topic of suicides. What I concluded early on is that the challenge we face cannot and should not be limited to simply reducing the number of suicides.

Suicide is without question the most severe and tragic outcome of a very complex and difficult situation. Fortunately, the vast majority of individuals struggling with behavioral health issues do not choose to end their lives. However, there are many other ways that we are seeing increased stress and anxiety manifested in a much larger segment of the Army's population, to include acts of violence, increased use of alcohol, drug abuse, infidelity, and reckless driving. We recognize that in order to effectively address and improve the overall behavioral health and well being of the force and our Families we must address these types of at-risk behaviors as well.

Therefore, I – and, the Army's other senior leaders – have consciously made the decision to expand our efforts to improving the overall mental health and well-being of the Force. We are confident that by doing so, we will also ultimately reduce the number of suicides in the Army.

That being said, I will provide some specific details on the current status of the Army's ongoing efforts to reduce the number of suicides across our Force, as well as our broader efforts to improve the overall resiliency and mental well-being of Soldiers and their Families.

Calendar Year (CY) 2008 and CY 2009 Army Suicides

During calendar year 2008 there were 140 suicides by Soldiers on active duty; a confirmed rate of 20.2 per 100,000. This is an all-time high for the Army.

And, for the first time in history, the number of suicides in CY 2008 also exceeded the national average (19.0 per 100,000 for a demographically comparable segment of the civilian population). However, it should be noted that the most recent data for civilian suicides reported by the Centers for Disease Control and Prevention (CDC) is from CY 2006.

Unfortunately, this trend has continued into CY 2009. We experienced an alarmingly high number of suicides in January and February with 41 compared to 16 in the same months of CY 2008. This prompted the establishment of the Army's Suicide Prevention Task Force, after which we began to see a reduction. Although I'm not prepared to say that we've "turned the corner" on preventing suicides, I can report that the number of suicides for the months of March through July is lower than the same period last year.

I, and the other senior leaders of our Army, readily acknowledge that these figures are still unacceptable and continue to explore ways to improve the mental wellness of the force.

Suicide is the result of a combination of factors

In this era of what I refer to as "persistent engagement" – Soldiers are required to maintain a heightened state of readiness and operate at an exigent tempo for prolonged periods of time. This undoubtedly contributes to higher levels of stress and anxiety.

However, we all must resist any attempt to generalize or oversimplify the challenges we are facing. Every suicide is as different and as unique as the people themselves. And, the reality is there is no <u>one</u> reason a person decides to commit suicide. That decision reflects a <u>complex combination</u> of factors and events that over time may lead the individual to feel completely hopeless – with no other option than to end his or her life.

Our analysis has shown that there are some common factors among suicide victims which we are working diligently to better understand so we can develop mitigation strategies.

The most common contributing factor in Army suicides is that the nearly three-fourths of Soldiers that have committed suicide had a significant relationship problem or lacked a significant relationship. Over two-thirds of Soldiers that have committed suicide had been deployed, while almost one third of the Soldiers who died by suicide had never deployed. The majority of those who had deployed had participated in one deployment (46%), and the remainder had two or more deployments (21%).

We recognize that behavioral health issues are a significant factor in suicidal behavior. While a very small number of Soldiers who died by suicide had been diagnosed with Post Traumatic Stress Disorder (PTSD) (5.5%), it is clear that other behavioral health issues are involved. Slightly more than 40% of those who died by suicide had received outpatient care for behavioral health treatment. The most common diagnosis is Adjustment Disorder (20.6%), followed by Substance Abuse (16.3%).

Although we have worked hard in the past two years to increase our understanding of suicidal behavior, there is much we still do not know. To help us better understand this complex issue, we have enlisted the aid of the National Institute of Mental Health (NIMH). The Army has funded NIMH to conduct a "Collaborative Study of Suicidality and Mental Health in the U.S. Army", the largest study of behavioral health ever undertaken by the Army. This five-year epidemiological study will examine behavioral health, psychological resilience, suicide risk, suicide-related behaviors, and suicide deaths across the active and reserve components over all phases of a Soldiers career. This groundbreaking study is being carried out by a consortium from the Uniformed Services University of the Health Sciences, Harvard University, the University of Michigan, and

Columbia University. We have very high hopes that this consortium will help illuminate the suicide problem and provide concrete recommendations for service-wide implementation, and potentially even national implementation.

The Army's Approach to the Issue

Today, the Army is in the process of instituting several key initiatives. Most notably, we are adopting a 2-prong approach to transforming the Army's comprehensive care system.

Our goal is to: 1) help Leaders and Soldiers alike better identify those Soldiers who are at-risk and may need extra attention or help; and, 2) increase Soldiers' overall resiliency, while also ensuring individuals who need help are aware of and have access to the resources and support programs that can provide them with the most benefit.

The Army's approach is based on two 'big ideas': the Comprehensive Soldier Fitness (CSF) program and the *Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention*.

The Army's Comprehensive Soldier Fitness program has been designed to raise mental fitness up to the same level of attention as we have historically given to physical health and fitness. We recognize people come into the Army with a very diverse range of experiences, strengths, and vulnerabilities in their mental as well as physical condition. Multiple studies have shown that mental and emotional strength are just as important as physical strength to the safety and well-being of our Soldiers. In fact, a Soldier who is mentally and emotionally fit is better prepared to withstand the challenges and adversity of combat.

In the past, the Army's approach was primarily focused on the right side of the assess, train, intervene, and treat continuum; simply stated, we were reactive. That has changed; today the focus of CSF is to assess, educate, and assist. We

will be proactive in an effort to early and throughout a soldier's career identify and mitigate issues before they become significant concerns.

As part of the CSF effort, the Army has instituted a resilience training program, with modules for essentially every juncture in a Soldier's career – from Basic Training to the Pre-Command Course. There are also pre- and post-deployment modules for both Soldiers and spouses. This resilience training program has already demonstrated the ability to reduce symptoms of post-traumatic stress upon redeployment. People who participated in the resilience training have reported reduced stigma attached to getting mental health care if needed than those who had not participated in the training.

In March 2009, we established the Army Suicide Prevention Task Force which created the *Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention.* The Campaign Plan contains approximately 250 tasks that will optimize existing programs and update policy. By early August, the Task Force will have accomplished almost half of the tasks. Some of the accomplishments to date include:

- Conducting a monthly Senior Review Group world-wide VTC to conduct detailed "After Action Reviews" on recent suicides to gather and disseminate lessons learned.
- Building a data collaboration network among the various Army Stakeholders which will allow the National Institute of Mental Health to conduct their five-year longitudinal study to better understand risk factors associated with suicidal behavior.
- Updating Army regulations and policies to better reflect current Army organization and operational requirements across all components.
- Establishing policies that help guard against accidental overdose and adverse drug interactions.

- Assessing the impact of leadership turn-over in recently redeployed units, stabilizing leadership and medical personnel with units as necessary, and improving access to counseling and behavioral health providers.
- Completing a three-phase suicide "stand-down" and chain teaching program.

A Team Approach

Improving the overall behavioral health and well-being of the Force and thereby effectively addressing the challenge of Soldier suicide is going to require a total team effort across all Army components, jurisdictions, and commands, as well as cooperation with partners outside of our organization, such as the Department of Veterans Affairs and NIMH.

Within the Army, Unit Ministry Teams (UMT) play a critical role in addressing this issue. These teams are comprised of chaplains and chaplain's assistants. Today, there is a unit ministry team assigned to most battalions in the Army. They train and deploy with the units, and work with other supportive agencies and health professionals to assist Soldiers and their Families. UMTs are able to provide a quick and effective response to crises, including suicidal crises, as a result of their integration with the unit, credibility with their Soldiers, and superior pastoral skills and experience. UMTs also provide countless interventions to prevent self-destructive behavior, not only at the point of suicidal crisis, but also in working with distressed Soldiers and Family members prior to a crisis.

Shortage of Health Care Providers

Another challenge we are facing is the insufficient number of health care providers, in particular psychiatrists, psychologists and other behavioral health specialists, including marriage and family therapists and substance abuse counselors, across our Force.

When we grew the Army from a force of 482,000 to a force of 547,400, we did not grow our active duty medical force structure to care for the additional Soldiers and their Family members. This left the Army with a suboptimal ratio of uniformed health care providers to service member which has had a significant impact on the access to care we provide our Soldiers and their Families in a time of war.

I can assure you, figuring out how to address these critical shortfalls continues to be a priority for our Army's senior leaders. U.S. Army Medical Department (AMEDD) is currently working to determine how many doctors, psychiatrists, psychologists, and other mental health care professionals are required to meet the needs of Soldiers and their Families. The reality is there is no precedent for how many health care professionals are needed to care for a Force after nearly eight years of war.

The Army is also educating more primary care providers on the symptoms and courses of action for depression, anxiety, and PTSD. What we discovered is that Soldiers who are unwilling to seek help from a mental health care professional will often go to a primary care physician instead. So, it is important for these doctors to know what to look for and how best to care for these individuals.

Another way that the Army is looking at improving access to counseling or Level 1 treatment for alcohol and substance abuse or other mental or behavioral health problems is through web-based care. *"Web-Care"* would provide online "real-time" counseling via video, email, live chat, or instant messaging. Individuals would be able to log-on in the privacy of their homes at times convenient to their schedules.

Changing the Army Culture

In the past, there has been a stigma associated with seeking help from any kind of mental 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 recognize that we need to do more, and we are committed to getting the message out to Soldiers that it is okay to get help. We are making progress. In fact, recent mental health assessments conducted in theater have shown a marked increase in the percentage of Soldiers willing to seek mental health care without undue concern that it will be perceived as a sign of weakness or negatively impact their careers.

As an example of this, current Army policy is that even if a Soldier self referred himself or herself into the Army Alcohol and Substance Abuse Program (ASAP) their Commander was informed that they were seeking help. This month, we initiated a pilot program at one installation that allows soldiers to self refer if they think they have a problem and the chain of command is not notified. To date one officer, one NCO and nine Soldiers have self referred into the program. ASAP offices remain open after the duty day and on weekends so Soldiers can make appointments and maintain their anonymity. We will expand it to three installations by the end of August, evaluate and make adjustments to the program, and if successful, change Army policy and allow self referral without chain of command notification throughout the Army.

Closing

Any time a Soldier chooses to end his or her life; the loss affects Family and friends, fellow Soldiers, and the Army. The reality is every suicide is unique, and there is no simple solution. To improve the overall health and well-being of the Force requires 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.

Again, I can assure the esteemed Members of this subcommittee that there is no greater priority for the 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.

Madam Chairwoman, Members of the Committee, I thank you again for your continued and generous support of the outstanding men and women of the United States Army and their Families. I look forward to your questions.

NOT FOR PUBLICATION UNTIL
RELEASED BY THE HOUSE
ARMED SERVICES COMMITTEE

STATEMENT OF

ADMIRAL PATRICK M. WALSH, U.S. NAVY

VICE CHIEF OF NAVAL OPERATIONS

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

HOUSE ARMED SERVICES COMMITTEE

"PSYCHOLOGICAL STRESS IN THE MILITARY: WHAT STEPS ARE LEADERS TAKING?"

JULY 29, 2009

NOT FOR PUBLICATION UNTIL
RELEASED BY THE HOUSE
ARMED SERVICES COMMITTEE

Chairman Davis, Congressman Wilson, and distinguished members of this subcommittee, I would like to thank you for this opportunity to testify about the organizational and command level efforts to prevent suicides in the Navy.

Suicide ranks as the third leading cause of death in the Navy behind accidents and natural causes. It is a loss that destroys families, devastates communities, and unravels the cohesive social fabric and morale inside our commands. While suicide is a difficult, emotional issue riddled with complexities, we have learned to understand, appreciate, and identify key factors that put a Sailor on the path to suicide. Symptoms are unique to each person, but a thread that is common to all victims is a sense of psychological emptiness and ache that leaves individuals impaired and unable to resolve problems.

Therefore, solutions to this tragedy must address the underlying causes that affect the ability of an individual to recover from change or misfortune and regain their physical and emotional stamina. The target of our policy and practice is the resilience of individual Sailors and their families. We consider it a core responsibility to build a resilient force, which means that leaders must look for and assist those challenged by seemingly intractable troubles with relationships and work, financial and legal matters, deteriorating physical health, as well as mental health issues and depression, similar to issues that affect suicide rates in the general U.S. population.

A successful prevention program must address Sailors on an individual level with an effort that can penetrate through a tough external veneer, made more challenging by a very real sense of personal vulnerability, fear, and cultural aversion to discussions about our own mental fitness or welfare. The Navy Suicide Prevention Program requires awareness and action at many

leadership and policy levels to build lives that are resilient, that can cope with personal adversity, and capable of responding to personal and professional challenges.

The Navy's suicide rate was 12.4 per 100,000 Sailors in the last year (July 2008-June 2009), for a total of 44 suicides. This loss reinforces the urgency for increased vigilance with suicide prevention efforts. When considering deployment as a possible risk factor, analyses over the last five years show a weak correlation between suicide and deployment history. From 2003-2008, the Navy suffered 240 suicides. Approximately half (48%) of suicides had not deployed at all in the previous three years; most (64%) of suicides had not deployed specifically in support of Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF); one-third (31%) had previously deployed for OIF/OEF; eight (3.3%) were in OIF/OEF at the time of suicide; one Individual Augmentee (IA) died from suicide while in OIF/OEF and one Sailor died 14 months after returning home from a 12-month IA assignment. Three Navy suicides had Post-Traumatic Stress Disorder (PTSD) diagnosis history whereas 22 had substance disorder diagnoses, and 58 had other mental health diagnoses, including depression.

The Role of Operational Leadership

Suicide prevention is an all hands evolution. Through training, outreach, intervention and reporting, the Navy executes prevention and intervention programs for all Sailors. Medical personnel, Chaplains, Fleet and Family Support Center (FFSC) counselors, health promotion program leaders, the Navy Reserve Psychological Health Outreach team and substance-abuse counselors support Commanding Officers (COs) with information in their areas of expertise, intervention services, and assistance in crisis management. We place strong emphasis in primary prevention efforts of building resilience and addressing early intervention for associated

stressors. The Navy directs local commands to take ownership of suicide outreach and training initiatives and tailor them to their unique command cultures, because we are a diverse force with many different missions.

Navy leadership actively conducts real time, down range surveillance and assessment of the mental health of our troops. Between August 2007 and August 2008, Sailors deployed to Iraq, Afghanistan, and/or Kuwait, and completed the Behavioral Health Needs Assessment Survey (BHNAS) (a battery of anonymous self-reports to evaluate their psychological well-being), told us that fatigue/lack of sleep were their most common problems. Scientific research indicates that these factors may contribute to PTSD and depressive symptoms. Similarly, unit cohesion was the most powerful protective factor that contributed to decreasing PTSD and clinically significant depression. Some missions, such as detainee operations and specific unit experiences, such as a mass casualty, significantly increase the likelihood that a Sailor will develop PTSD and depression. BHNAS also suggested other extremely high OPTEMPO missions, such as annually recurring aviation combat deployments, have a greater risk for marital and family problems during deployment. The BHNAS also revealed many Sailors reported personal growth while on deployments, even when they also report symptoms of PTSD. Armed with these findings, Navy amended work schedules, changed staffing levels, and modified deployment extensions accordingly.

Operational Stress Control (OSC)[1] is a comprehensive approach designed to address the psychological health needs of Sailors and their families; it is a program led by operational leadership and supported by the naval medical community. OSC provides practical decision-making tools for Sailors, leaders and families so they can identify stress responses and mitigate problematic tension. By addressing problems early, individuals can mitigate the effects of

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

personal turmoil, and, get the necessary help when professional counseling or treatment warrants. The Stress Continuum[2] is an evidence-informed model that highlights the shared responsibility that Sailors, their families, and their leadership have for maintaining optimum psychological health.

The stigma associated with the assessment and treatment of depression and substance abuse are barriers for those who need to seek help. Stigma, better thought of as a reluctance or resistance to accepting one's emotional difficulties can be derived from internal, external or institutional sources. We must endeavor to eliminate the perceived shame and dishonor (internal source) of asking for help, and take the charge given to all of us by the Chairman, Joint Chiefs of Staff, "that the act of reaching out for help is, in fact, one of the most courageous acts and one of the first big steps to reclaiming your career, your life and your future."[3] Eliminating peer-to-peer (external) stigma is challenging, Navy leadership can and must address institutional stigma. Some strides have already been made.[4] Our commands have an important role to play in setting a helpful, supportive climate for those who need to admit their struggle and seek assistance.

The Navy has supported an initiative for a standardized network of Command-sponsored Suicide Prevention Coordinators to communicate Navy-wide initiatives while also encouraging individual commands to take ownership of the programs and teach Sailors effective responses to stress. Some efforts include command led programs to de-glamorize alcohol, prevent drug abuse, encourage physical fitness, and teach problem-solving skills. Medical professionals provide support and treat depression, anxiety and sleep problems. In addition to command

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[2] The Navy and Marine Corps utilize the Stress Continuum Model. Historically, Navy viewed those under stress as either fit or unfit whereas now we understand four distinct stages of stress responses: Ready (Green), Reacting (Yellow), Injured (Orange) or Ill (Red). This model is used to recognize and intervene when early indicators of stress reactions or injuries are present before an individual develops a stress illness, such as PTSD or depression.
[3] Admiral Michael Mullen, May 01, 2008
[4] The DoD has recently amended the security clearance questionnaire exempting a service member from disclosing psychological services obtained for combat related stress or family difficulties.

involvement, the Navy empowers Fleet and Family Services, ombudsmen, spiritual and religious ministries to foster cohesive units, families and communities.

Healthy factors, such as positive attitude, solid support networks, good problem solving skills, and healthy stress controls reduce the risk of intentional self-harm. Preventing suicide in the Navy begins with promoting health and wellness consistent with keeping service members ready to accomplish the mission.

Policy, Procedures, and Responsibilities

The Chief of Naval Operations (CNO) directed the establishment of the Navy Preparedness Alliance (NPA) to address a continuum of care that covers all aspects of individual medical, physical, psychological, and family readiness across the Navy. The forum has proven to be a valuable venue to examine the tough readiness issues that cross stakeholder boundaries and make informed decisions on identified issues. For example, the Navy placed a limitation on the tour length for personnel assigned to detainee operations, based upon a review of the results of BHNAS. The Chief of Naval Personnel chairs the NPA and routinely reports its findings directly to the CNO.

Operational leadership sets the climate to facilitate early actions to prevent suicide. At the highest levels, Navy leadership maintains a close watch on the Tone of the Force, by conducting a comprehensive quarterly review of personal and family readiness metrics and trends. The Navy polls extensively and tracks statistics on personal and family-related indicators such as stress, financial health, and command climate, as well as Sailor and family satisfaction with the Navy. The Navy conducts a BHNAS for targeted groups of deployed Sailors.

Additionally, CNO and senior leadership receive briefings each month on Navy suicides and suicide prevention efforts.

Over the past year, Navy Safe Harbor[5] has expanded its mission to non-medical support for all seriously wounded, ill, and injured Sailors and their families, increasing its capabilities with the establishment of a headquarters element to support Recovery Care Coordinators and Non-medical Care Managers covering 15 locations. With these changes, Safe Harbor's enrolled population has increased from 145 to over 440. Safe Harbor is providing recovering Sailors a lifetime of individually tailored assistance designed to optimize the success of their recovery, rehabilitation, and reintegration activities.

The Navy outlines its policies, procedures and responsibilities for its Suicide Prevention Program in OPNAV Instruction 1720.4.[6] The program aims to reduce the risk of suicide for all Department of the Navy (DON) members, minimize adverse effects of suicidal behavior on command readiness and morale, and preserve mission effectiveness and warfighting capability. Specifically, the Navy has implemented an action plan for all Active-Duty and Reserve sailors to address negative suicide risk factors and strengthen associative protective factors through the following four key elements: Training, Intervention, Response and Reporting.

Training

All Sailors receive annual suicide prevention training with plans to extend this training to civilian employees and full-time contractors who work on military installations. Suicide prevention training includes, but is not limited to: everyone's duty to obtain assistance for others in the event of suicidal threats or behaviors; recognition of specific risk factors for suicide; identification of signs and symptoms of mental health concerns and operational stress; protocols

[5] Safe Harbor is a Navy program, established in 2005, for the non-medical care management of severely wounded, ill, or injured Sailors and their families. Safe Harbor Sailors have had no suicides.
[6] A revision to the 28 Dec 2005 instruction, OPNAV Instruction 1720.4A, is currently under review.

for responding to crisis situations involving those who may be at high risk for suicide; and contact information for local support services.

Life-skills/health promotion training, such as alcohol abuse avoidance, parenting skills, personal financial management, stress, conflict resolution, and relationship building enhance resilience and mitigate problems that might detract from personal and unit readiness.

Highly stressful experiences often cause breakdowns in communication between Sailors and their families. A recent Center for Naval Analysis study on family attitudes and reactions resulting from Combat and Operational Stress demonstrated that over 40% of Navy spouses rate the training and services as "low" experienced by their military spouse for deployment related stress. A novel program developed by UCLA and partnered with the Navy, Project FOCUS (Families Overcoming Under Stress) now provides structured activities and developmentally appropriate combat stress and deployment education. By creating a "family tool box" in order to address difficulties and operational stressors that service members, families, and children face during multiple deployments, Project FOCUS also helps develop critical skills related to emotional regulation, problem solving and communication. These early, resilience-based interventions build social support with family-level techniques, tools which highlight areas of strength and resilience within the family and identify areas in need of growth and change. The Navy finds that when a family becomes resilient and able to deal with the stresses of deployments, Sailors and Marines are better equipped to carry out their missions.

COs provide current suicide prevention information and guidance to all personnel, which emphasizes promoting the health, welfare, and readiness of the Navy community, providing support for those with personal problems, and ensuring access to care for those who seek help.

Each CO appoints a Suicide Prevention Coordinator to ensure that the command implements each facet (training, outreach and response) of the suicide prevention. Commands must have a written crisis response plan so Duty Officers have ready access to emergency contacts, guidance, and basic safety precautions to assist a Sailor at risk.

The Navy continues a robust communications plan about suicide awareness and promoting the core message: "Life Counts!" A dedicated website (www.suicide.navy.mil), poster series, brochures, videos, leadership messages and newsletters all communicate the Navy's messages on suicide prevention.

Intervention

Initially piloted by Navy Seabees, one of the most heavily deployed communities within the Navy, the Warrior Transition Program is a three-day respite in Kuwait offered to de-escalate and wind down from the adrenaline-soaked states of mind warriors develop over combat deployments. Functionally analogous to the long voyage home experienced by World War II veterans, all Individual Augments undergo this process of decompression routinely called (and offered by most NATO countries) as Third Location Decompression. Conducted by counselors, chaplains, and peers, sailors spend two to three days in reflection and recollection and are provided time for appropriate rituals of celebration or grief, restoration of normal sleeping patterns, and importantly, time to say their good-byes. We feel this best practice is critical in preparing returning warriors to resume the role of parent, spouse, shipmate and neighbor.

COs are directed to have written suicide prevention and crisis intervention plans that include the process for identification, referral, treatment, and follow-up for personnel who indicate a heightened risk of suicide. In addition, they are entrusted to promote activities to improve psychological health in the unit.

COs provide support for those who need help with personal problems. Access is provided to prevention, counseling, and treatment programs and services supporting the early resolution of mental health, family and personal problems that can underlie suicidal behavior.

If an Active-duty or Reserve Sailor's comment, written communication, or behavior leads the command to believe there is an imminent risk that the person may cause harm to himself or others, command leadership will take safety measures that include increased supervision, restricting access to instruments that can be used to inflict harm and seeking an emergency mental health evaluation.

Providing mental health support and suicide prevention to the Reserve Sailors is a challenging yet integral component of Navy mental health, given the many valued contributions the Naval Reserves continue to make in Overseas Contingency Operations. To meet this challenge, the Navy implemented the Reserve Psychological Health Outreach (RPHO) Program in Fiscal Year 2008. This program provides two RPHO Coordinators and three Outreach team members (all licensed clinical social workers) to each of the five Navy Reserve Regions. As a result of this program, Naval Reservists can now call upon a dedicated team of mental health professionals for mental health support. The RPHO teams engage in active outreach, clinical assessment, referral to care, and follow-up services to ensure the mental health and well-being of reserve Sailors. The RPHO teams are thus the Navy's first line of defense in suicide prevention, and if necessary, intervention for Reserve Sailors.

Since the inception of the RPHO program in FY08, the program has contacted 1390 Reserve Sailors and provided 628 clinical assessments. The RPHO coordinators have also played a critical part in helping 1,990 reservists and 1,476 family members attend 28 mental health retreats called "Returning Warrior Weekends" where Sailors and their spouses are

provided a chance to share deployment experiences with fellow service members as well as seek one-on-one support from chaplains and mental health counselors. In addition, Navy Medicine has hired a full-time Director of Psychological Health for Navy Reserve to oversee and expand reserve Navy Reserve psychological health programs.

Response and Reporting

In the event of a suicide or suicide-related behavior, command and local mental health resources provide support for Sailors and their families. Navy commands assess requirements for supportive interventions for units and affected service members and coordinate with all local resources to implement interventions when needed. The Navy reports all suicides and suicide-related behaviors. In instances when the medical examiner has made an undetermined cause of death and has not excluded suicide, commands complete the Department of Defense Suicide Event Report (DoDSER) within 60 days of notification of death.

As a result of a CNO directed review of our suicide prevention program, we have improved how commands report active-duty suicide attempts (or reserve in drill or activated status). In these situations, the Military Treatment Facility (MTF) responsible for the individual's assessment, care, or referral also has responsibility for completing the DoDSER within 30 days of the event. We have recently started collecting information on Navy civilian employee suicides.

We monitor the number of suicides, follow trends, as well as coordinate the development and maintenance of an appropriate Navy database to track all suicides in the Navy. Additionally, there is continual coordination and collaboration with Navy Behavioral Health, Navy Casualty Office, the Office of the Armed Forces Medical Examiner, and the Defense Centers of

Excellence for Psychological Health and Traumatic Brain Injury. Our primary goal remains saving and improving lives.

In conclusion, on behalf of the men and women of the United States Navy, I thank you for your attention and commitment to the critical issue of suicide prevention. By teaching Sailors better problem solving skills and coping mechanisms for stress, the Navy will make our force more resilient. The Navy is committed to a culture that fosters individual, family and command well-being. We honor the service and sacrifice of our members and their families, and we will do everything possible to support our Sailors, so that in their eyes, their lives are valued and are truly worth living.

NOT FOR PUBLICATION
UNTIL RELEASED BY
THE HOUSE ARMED
SERVICES COMMITTEE

STATEMENT OF

GENERAL JAMES F. AMOS

ASSISTANT COMMANDANT OF THE MARINE CORPS

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE

SUBCOMMITTEE ON MILITARY PERSONNEL

CONCERNING

"PSYCHOLOGICAL STRESS IN THE MILITARY: WHAT STEPS ARE LEADERS TAKING?"

29 JULY 2009

NOT FOR PUBLICATION
UNTIL RELEASED BY
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SERVICES COMMITTEE

General James F. Amos
Assistant Commandant of the Marine Corps

General James F. Amos, USMC, is the 31st and current Assistant Commandant of the Marine Corps. A Naval aviator by trade, General Amos has held command at all levels from Lieutenant Colonel to Lieutenant General. Most notably he commanded the 3rd Marine Aircraft Wing in combat during Operations Iraqi Freedom I and II from 2002-2004, followed by command of the II Marine Expeditionary Force from 2004-2006. He subsequently served as the Commanding General, Marine Corps Combat Development Command and as the Deputy Commandant, Combat Development and Integration from 2006 to July 2008. General Amos was promoted to his present rank and assumed the duties of Assistant Commandant of the Marine Corps on 2 July 2008.

Operational assignments include tours with Marine Fighter Attack Squadrons 212, 235, 232 and 122 where he flew the F-4 Phantom II. In 1985 General Amos assumed command of Marine Wing Support Squadron 173. Later, transitioning to the F/A-18 Hornet, he assumed command of Marine Fighter Attack Squadron 312 and subsequently joined Carrier Air Wing Eight onboard USS Theodore Roosevelt (CVN-71). General Amos took command of Marine Aircraft Group 31 Beaufort, SC in May 1996.

General Amos' staff assignments include tours with Marine Aircraft Groups 15 and 31, the III Marine Amphibious Force, Training Squadron Seven, The Basic School, and with the MAGTF Staff Training Program. Promoted to Brigadier General in 1998 he was assigned to NATO as Deputy Commander, Naval Striking Forces, Southern Europe, Naples Italy. During this tour he commanded NATO's Kosovo Verification Center, and later served as Chief of Staff, U.S. Joint Task Force Noble Anvil during the air campaign over Serbia. Transferred in 2000 to the Pentagon, he was assigned as Assistant Deputy Commandant for Aviation. Reassigned in December 2001, General Amos served as the Assistant Deputy Commandant for Plans, Policies and Operations Department, Headquarters, Marine Corps.

I. Introduction

Chairwoman Davis, Ranking Member Wilson and distinguished Members of the Committee; on behalf of your Marine Corps, I would like to thank you for your continued generous and faithful support over the past few years, and look forward to this opportunity to discuss the efforts we are taking to prevent suicides in the Marine Corps. Your Marines know that the people of the United States and their Government are behind them; your support has been exceptional.

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 fundamental questions of why, how and what. Why did this happen? How can we avert a future tragedy? What actions did we take or fail to take, and what could we have done to identify these Marines who most needed our help and get them that support? What lessons can be learned to prevent another loss? As Marines, we pride ourselves in "taking care of our own;" it is this commitment to one another that will mark our efforts in learning from these tragedies and guide us in our vital work of suicide prevention.

II. Understanding the Statistics

Between 2001 and 2006, the number of suicides in the Marine Corps fluctuated between 23 and 34, but in the past two years we have seen a disturbingly sharp increase. From a recent low point of 25 suicides in 2006, the number increased to 33 in 2007, and in 2008, the Marine Corps had 42 confirmed or suspected suicides. Our suicide rate in 2008 of 19.5 suicides per 100,000 Marines approaches the national civilian rate of 19.8 per 100,000. In 2008, we had 146 reported suicide attempts, a significant increase from

99 attempts in 2006 and 103 in 2007. The number of Marine suicide attempts has consistently been between three and four times the number of actual suicides.

These increases are unacceptable. We have looked at the data to try to find answers that will enable us to address this needless loss of life. The data shows that the most likely Marine to die by suicide corresponds to our institutional demographics: Caucasian male, 18-24 years old, and between the ranks of Private and Sergeant (E1-E5). The most common associated stressor is a failed relationship. Male Marines are at greater risk of suicide than female Marines, similar to the civilian population. The most common methods of suicide are gunshot or hanging, also similar to our civilian counterparts.

We have been concerned that one outcome of the stress from operational deployments might be increased suicides; however, to date, we have not seen that hypothesis prove out. Although the number of Marines who kill themselves and have a deployment history has increased, that increase is proportionate with the overall deployment history of all Marines. In 2008, 68 percent of our confirmed or suspected suicides were Marines with a current or past deployment history in support of OPERATION ENDURING FREEDOM / OPERATION IRAQI FREEDOM (OEF/OIF), which is roughly the same as the percentage of all Marines with deployment experience (69%). Marines with multiple deployments are similarly not over-represented in the suicide population. For the six year period of 2003-2008, 48% of our suicides were Marines with a deployment history, and 52% were Marines with no OIF/OEF deployment history. Sixteen percent of all Marine suicides in this period occurred in the OEF or OIF area of operations, and 32% of Marines who committed suicide during this period had been deployed in OEF/OIF. Taken together, this data suggests that while the

continuing stress resulting from overall Operational Tempo (OPTEMPO) may be a factor in our increasing suicide rate, there does not appear to be a difference in suicide risk resulting from deployment history. Preliminary data from a current analysis of suicide and deployment related factors suggest that there is no specific time period post deployment associated with increased risk for suicide for Marines. Studies of combat injuries also show no relationship to suicide related incidents.

III. Suicide Reporting, Risks, and Stressors

We review all non-hostile casualty reports to identify possible suicides and coordinate weekly with the Armed Forces Institute of Pathology, who is the final arbiter on manner of death for the Marine Corps. Investigations into the possible suicide of a Marine often include the command investigation and reports from the Naval Criminal Investigative Service, the Armed Forces Medical Examiners Office, and civilian police and medical personnel. After each suicide, we do an extensive review of the factors leading up to the suicide. We seek 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 in our analysis when available in such a manner that will not compound the family's loss. A comprehensive survey tool, the Department of Defense Suicide Event Report, is required for all Marine suicides and suspected suicides. We, in conjunction with the Navy, are currently determining the best approach to facilitate the use of that survey tool for all suicide attempts as well.

From our analysis, the most common risk factors associated with suicides include a history of previous suicides in family or by a close friend, depression, psychiatric treatment, anxiety, and a sense of failure. As we look deeper into these cases, the most

prevalent associated stressors we find are romantic relationship troubles, work-related problems, pending adverse legal or administrative actions, physical health problems, and job dissatisfaction. While all these risks and stressors can be commonly found in the civilian sector, they are exacerbated in the young, male, single population that makes up much of the Marine Corps. In many cases, our younger Marines are still developing the life skills and resiliency that will enable them to better cope with the stressors in their lives.

We continue to look at our data to identify actionable differences. Unfortunately, the relatively small size of our suicide population limits in–depth analysis into causal factors or contributors. In most cases, multiple stressors and risk factors are present. In a third of our suicides, we have found more than ten stressors or risk factors present. We are confident that there is no single answer that will prevent suicides, and solutions must include initiatives that approach the problem from multiple angles and from multiple disciplines.

IV. Actions Taken

Training and Education

Suicide awareness has been an annual training requirement for all Marines since 1997. This requirement is inspected by the Marine Corps Inspector General (IG) at every command inspection visit and has been a Commandant Special Interest area for the IG for over a year. Suicide prevention is required training for recruits in boot camp and for new officers at The Basic School. It is part of the curriculum at our Staff Non-commissioned Officer Academies, Commanders Courses, and other professional military education courses. We have incorporated suicide prevention training into the Marine Corps Martial Arts Program, a program practiced by all Marines. Simply put, suicide prevention

training is incorporated into our formal education and training at every level of professional development and throughout a Marine's entire career.

An additional new training opportunity which we provide is our Frontline Supervisors Training, a three to four hour gatekeeper-type training for Marines in leadership positions. The training reinforces the leadership skills all Non-Commissioned Officer (NCO) and Staff Non-Commissioned Officer (SNCO) Marines have learned and further teaches these leaders how to recognize the signs of distress, to engage their Marines in a discussion about suicide related thoughts and risk, to effectively refer them to local support resources, and to recognize the importance of sustained effort even after a Marine has received professional assistance. We have instructors at all Marine installations who are prepared to provide additional training for our NCOs, SNCOs, and junior officers.

In November, 2008 and April, 2009, I met with our two and three star commanding generals, their sergeants major, and representative non-commissioned officers (NCOs) to review our suicide awareness and prevention program in depth. At those meetings, the NCOs present asked us to provide them with additional training so that they could take ownership of suicide prevention for their peers and their Marines. The goal of this initiative is to fully engage our non-commissioned officer leaders by providing them Marine-relevant information to assist them in identifying and responding to distress in their Marines. Given the fact that 85% of our suicides in 2008 were Marines of the rank of Sergeant and below, this is a strategic initiative towards our target population. To accomplish this, we developed a mandatory, high-impact, peer led, leadership training program, focused on our non-commissioned officers and corpsmen, to provide them additional tools to identify and assist Marines at risk for suicide. Our

NCOs have the day-to-day contact with their Marines and the best opportunity to recognize changes in their behavior. Properly equipped, we believe our NCOs, the first line of defense, will have a real impact. This cutting-edge training program is rolling out across the Marine Corps this summer, during which all of our 67,000 NCO's and Corpsman will be instructed by trained Sergeant instructors.

One challenge we must overcome is the perception that asking for help will damage your career or somehow makes you less of a Marine. We are combating this stigma with focused leadership, communicating the message that it is okay to seek help. Marines must know that being ready for the mission means ready in every way, and getting help is a duty, not an option. We teach Marines at all levels that seeking help, and looking out for their buddy, is the right and necessary thing to do. One initiative aimed at reducing stigma is the creation of suicide prevention leadership videos by all General Officers in command and their Sergeants Major. These 3-5 minute personal videos include messages from senior leadership designed to demonstrate the importance of addressing this tragedy at the most senior levels and reduce the stigma inherent throughout society of asking for help.

To rapidly raise the level of awareness across the Marine Corps, 100% of all Marines received additional training on suicide prevention during the month of March of this year. The training package was delivered by Marine leaders and educated all Marines on warning signs, engagement with their buddies, and how to access the variety of local and national support resources.

Additionally, I recently directed the Marine Corps Combat Development Command to take an additional and independent look at our suicide prevention training throughout the entire Corps. A special task force commenced their study this month and

is examining how we are specifically training our Marines, and exploring how we can modify training at all levels to improve resilience, decrease stigma, and to strengthen the character of our Marines such that taking one's life is not an option.

The Combat Operational Stress Control Program

The Combat Operational Stress Control Program (COSC) is a program through which Marine leaders are trained by mental health professionals and chaplains in the operating forces to detect stress problems in warfighters as early as possible. COSC provides leaders with the resources to intervene and manage these stress problems in theater or at home. Collaboration between warfighters in the Marine Expeditionary Forces, Navy Medicine, and Navy Chaplains resulted in the Combat Stress Continuum Model. This tool facilitates the identification of distress in Marines and offers a decision tree to guide leaders in what to do.

To assist with prevention, rapid identification, and effective treatment of combat operational stress, we are expanding our program of embedding active duty Navy mental health professionals in operational units — the Operational Stress Control and Readiness (OSCAR) Program — to directly support all active and reserve ground combat elements and eventually all elements of the Marine Air Ground Task Force. We currently have three teams with forward deployed units. Our goal is that OSCAR capabilities are extended down to all of our infantry battalions and companies by providing additional training to existing medical personnel (doctors and Corpsmen), chaplains, and selected leaders within each unit to make the expertise more immediately available, and to decrease stigma through building relationships. In addition, Navy Medicine has increased the number of mental health providers in Deployment Health Clinics and in the TRICARE network over the past two years.

We coordinate our suicide prevention efforts with other experts from across the federal government, our civilian counterparts, 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 Veterans Affairs (VA) partners to join efforts in reducing suicides. The Marine Corps currently chairs the Federal Executive Partners Priority Workgroup on Suicide Prevention. This program, led by the Department of Health and Human Services (HHS), provides an opportunity to share best practices and build collaboration between all of our federal partners. Besides VA and HHS, this workgroup includes members from 12 other federal agencies working together to facilitate efforts in support of the National Strategy on Suicide Prevention. The Marine Corps also chairs the International Association of Suicide Prevention Task Force on Defense and Police Forces. This Task Force includes membership from 15 different countries working together to develop effective suicide prevention programs, building on shared unique experiences in military culture that crosses national boundaries.

Prior to deployment, all Marines complete a comprehensive Pre-Deployment Health Assessment which gives us a chance to identify and respond to problems before Marines leave their home station. During the re-deployment process, Marines complete a Post-Deployment Health Assessment designed to alert medical personnel to medical and mental health issues. Within 90-120 days after return to home installations, a Post-Deployment Health Reassessment is conducted. This is designed to identify problems that might not have surfaced immediately upon their return home. These examinations provide us another opportunity to detect Marines who may be at risk.

V. Conclusion

We believe that focused leadership at all levels is the key to having an effect on the individual Marine and in reducing suicides. Understanding that there is no single suicide prevention solution, we are actively engaged in a variety of prevention efforts and early identification of problems that may increase the risk of suicide. We are working to reduce the stigma sometimes associated with seeking help by creating a command climate in which it is not only acceptable to come forward, but is a duty of all Marines through taking care of our own.

Suicides are a loss that we simply cannot accept, and leaders at all levels are personally involved in efforts to address and prevent future tragedies. 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. Thank you again for your concern on this very important issue.

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL
UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: UNITED STATES AIR FORCE SUICIDE PROGRAMS

STATEMENT OF: GENERAL WILLIAM M. FRASER III
VICE CHIEF OF STAFF, UNITED STATES AIR FORCE

29 JULY 2009

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

1. INTRODUCTION

America's Airmen are proud of their contributions to our Nation's defense, responding magnificently to their Nation's call. Yet increasing demands from frequent deployments, increased workload, and other environmental factors such as economic pressures place a heavy burden on our Airmen and their families. As a result, we continue to see evidence of the strain on personal and family relationships, and are witnessing an increase in some negative behaviors and in the psychological injuries borne by our force from the current conflicts. Whether deployed or at home station, there are immense pressures on our men and women in uniform.

As part of our key priority to Develop and Care for Airmen and Their Families, we are dedicated to the well-being of our Airmen and their overall physical and psychological health. The tragedy of suicide has the potential to strike across our Air Force and is not limited to Airmen who have deployed or will deploy, nor is it bound by rank, gender, ethnicity, or geography.

We continue to take aggressive action to deal with these trends, closely monitoring suicide prevention programs and implementing policies benchmarked across the federal government and military Services. Using modern tools to address the total psychological health of all our men and women, Active Duty, Guard, Reserve and Civilian, we are making significant progress in the quality of medical care that our Airmen receive and deserve. Through this Total Force approach, and recognizing that no one is immune to the consequences of this destructive act, we are doing all we can to heighten awareness, focus on prevention, prepare Airmen for deployments and redeployments, support military families, and take care of our Air Force's most vital asset: its people.

2. AIR FORCE SUICIDE TRENDS

We recognize the personal tragedy of any suicide attempt. While any discussion here will necessarily focus on statistics and measure effectiveness through quantifiable data, each case represents a unique scenario and personal crisis for one of our Airmen. Each incident has further dramatic impacts on family, friends, co-workers and the community.

Since the beginning of major combat operations in Iraq, the five year average (CY03-08) for Air Force suicides is 11 per 100,000. The Air Force has averaged 12.4 suicides per 100,000 people (as of 10 July 2009) thus far for Calendar Year (CY) 2009, which matches the overall rate for CY2008. While this rate is still below the adjusted average for American society as a whole, we recognize that even one suicide is too many.

We have unfortunately experienced a small number of suicides thus far in 2009, consistent with identified suicide trends during the full reporting year of 2008, yet across years, we have witnessed some observable patterns. From CY03-CY08, 70% of the Active Duty Air Force suicides had relationship problems, 44% had legal problems, 29% had financial problems, 21% had deployed in the previous year, and 25% were receiving psychological health services. There does not appear to be a strong correlation between deployments and suicide, with only one Airman committing suicide

while deployed in Afghanistan in 2007. Similarly, from CY03-CY08, the most frequent reasons people were seen in mental health clinics have been relationship problems, alcohol abuse or dependence, and adjustment disorders to life stressors. While these numbers are specific to our Active Duty component, we find similar trends across the Air Force Reserve and Air National Guard components of our Total Force.

In response to recent suicides, our Air Force Chief of Staff, General Norton Schwartz, communicated the importance of supporting Airmen in distress to all Air Force Major Command (MAJCOM) Commanders. We have also re-invigorated the components of the Air Force Suicide Prevention Program with a renewed focus in the following areas:

- Male E1-E4s between the ages of 21 and 25 are at the highest risk for suicide.
- Relationship problems continue to be a key risk factor.
- Members who receive care from multiple clinics or agencies are at risk for poor hand-off of care.
- Airmen appear most at risk to commit suicide between Friday and Sunday, highlighting the need by leadership to stress weekend safety planning.
- Good communication between commanders, first sergeants and mental health providers and staff is critical for the success of this team effort.

The senior leadership of the Air Force also continues to closely monitor suicide programs, with the Secretary and Chief of Staff notified immediately on all suspected suicides and receiving weekly updates on suicide incidents and trends. The Air Force Community Action Information Board (CAIB), chaired by the Assistant Vice Chief of Staff, reviews the Suicide Prevention Program quarterly to address continuous improvement of the program and is working to better understand the trends in suicide data.

We are giving renewed attention to the 11 elements in our Air Force Suicide Prevention Program with a leadership emphasis on help-seeking behaviors, stigma reduction, and managing personnel in distress. These initiatives are also informing actions across our force, such as moving mental health care providers to primary care clinics to decrease the stigma of seeking help. Our wingman concept develops a culture of looking out for fellow Airmen, helping to define the community approach to strengthening suicide prevention. We are also standardizing risk assessments and enhancing treatment of suicidal members while providing high-quality annual training on suicide risk factors to all Airmen.

3. The Air Force Suicide Prevention Program

The Air Force has a long history of focusing on suicide prevention and is recognized as a key leader in the field. The Air Force Suicide Prevention Program (AFSPP), first implemented in 1997, is a benchmarked effort in the area of suicide prevention, standing as one of only 12 evidence-based suicide prevention programs identified by the Substance Abuse and Mental Health Services Administration. The program itself is devoted to reducing the number and rate of Air Force suicides, advocating for a community approach to suicide prevention, providing assistance and guidance to

organizations and individuals involved with AFSPP components, and developing responses to reduce the impacts of factors contributing to suicides.

Since implementation, the program has achieved dramatic results. The pre-AFSPP suicide rate from 1987 to 1996 was 13.5 suicides per 100,000. The post-AFSPP suicide rate average from 1997 to 2008 is 9.8 suicides per 100,000, a 28% rate reduction. The AFSPP centers on effective education, detection and treatment for persons at risk, heightening community awareness of suicide and suicide risk factors. Additionally, it creates a safety net which provides protection and adds support for those in trouble.

Recognizing that leadership is necessary for the proper prevention of suicide, the AFSPP is a commander's program, and thus the responsibility of every commander to ensure it is fully implemented as we continue to develop effective tools to assist potential victims. The AFSPP also embraces the Wingman culture, focusing on the total community effort and shared responsibility to use the range of programs available.

3.1 AIR FORCE SUICIDE PREVENTION PROGRAM INITIATIVES

The Air Force Suicide Prevention Program consists of 11 specific policy and training elements which collectively comprise our approach to taking care of Airmen. These initiatives include:

Leadership Involvement. Air Force leaders actively support the entire range of suicide prevention initiatives in the Air Force community. Regular messages from the Air Force Chief of Staff, other senior leaders and commanders at all levels motivate Airmen to fully engage in suicide prevention efforts.

Addressing Suicide Prevention Through Professional Military Education. Suicide prevention education is included in all formal military training.

Guidelines for Commanders: Use of Mental Health Services. Commanders receive training on how and when to use mental health services and their role in encouraging early help-seeking behavior.

Community Preventive Services. Community prevention efforts carry more impact than treating individual patients one at a time. The Medical Expense and Performance Reporting System (MEPRS) was updated to track both direct patient care activities and prevention services.

Community Education and Training. Annual suicide prevention training is mandatory for all military and civilian employees in the Air Force.

Investigative Interview Policy. The period following an arrest or investigative interview is a high-risk time for suicide. Following any investigative interview, the investigator is required to hand-off the individual directly to the commander, first sergeant or supervisor. The unit representative is then

responsible for assessing the individual's emotional state and contacting a mental health provider if any question about the possibility of suicide exists.

Trauma Stress Response (formerly Critical Incident Stress Management). Trauma Stress Response teams were established worldwide to respond to traumatic incidents such as terrorist attacks, serious accidents or suicide. These teams help personnel deal with their reactions to traumatic incidents.

Integrated Delivery System (IDS) and Community Action Information Board (CAIB). At the Headquarters Air Force, MAJCOM, and base levels, the IDS and CAIB provide a forum for the cross-organizational review and resolution of individual, family, installation and community issues that impact the readiness of the force and the quality of life for Air Force members and their families. The IDS and CAIB help coordinate the activities of the various agencies at all levels to achieve a synergistic impact on community problems.

Limited Privilege Suicide Prevention Program. Patients declared at risk for suicide are afforded increased confidentiality when seen by mental health providers as part of the Limited Privilege Suicide Prevention Program. Additionally, Limited Patient-Psychotherapist Privilege was established in 1999, limiting the release of patient information to legal authorities during Uniform Code of Military Justice proceedings.

IDS Consultation Assessment Tool (formerly Behavioral Health Survey). The IDS Consultation Assessment Tool was released in December 2005. This tool, administered upon the request of the commander, allows commanders to assess unit strengths and identify areas of vulnerability. Commanders use this tool in collaboration with IDS consultants and other AFSPP initiatives to design interventions to support the health and welfare of their personnel.

Suicide Event Surveillance System. Information on all Air Force active duty suicides and suicide attempts are entered into a central database that tracks suicide events and facilitates the analysis of potential risk factors for suicide in Air Force personnel.

To further enhance the AFSPP program, we are focusing our prevention efforts on effective detection and treatment. The Air Force implemented computer-based training in 2007 as part of the Chief of Staff's Total Force Awareness Training initiative, and continues to monitor the impact of this training through ongoing research studies. The Air Force has also recently introduced Frontline Supervisors Training to enhance supervisor skills for assisting Airmen in distress.

4. Air Force Support Programs

In support of our AFSPP initiatives, we have developed other programs dedicated to recognizing and aiding Airmen at risk. Our Air Force Community and Family Readiness programs follow a community-based approach and build resilience and strength in Airmen and their families by giving them the skills to adapt to the demands of military life.

These programs provide early interventions to support Airmen and families at risk. They also help families cope with issues such as relocation and transition assistance and assist families with deployment and reintegration. Further, to support our Airmen and their families facing specific challenges, we offer military family life consultants to provide individual, marriage and family counseling; financial education services; and education and advocacy on a number of other areas. Through the Military OneSource program, the Air Force provides an information hotline that is available 24 hours a day, 7 days a week and allows for immediate referrals for non-medical counseling. These programs provide the necessary support networks, education, skill-building services and counseling to help Airmen at risk adapt to their current environment.

4.1 DEPLOYMENT AND PSYCHOLOGICAL HEALTH

The current environment for many of our Airmen is one of increased operational tempo which includes more frequent and longer deployments. We remain mindful of the increased stresses and requirements these place on our Airmen and their families.

The Air Force employs a variety of screening tools to monitor Airmen's health, increase awareness of psychological issues and provide for early intervention when required. All Airmen are screened for mental health concerns upon accession and annually via the Preventive Health Assessment (PHA). Additionally, those that deploy complete a Post-Deployment Health Assessment (PDHA) at the time they leave theater, as well as a Post-Deployment Health Reassessment (PDHRA) 90 to 180 days after returning from deployment. Collectively, these programs screen for a spectrum of mental health concerns, including Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), depression, alcohol use, and family problems.

At an enterprise level, the PDHA identifies Airmen exposed to trauma in theater and tracks symptoms to identify Air Force-wide trends. The PHA/PDHA/PDHRA process facilitates the identification and treatment of Airmen with significant trauma exposure history and/or traumatic stress symptoms. It also increases awareness by commanders and unit members who can refer Airmen to appropriate Military Treatment Facilities.

4.2 LANDING GEAR PROGRAM

Just as an aircraft's landing gear serve as the critical component during launch and recovery, we recognize that the time immediately surrounding departure and homecoming are critical phases of a deployment for Airmen. Our Landing Gear Program, which borrows from benchmarked initiatives of the Army's *Battlemind* program, is centered on effective risk recognition and help-seeking for Airmen during these difficult times. The Landing Gear Program serves as a bridge to care and is designed to increase the recognition of Airmen suffering from traumatic stress symptoms and connect them with helping resources. It provides a standardized approach to the mental health requirements for pre-exposure preparation training for deploying Airmen and reintegration education for redeploying Airmen. Specifically, the program helps Airmen recognize the risk factors, including those associated with deployments, and when and how to get help.

We also recognize the realities Airmen face in theater. Groups at the highest risk include security forces, explosive ordnance disposal crews, medics, Airmen imbedded with other service combat units, and those with multiple deployments or deployments greater than 180 days. This exposure to battlefield trauma places Airmen at risk for PTSD and other mental health problems. Landing Gear is effective at identifying those at risk and getting them the necessary help. Recent data suggests that prompt medical intervention greatly improves the outcomes for Airmen dealing with PTSD and related mental injuries.

4.3 AIR FORCE CHAPLAINS

The Air Force continues to examine a myriad of other outlets for conducting suicide prevention programs, including the use of the Air Force Chaplaincy. Our military chaplains are trained and ready to help Airmen in facing difficult social and domestic issues as well as providing for their spiritual well-being. Chaplains play a critical role for Airmen in all facets of their military career, including counseling activities related to suicide prevention. Chaplains also track data as part of a larger Chaplaincy program to identify trends in suicide interventions, providing confidential communication, and counseling to deal with suicidal tendencies when warning signs are identified.

While Chaplains are often called upon to provide briefings on suicide and grief counseling at the Wing level, the Air Force Chaplaincy has also instituted programs specifically designed to target suicide prevention. The Applied Suicide Intervention Skills Training (ASIST) program, built in conjunction with LivingWorks Education, Inc., prepares Chaplains with tools to intervene appropriately when they recognize suicidal warning signs. ASIST provides Chaplains with tools to be more comfortable, competent, and confident when dealing with at-risk Airmen, and has been provided to all incoming Chaplain and Chaplain Assistants since 2005. The Chaplaincy has also partnered with LivingWorks to utilize their safeTALK program to ensure Air Force personnel are equipped to connect those considered to be at risk with counselors properly trained to provide suicide first aid.

5. PARTICIPATION IN DOD AND VA PROGRAMS

While we continue to make significant progress on suicide and mental health issues within the Air Force, we are fully committed to partnering with our sister Services and Interagency associates. Collaborating with these partners, the Air Force has both shared and adopted best practices across respective suicide prevention offices, including our recent work to benchmark from the Army interactive suicide prevention videos.

At the Department of Defense-level, the Air Force works across the Services and other defense agencies to participate in the medical advances and ground-breaking work that occurs through this collaboration. These mutual efforts include work with the Defense Center of Excellence to address psychological health and traumatic brain injury issues. The Air Force is also fully engaged with the newly forming Defense Health Board Task Force on the Prevention of suicide by Members of Armed Forces, working closely with the task force leadership on identifying new areas for suicide

prevention in the future. In collaboration with other agencies, the Air Force participates in the Department of Defense's Suicide Prevention and Risk Reduction Committee (SPARRC) to share best practices Department-wide. Created in 2001, Air Force representatives meet with other SPARRC members from across the Defense Department to discuss suicide trends and prevention practices and to provide information for their annual report on trends and activities in suicide prevention.

At an interagency level, we are focused on working with the Department of Veterans Affairs to ensure a smooth transition for returning Operation Iraqi Freedom and Operation Enduring Freedom veterans and ensure their continued healthcare. When a deployed Airman is ill or injured, we rapidly respond through a seamless system from initial field response, to stabilization care at expeditionary surgical units and theater hospitals, to in-the-air critical care in the aeromedical evacuation system, and ultimately home to a military or VA medical treatment facility. Our goal is to keep wounded Airmen on active duty until we are assured that they have received all necessary follow up care, and should a combat wounded Airman want to reenlist, we will provide every opportunity for them to remain a part of the Air Force team. To that end, we recently formalized policies that will afford our wounded Airmen opportunities for retention, priority retraining, and promotions.

6. Mental Health Professional Manning

Recognizing the criticality of our healthcare providers in suicide prevention programs, we continue to closely monitor manning issues in our mental health field. Currently, we are at 90% of our total Active Duty manning requirements in our mental health field, meeting the full 100% requirement when supplementing our personnel with contractor support. While this requirement continues to evolve and is closely monitored, we feel that we have the right mix of personnel based on the current requirement. In the uniformed sector, the Air Force capitalizes on Air Force residency programs as a key source of psychologists and psychiatrists, simultaneously providing them training in Air Force issues and their military specialty. Since we rely on our uniformed mental health providers as deployable assets, deploying 18 psychologists, 8 psychiatrists and 12-13 social workers for 179-day rotations, we continue to utilize special pay initiatives, including accession and retention incentive bonuses up to $31,000 per year, to ensure we meet our authorizations and maintain a force able to meet all requirements.

7. Suicide Prevention Working Group

Recognizing the need to continually refine our programs and processes, the Air Force Chief of Staff tasked a collaborative effort between Air Force Safety and the Air Force Surgeon General in February 2009. One month later, the group was officially chartered as the Suicide Prevention Working Group. The working group, tasked with reviewing and enhancing existing suicide prevention efforts, is comprised of representatives from the offices of the Surgeon General, the Director of Safety, the Chief of Chaplains, The Air National Guard, the Air Force Reserve, the Deputy Chief of Staff for Manpower and Personnel, the Judge Advocate General and the Office of Special Investigations. The group recently conducted a top-to-bottom review of all current suicide

prevention policies and procedures, and made additional recommendations to the Vice Chief of Staff which centered on improving policies, training, data collection, education and resourcing.

8. Conclusion

Our Air Force leadership is committed to providing the best possible training and care to our Airmen and their families. We recognize the serious threat that suicide represents to our Airmen and its tragic consequences for Airmen, their families, and our Air Force community. We have seen measurable successes with the programs we have implemented, and we continue to focus on providing every tool to assist Airmen in distress.

The Air Force is proceeding deliberately with programs and policies designed to improve our Airmen's total psychological health, collectively and individually. We are committed to working closely with our DOD and VA counterparts to ensure a continuity of care and treatment options. Caring for our Airmen is a moral duty that we require of ourselves and that the Nation expects. We look forward to executing these programs and supporting our Airmen and their families.

DOCUMENTS SUBMITTED FOR THE RECORD

JULY 29, 2009

Dow Jones Factiva

LOCAL; A

Women veterans address challenges

Erin Pueblo
511 words
25 March 2009
Pacific Daily News, Hagatna
2
English
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Capt. Sheila Compton-Rivo of the Guam Army National Guard said one of the hardest things about being deployed was worrying about her family.

"My husband's (on Guam) with my two daughters, who have a mind of their own, and he's got his own issues and challenges that he faces being both mom and dad," Compton-Rivo said yesterday. "And me, feeling guilty because I'm not there and missing out on major events of my children's lives."

Compton-Rivo was the keynote speaker at the third Women Veterans Conference held yesterday at the Guam Marriott Resort and Spa.

Women who had been deployed with the U.S. military were able to obtain information on readjusting to their civilian lives at the conference, which was held by the Guam Vet Center in conjunction with the Purple Ribbon Campaign and other military and government services on-island.

Compton-Rivo emphasized the importance of understanding the reasons for a readjustment period.

"There's incidents where my daughter would say something and I'd snap. She'd say 'Mom, we're not the enemy. You're at home.'" Compton-Rivo said. "I'm having to readjust to my family ... It was re-entering something totally new, just having to adapt to each other."

She said part of readjusting is accepting how deployment has changed you.

"My outlook on life had changed, all my priorities had now shifted ... Now I have to accept the changes," she said."After I've accepted ... how do I adjust? How do I adapt the changes that I'm bringing home?"

Compton-Rivo recently returned from a one-year deployment in Afghanistan as part of Operation Enduring Freedom. She served as an intelligence/administration officer and Platoon Officer-In-Charge of Alpha Company, the first 294th Infantry Regiment. Sgts. Brian Leon Guerrero and Samson Mora were part of her unit. They were killed in July last year when their vehicle hit a explosive device in Afghanistan.

Cathy Illarmo, team leader for the Guam Vet Center, said the conference was a way to reach out to women veterans. Information about employment opportunities, knowing where to go for help and what services the Veterans Affairs Office offers were available, Illarmo said.

A yoga session was also included in the conference agenda.

"We've been talking about not taking care of ourselves as women ... we hope to sponsor a yoga class," Illarmo said.

The primary service available at the Guam Vet Center is counseling for soldiers and their families, Illarmo said. "We do individual counseling, groups and have recreational activities as well."

According to information provided by the Guam Vet Center, women veterans make up 6.8 percent of the military population and 15 percent of active-duty troops. Currently, the Guam Army Reserve currently has 168 female soldiers.

RESOURCES
Guam Vet Center: 472-7161
Navy Fleet and Family Support Center: 333-2056/57
Guam Veteran's Affairs Office: 475-8388/89
Army National Guard Yellow Ribbon Program: 735-0434
112448062.xml
Document PDNG000020090326e53p00005
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Guampdn.com

July 4, 2009

Family copes with deployment

By Johanna Jorgensen
Pacific Daily News

Imagine one of your immediate family members being deployed with the U.S. military. Now imagine three.

This was a reality for Guam Army National Guard Staff Sgt. Rose Marie Mesa. Mesa, her daughter, U.S. Air Force Sgt. Crysty Sandwick, and son, Guam Army National Guard Sgt. Macario T. Penaflor, who all were deployed at the same time last year.

"I thought my husband was going to have a heart attack," said Rose Marie Mesa. Benjamin and Rose Marie Mesa have eight children, four of whom are under the age of 14.

"All three of us were deployed at the same time to all different corners of the globe," said Rose Marie Mesa. "Each of us defending our freedom in our small way."

Rose Marie Mesa was deployed to Afghanistan with more than 200 other soldiers from Alpha Company, 1st battalion of the 294th infantry regiment of the Guam Army National Guard, according to Guam Army National Guard Public Relations Officer Maj. John Guerrero.

She was deployed with the same unit as Sgt. Brian Leon Guerrero and Sgt. Samson Mora, both of whom died from injuries sustained after their vehicle struck an improvised explosive device in July 2008, according to Pacific Daily News files.

Rose Marie Mesa left with her fellow Guardsmen in February 2008 for Afghanistan after extensive training, she said, adding that it was the first time she was deployed in 15 years with the Guam Army National Guard. It was the third time for Sandwick and Penaflor.

Injury

One morning during physical training in Afghanistan, Rose Marie Mesa got disoriented and her "bones were burning." She then was medivacked to Landstuhl Military Hospital in Germany, and then to Tripler Army Medical Center in Honolulu. After numerous MRIs and CT scans, doctors discovered Rose Marie Mesa had a neck injury. She had neck disc replacement surgery and now has six screws in her neck, said Mesa.

"After surgery I was assigned to the Warriors Transition Unit in Honolulu and will be here for the duration of my treatment," Rose Marie Mesa said.

She has been undergoing physical therapy and numerous other treatments for months now, she said. Benjamin Mesa flew out to be with her in July and has been in Honolulu supporting his wife ever since.

Tripler Fisher House

Rose Marie and Benjamin Mesa have been living at the Tripler Fisher House. Both of the Tripler

Fisher Houses were gifts from the Fisher House Foundation, which began in 1991. The foundation offers service members and their families a home away from home while they are being treated at a near by military medical facility, according to the Tripler Fisher House Web site. The Mesas, like all the other families at Fisher Houses around the globe, stay there free of charge.

"The Fisher House is very family oriented, from the management down to the residents. Everyone here has an injury or illness and are all supporting each other," said Rose Marie Mesa. The Mesas' four younger children all flew to Honolulu in October 2008 to visit their mom, who they hadn't seen since February.

Rose Marie and Benjamin Mesa's four younger children live in the families' home in Dededo with their grandfather.

The Tripler Fisher House Manager Theresa Johnson made her children's stay a lot of fun by bringing toys and making sure everyone was comfortable, said Rose Marie Mesa.

"She's an Army spouse and very well-rounded with the needs of any military individual, be it a retiree or a divorced military spouse," Rose Marie Mesa said about Johnson.

Rose Marie Mesa said she's so thankful for the Tripler Fisher House and the Guam Army National Guard.

"Without being in the Guard, I would have never known about the Fisher House," she said. "Being in the Guard has helped me mold my family and being a part of a whole bunch of people with significant injuries helped me to appreciate life."

Many of the people Rose Marie Mesa met at the Tripler Fisher House have been from Guam -- people from all ethnic groups that retired or live on Guam.

"It's tough. There are times when I just want to throw in the towel," said Rose Marie Mesa. "They're growing up and the only thing holding me back here is my medical issues."

Missing home

Rose Marie Mesa was told in April that she would be able to come back to Guam in June, but her doctors are saying she's not ready to leave yet. She hopes to be back in Guam with her family before the summer ends.

"Every other year, we have a summer family reunion and with three of us deployed last year, we haven't seen each other in two years," said Rose Marie Mesa. Sandwick will be coming to Guam in August from her duty station at Osan Air Force Base in Korea, said Mesa.

"Thanks to my family support on the home front, I can heal faster," said Mesa. "It's easier if you have family homefront support and I've got a very good family homefront support."

Additional Facts

TO THE POINT

- A family deals with the separation caused by having three members deployed with the military.

The Washington Post

Crime Rate of Veterans in Colo. Unit Cited

Soldiers Tell Newspaper of Sharp Rise in Violent Incidents After Iraq Deployments

By R. Jeffrey Smith
Washington Post Staff Writer
Tuesday, July 28, 2009

Soldiers returning from Iraq after serving with a Fort Carson, Colo., combat brigade have exhibited an exceptionally high rate of criminal behavior in their home towns, carrying out a string of killings and other offenses that the ex-soldiers attribute to lax discipline and episodes of indiscriminate killing during their grueling deployment, according to a six-month investigation by the Colorado Springs Gazette newspaper.

Members of the 3,500-soldier Fourth Infantry Division's Fourth Brigade told the publication that the brutal conditions in Iraq from 2004 to 2007 and the Army's failure to provide proper treatment for stress were in part to blame for the incidents of rape, domestic abuse, shootings, stabbings, kidnappings and suicides, the paper said.

Ten of the brigade's members committed or attempted to commit homicides after their return from Iraq, a rate said to be 114 times the murder rate in Colorado Springs, adjacent to the unit's base.

During their deployment, some soldiers killed civilians at random -- in some cases at point-blank range -- used banned stun guns on captives, pushed people off bridges, loaded weapons with illegal hollow-point bullets, abused drugs and occasionally mutilated the bodies of Iraqis, according to accounts the Gazette attributed to soldiers who said they witnessed the events. The unit's casualty rate was double the average for Army combat teams deployed to Iraq and Afghanistan, the paper said.

In December 2007, a member of the brigade wrote senior Army officials about what he described as "war crimes" committed by the unit, including the shootings and dismemberment of a 16-year-old boy and several civilians.

The Army told the newspaper its investigators found no evidence to sustain some of these allegations. Several soldiers involved in improper conduct were dishonorably discharged.

The Army has taken a special interest in the unit's troublesome track record, commissioning a task force that examined eight of the homicides committed after soldiers returned home. It affirmed in a 126-page report this month that "combat exposure/intensity, leadership, and barriers to seeking care" may have increased the risks of "negative outcomes" for ex-soldiers.

Maj. Steve Wollman, who was recently appointed as a spokesman for Fort Carson, said Monday he couldn't "speak to the past, but in the present and future, we are working very hard to provide the best behavioral health for our soldiers and their families." He said efforts were being made to overcome the

stigma attached to applying for mental health treatment, a key problem cited in the Army's task force report.

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WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

JULY 29, 2009

RESPONSE TO QUESTION SUBMITTED BY MR. JONES

General AMOS. Headquarters Marine Corps will coordinate, upon request, to have a command representative from the Operating Forces give a detailed "Death Debrief" to any interested Member or Members of Congress. Such a request should be sent to the Marine Corps Office of Legislative Affairs so that appropriate staff action and coordination can be made.

In the debrief, information such as the Marine's family history, photographs of the incident, and circumstances surrounding the incident will be presented. From the time of death, such a brief may be available to Members of Congress in as few as 8 days; however, this timeline is entirely dependent upon the release of information resulting from the incident investigations. [See page 15.]

RESPONSE TO QUESTION SUBMITTED BY MS. SHEA-PORTER

General CHIARELLI. Of the 696 Army deaths by suicide from January 2003 until July 31, 2009, 114 Soldiers had been diagnosed with a substance related disorder (16.4%). This percentage has been fairly consistent over the past four years, ranging between 13.2% and 20.7%. In the past year, the Army has initiated two major programs to increase our ability to provide substance abuse counseling and treatment in the past year. First, the Confidential Alcohol Treatment and Education Pilot (CATEP) program allows Soldiers who have an alcohol or drug problem to self-refer into, and seek treatment from, the Army Substance Abuse Program without their chain of command notified. The Army will conduct the CATEP program at three installations: Schofield Barracks, Hawaii; Fort Lewis, Washington; and Fort Richardson, Alaska. The pilot program runs through February 24, 2010. Second, the Army has increased the authorization for Substance Abuse Counselors and increased hiring and incentive programs. The goal of both initiatives is to increase access and encourage participation in Army Substance Abuse Program. [See page 29.]

RESPONSES TO QUESTION SUBMITTED BY MS. TSONGAS

General CHIARELLI. The Army has been collecting comprehensive suicide data since 2001 using a formal process that documents completed suicide events. Army Suicide Prevention Program data analysts monitor the Defense Casualty Information Processing System, which is managed by the Army Casualty and Mortuary Affairs Operations Center and captures the cause of death. Data from the Defense Casualty Information Processing System and other Army information systems are acquired and conjoined for a focused review of Soldier data (such as age, marital status, job specialty, deployment, and other service information) to assist in identifying possible trends or common factors that may promote suicidal behavior. The extrapolated data allows Army Suicide Prevention Program data analysts to gather information to include Army commands, installations, and unit assignment of Soldiers who die by suicide. This allows further analysis of potential clustering that may be evident based on common elements within the command or organizational structures of units to which Soldiers are assigned and daily perform their duties. The analysis of data does not infer contagion of suicides in the Army.

In addition to data analysis, the Army has "postvention" activities outlined in Army Regulation 600–63, Army Health Promotion, and Casualty assistance activities outlined in Army Regulation 600–8–1, Army Casualty Program. These activities are required when an individual has attempted or committed suicide. After an attempt, commanders, noncommissioned officers, and installation gatekeepers (those on our camps, posts and stations that interact with the general population on a daily basis—emergency response, chaplaincy, medical, small unit leaders) must take steps to secure and protect such individuals before they can harm themselves and/or others. Other "postvention" activities also include unit-level interventions following suicides, to minimize psychological reactions to the event, prevent or minimize potential for suicide contagion, strengthen unit cohesion, and promote continued mission readiness. [See page 26.]

Admiral WALSH. The record of multiple suicides at the same Navy unit within any 12 month period from 1999–2009 is:

1999	4 units with 2 deaths each
2000	2 units with 2 deaths each, 1 unit with 5 deaths
2001	2 units with 2 deaths each
2002	2 units with 2 deaths each
2003	2 units with 2 deaths each
2004	1 unit with 2 deaths
2005 to 2006*	2 units with 2 deaths each
2007	4 units with 2 deaths each
2008	none
2009	2 units with 2 deaths each

* Deaths occurred less than 9 months apart, crossing calendar years

With the exception of the five deaths at Service School Command Great Lakes in 2000, there have been no instances that qualify as suicide clusters. In that instance the Sailors were assigned to four different training programs within the Service School Command.

Although suicide clusters (multiple suicides in the same place in a short period of time) are rare, there is research in the field that documents an elevated lifetime risk of suicide for those individuals exposed to suicide in the workplace or in family or close friends.

Any suicide impacts the members of a unit; consequently, prevention is key. Navy has trained Suicide Prevention Coordinators at each command to assist Commanding Officers in implementing a command level prevention program. Each command is required to have a written crisis response plan. Navy has a holistic prevention program that ranges from resilience building to vigilance and early intervention, crisis response, and "post-vention."

In the aftermath of a suicide loss, Navy focuses on "post-vention" activities as critically important to suicide prevention efforts, and vital to the morale, welfare and mission readiness of those exposed to the suicide. An assessment is conducted to determine the requirements for supportive interventions for the unit and its individual members. The unit then coordinates with all command and local resources, including Chaplains, Fleet and Family Support Counselors, and Special Psychiatric Rapid Intervention Teams (SPRINT) for the provision of individual and unit support, grief counseling and mental health support. [See page 26.]

General AMOS. From January 2007 through October 2009, there were 117 suicides spread out across 108 different units. 8 of the 108 battalion/squadron sized units experienced more than one suicide within a given year. Seven of the eight had two suicides and one of the units had three. Most of the suicides within a battalion were spread out across the year by 3–8 months. Only two of the units experienced two suicides within the same month.

A review of the specifics of the suicides that occurred within the same unit within the same month, demonstrates:

- The suicides did not occur in the same locations
  - Battalion I: suicides occurred in Rhode Island and North Carolina;
  - Battalion II: suicides occurred in California and Texas
- Communication with commands confirmed that their investigations concluded that the cases were unrelated. [See page 26.]

General FRASER. A review of Air Force suicides from 2003 through 2008 shows 6 incidents in which two suicides occurred on the same base, using the same means within a three month period. In all but one of these cases the method of suicide was gunshot (by far the most common means of suicide in the AF). There do not appear to be other links between these cases to suggest that they were "copy cat" suicides. [See page 26.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

JULY 29, 2009

QUESTIONS SUBMITTED BY MR. WILSON

Mr. WILSON. In a recently published article in Joint Force Quarterly, author Colonel Drew Doolin discusses military mental health services and psychological wellness programs that are available to military commanders today. Colonel Doolin asserts that although the services have several good programs aimed at helping commanders and troops deal with psychological stress, the services have failed to get the word out on each program. How does each of the services publicize these programs? What are you doing to make sure service members at all levels and their families know about your programs and know how to access these services?

General CHIARELLI. The Army is making a significant effort at the national and local levels to inform Soldiers and Families about our behavioral health programs and to reduce the stigma associated with seeking help. We have developed a Strategic Communications Plan to publicize relevant programs and ensure Soldiers and their Families are aware of available resources. This plan addresses national and local opportunities to disseminate information to Soldiers and Families. At the national level, Army Senior Leaders discuss behavioral health programs in testimony before Congress, in national conferences with military and civilian audiences, and in media roundtables with national publications. The Army Home Page, the Army STAND-TO!, and other print and electronic information venues managed by Headquarters, Department of the Army, regularly highlight behavioral health programs and resources available to Soldiers.

In 2007, the Army Chief of Staff directed that all Soldiers in every component of the Army participate in a chain teaching program on post traumatic stress disorder and traumatic brain injury. This chain teaching program detailed the steps Soldiers should take if they identified concerns about themselves or their buddies. This program has since been incorporated into the Battlemind Training Program that is required for all deploying and redeploying Soldiers and is also available for family members.

At the local level, garrison, hospital, and unit commanders use a host of venues to publicize behavioral health programs. All newly arriving Soldiers at Army installations are required to attend newcomer's briefings as part of their inprocessing. Installation and unit newspapers are a great source of information, as are billboards, flyers, and brochures. All hospital and garrison commanders conduct regular Town Hall meetings that are open to all Soldiers and Families. These events feature briefings, displays, and discussions concerning community programs and services. Concurrent with each of our publicity efforts for specific behavioral health programs, we are sending the overarching message that seeking help for behavioral health concerns is a sign of strength.

Mr. WILSON. General Chiarelli, your testimony includes your assurance that Army senior leaders consider addressing the critical shortfall of uniformed health care providers a priority. However, I understand that the Army plans to increase the operating force by approximately 12,000 soldiers by the end of fiscal year 2010. At the same time the Army plans to decrease the generating force, which includes medical personnel, by approximately 6,200 by the end of fiscal year 2010. Given your testimony, would any of the 6,200 reduction be medical personnel? Along with your testimony today, the Sergeant Major of the Army testified last week before this committee that the Army needs more medical providers. How will the Army maintain the number of mental health personnel to meet the needs of this larger force?

General CHIARELLI. The Army is committed to meeting the health care and behavioral health needs of all Soldiers and family members. In order to meet the health care needs of the growing force, the Army is increasing the number of health care professionals in both the operating force and the generating force. This includes increasing military billets and pursuing additional civilian personnel.

Our of our highest priority requirements is for behavioral health providers. For the operating force, Army is investing over 1,000 Behavioral Health Specialists into Brigades across all three components. Although the Army is adjusting the generating force, our medical structure will not be decreased. In fact, as a result of the recently concluded Total Army Analysis review of the generating force, an additional

545 military billets have been allocated to the U.S. Army Medical Command (MEDCOM) to support the increase in medical workload. Assessment by specialty and location on how best to distribute the 545 is currently on-going. This growth is in addition to the previous alignment by the Army to MEDCOM of 738 additional military spaces in FY08 and 554 military spaces in FY09. These increases in FY08 and FY09 included 24 psychiatrists, 19 social workers, 12 psychologists, and 100 enlisted mental health specialists. In conjunction with these increases in military billets, the MEDCOM is actively recruiting civilian and contract providers to fill all of the anticipated requirements to support the growing Army. Current shortfalls in the medical workforce include primary care physicians (family practice, pediatrics, and internal medicine), as well as behavioral health professionals (psychiatrists, psychologists, and psychiatric health nurses).

To retain military behavioral health personnel, we are successfully employing a variety of special pays and bonuses targeted at psychiatrists, clinical psychologists, psychiatric health nurses, and social work officers. Participation among officers eligible to contract for special pays and bonuses ranges from 75% to 95%. To recruit military behavioral health personnel, we offer accession bonuses and participation in the Active Duty Health Professions Loan Repayment Program, which offers a maximum of $40,000 annually for fully qualified applicants.

The Army Medical Department Center and School and Fayetteville State University developed a partnership in February, 2008, to establish the U.S. Army-Fayetteville State Master of Social Work Program. The graduate social work program was created as a force multiplier to offset the decrement of licensed clinical social workers available in the active duty Army inventory. The program graduated 15 social workers last year and has a class of 13 students this year.

The Army has also made significant efforts to contract for or hire civilian behavioral health professionals to augment our military providers. Over the last two years, the Army has increased our pool of military, civilian, and contract behavioral health providers by 48 percent and we continue to pursue hiring actions. During that same timeframe, TRICARE, the Department of Defense healthcare program for members of the uniformed services, their families, and survivors, increased its network of behavioral health providers by over 25 percent.

Additionally, the Army uses virtual technology to expand our current capabilities for providing behavioral healthcare. We currently have a number of telehealth programs and are planning to expand our capability to support care for warriors with traumatic brain injury and post traumatic stress via telehealth. A Virtual Behavioral Health Pilot Program was recently conducted in Hawaii to determine the effectiveness and technical requirements for virtual BH counseling. Initial results are highly encouraging and we plan to expand the program to additional sites.

On August 1, 2009, TRICARE expanded its services to include two new online video BH programs. The two online video programs are TRICARE Assistance Program (TRIAP) and Tele-behavioral Health which have both been developed to help eliminate obstacles to seeking BH treatment. Both programs are available to active duty service members and their Families. TRIAP and Tele-behavioral Health have the combined capability to provide secure online Internet therapy with licensed BH counselors located throughout the United States. Through these programs Soldiers and Families anywhere in the world can access licensed BH counselors for short-term, real-time, face-to-face confidential counseling utilizing video technology and software such as Skype or iChat.

Mr. WILSON. General Colleen McGuire, who heads the Army's Suicide Prevention Task Force, was quoted recently saying, "we have young leaders who have not been trained in the art of . . . just taking care of soldiers." General Chiarelli, what is your assessment of her statement? How does the Army balance the time it takes to develop young leaders with the time it takes to prepare for combat? I am interested to hear from the other service leadership if they are faced with a similar challenge.

General CHIARELLI. I think the Army does a very good job of developing leaders even as we prepare for war. However, we may be neglecting the art of garrison leadership. Our programs that care for Soldiers have not evolved to keep up with the constant transitions that are the hallmark of our expeditionary Army, and many of our young leaders who have spent the majority of their time in a combat environment may not be familiar with the programs that translate well to a garrison environment.

We do face some challenges in getting our leaders trained on leadership skills required for taking care of our Soldiers due to the operational demands. The foundational education and training on the art of taking care of Soldiers is normally provided in formal Army schools, specifically Basic Officer Leader Course (BOLC) for lieutenants and warrant officers and the Warrior Leader Course for noncommis-

sioned officers (NCOs). Lieutenants and warrant officers attend the BOLC prior to being assigned to their first units. The foundation of this training is aligned with the Army's Strong Bonds, Suicide Prevention, and Battlemind for Leaders programs.

The reality is that many of the Army's junior NCOs are serving in leadership positions without having received formal leadership education because of the operational requirements.

The Army is striving to balance training, education and experiences for our leaders. In the relatively short periods of time spent in Professional Military Education provide theory, conceptual information, doctrine, policy, and lessons learned. The actual application and mastery of leadership skills are achieved during operational assignments while preparing for combat or while deployed for combat.

QUESTIONS SUBMITTED BY MR. LOEBSACK

Mr. LOEBSACK. What steps are the Services taking to assure that military kids, including those whose parents are in the Reserve Components, have access to mental health care?

General CHIARELLI. The Army is currently working to eliminate the barriers that exist for providing timely, convenient, and appropriate behavioral health (BH) services for all military children of active, Army Reserve (USAR) and Army National Guard (ARNG) Soldiers. Current initiatives include the Military Child and Adolescent Center of Excellence (MCA CoE), school BH programs, and the opening of Child and Family Assistance Centers. Although the Army is leaning forward with these initiatives, we recognize that gaps remain, especially for children of those in the Reserve Components (RC).

The Army Medical Command (MEDCOM) approved the development of the MCA CoE, a center that focuses on interventions, programs and policy to combat the impact of being a military child with a parent deploying, wounded, or killed in action. MCA CoE will execute a plan that provides support for the development of direct BH support for Army children and their families at large deployment installations.

The MCA CoE concept for the delivery of BH care is to: (1) provide a diversity of BH resources/services for Army children and Families, including school BH, integrated under a single umbrella organization; (2) facilitate the coordination of services and improve capacity and access to BH care; (3) reduce stigma associated with behavioral healthcare; (4) provide Outreach Community Services/Programs to promote resilience and well-being throughout the Army community; and (5) train pediatricians and family practice providers in early identification and treatment of common BH concerns. The MCA CoE will also develop a database of current standards of care for use by other military youth-serving professionals across the country. Emphasis will be placed on following military youth longitudinally over deployment cycles and beyond to comprehensively describe deployment impact, parental injury or death on children and adolescents and to discover unique protective and risk factors among military Families.

The Army is also working through the MCA CoE to streamline existing BH support services for children by funding five school BH programs. The programs are family-centered and will provide support for children attending schools on military posts. The current locations are Landstuhl Army Medical Center, Germany; U.S. Army Medical Clinic, Vilseck, Germany; Tripler Army Medical Center, Hawaii; Walter Reed Army Medical Center, Washington, DC; and Blanchfield Army Community Hospital, Fort Campbell, Kentucky. Madigan Army Medical Center, Fort Lewis, Washington, is on track to begin a program in the coming year. The programs in Germany are just beginning, but the other three are already well established.

Children of RC Soldiers may be eligible for BH services through TRICARE, the Department of Defense's healthcare program for members of the uniformed services, their Families, and survivors. Through enrollment in TRICARE Reserve Select (TRS) or the Transitional Assistance Management Program (TAMP), children of RC Soldiers may receive BH services.

TRS is a premium-based health plan that qualified ARNG and USAR members may purchase. TRS, which requires a monthly premium, offers coverage similar to TRICARE Standard and Extra. To qualify for TRS, RC Soldiers must be a member of the Selected Reserve of the Ready Reserve (participate in monthly drills).

TAMP provides 180 days of transitional health care benefits to help uniformed services members and their Families transition to civilian life. Generally, TAMP coverage is available to ARNG and USAR service members who are separating from the ARNG or USAR after a period of active duty that was more than 30 consecutive days in support of a contingency operation.

Additionally, dependents are authorized 12 sessions of BH from the Military OneSource, which is provided to all dependents regardless of the Soldier's service, component, or duty status. All dependent behavioral health services are contracted with a licensed therapist in the family member's local community. Dependents are entitled to 12 sessions per concern, so if the family member is experiencing depression and later on becomes fearful of an upcoming parental deployment, he or she could be seen for 12 sessions per issue.

The MCA CoE has dedicated a section in their organization to outreach in support of military children of ARNG and USAR Units. Short term plans are to provide educational programs to parents and school staff serving these children, on issues such as "The effects of Deployment on Children," "Children and Reunion," "Rumors During Deployment," etc. Tripler Army Medical Center already has begun reaching out to the Guard/Reserve on the islands neighboring Oahu. The MCA CoE is also developing a video tele-health program to evaluate and treat children in remote areas. Efforts are being made to develop this program in the State of Washington and expand into other areas as the program develops.

Mr. LOEBSACK. What, if any, efforts are being undertaken to address the correlating impact on children when a servicemember is determined to be suffering from PTSD or when they are recovering from a significant injury?

General CHIARELLI. The Army provides inpatient and outpatient behavioral health (BH) care as well as medical treatment by healthcare professionals who have been trained to address the impact of post traumatic stress disorder (PTSD) and significant injury on military children and Families. These services are provided through installation medical treatment facilities (MTF).

The Army has instituted PTSD training for health care providers so they can accurately diagnose and treat combat stress injuries as well as address the impact on children and Families. The Army additionally leverages local healthcare providers in the surrounding communities through the TRICARE Network system, which includes professionals who specialize in trauma, family, and child BH issues.

In addition to the behavioral health programs for military children and adolescents, Walter Reed Army Medical Center Child and Adolescent Psychiatry created Operation Brave Families in 2003. The program aims to build resilience, value, and empower Families. Operation Brave Families assists military Families with communicating to children about wartime injuries and illnesses, emphasizes optimal parenting and family communication, and facilitates optimal adjustment to changes due to physical injuries and/or psychological conditions.

Operation Brave Families offers a full range of services for any emotional problems children and parents may experience. Services include therapeutic art sessions, therapeutic play sessions, education, individual and family supportive therapy, case management assistance, and referrals as needed. Treatment is provided by a multidisciplinary team that includes a psychiatrist, psychologist, social worker, art therapist, and a child activity specialist. In addition, the program offers flexible and mobile services allowing staff to provide support at hospitals, lodging facilities, Fisher Houses, or Child and Adolescent Psychiatry clinics. A similar program has been modeled at Fort Sam Houston and other installations.

Mr. LOEBSACK. What steps are the Services taking to assure that military kids, including those whose parents are in the Reserve Components, have access to mental health care?

Admiral WALSH. Meeting the mental health care needs of military children is a priority for Navy Medicine. In order to meet this need services are provided by Military Treatment Facility (MTF) providers, TRICARE network providers, contract providers working specifically with the Reserve Components, and counselors working for Navy, Marine Corps and Joint Family Support programs.

Navy MTFs work closely with the Managed Care Support Contractors to optimize provision of child mental health services for active duty and retired family members when the indicated services are not available in the MTF. Additionally, case managers and social workers are available to assist in finding network services to provide mental health care.

There are several TRICARE/TMA mental health specific programs. Most recently, TRICARE Assistance Demonstration Project (TRIAP) and Tele-Mental Health programs have been developed and marketed. Under TRIAP, licensed professionals assess and deliver short-term, non-medical counseling that consists of one-on-one private, non-reportable conversations. This is a free service for beneficiaries (no billing for the service).

Navy Fleet and Family Service Centers and Marine Corps Community Service Centers also provide professional counseling for children and families. Additionally, Commander Navy Installations Command, the Navy Reserve Forces Family Support Coordinator and the five regional Family Support Administrators work closely with

Ombudsmen at each command to ensure families are aware of these services. Together they facilitate the connection of reserve families to each other, to supportive military and community resources and improve community awareness of military families' experiences and needs. The primary focus of these efforts is to support families living apart from military installations. The Family Support Administrators liaison with their assigned Navy Operational Support Center (NOSC) staffs to ensure families are supported by Navy and other services' family support programs, including the Joint Family Support Assistance Programs (JFSAP). All of our Fleet and Family Support programs are designed to provide high quality service to both the Active and Reserve components of the Total Force.

The Navy Reserve Psychological Health Outreach Program (PHOP) was established in 2008 to provide early identification and clinical assessment of Navy Reservists returning from deployment who are at risk for not having their stress injuries identified and treated in an expeditious manner. This program also provides outreach and educational activities to improve the overall psychological health of Navy Reservists and to identify long-term strategies to improve psychological health support services for the Reserve community. The PHOP facilitates access to psychological health support resources for Reservists and family members.

Mr. LOEBSACK. What, if any, efforts are being undertaken to address the correlating impact on children when a servicemember is determined to be suffering from PTSD or when they are recovering from a significant injury?

Admiral WALSH. Mental Health Providers in Navy Military Treatment Facilities (MTFs) address the specific needs of our wounded warriors, including those suffering from PTSD. In the Navy tertiary care centers consult teams meet regularly with these families. These teams consist of a health educator who assists in training the families of wounded service members, and a child/adolescent social worker who is trained to deal specifically with children.

We also have counseling services for children by licensed professional counselors in our Navy Fleet and Family Service Centers (FFSC) and Marine Corps Community Service Centers. Navy Command Ombudsmen are also trained to refer families with concerns about the impact a parent with PTSD or other injury has on children to these counselors for services.

Additionally, FFSC staff work closely with the Navy Reserve Forces Family Support Coordinator to facilitate the connection of reserve families to supportive military and community resources including the Joint Family Support Assistance Programs (JFSAP). All of our Fleet and Family Support programs are designed to provide high quality service to both the Active and Reserve components of the Total Force.

Although FFSC deployment staff have always worked with families through the cycles of deployment, a growing awareness of the significant challenges of these deployments on military family life and child and family well-being prompted a recent initiative by the Department of Navy Bureau of Medicine and Surgery called FOCUS (Families OverComing Under Stress). FOCUS provides state-of-the-art family resiliency services to military children and families at selected installations.

Topics including PTSD and other injuries impact on families are addressed during Returning Warrior Workshops to assist returning Sailors with reintegrating with their families and communities, and to better understand the resources available to them. Additionally, the Psychological Health Outreach Program (PHOP) workers ensure coordination of access to psychological health support resources for Reservists and their Family members.

Finally, in an ongoing effort to fully understand the Navy and Marine Corps family, Navy Medicine has embarked in a collaborative effort with the Military Family Research Institute of Purdue University to assess the needs of our Navy and Marine Corps families and to ensure that programs, policies and practices fulfill the needs of all families.

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Mr. LOEBSACK. What steps are the Services taking to assure that military kids, including those whose parents are in the Reserve Components, have access to mental health care?

General FRASER. Within the continental U.S., the vast majority of mental health care for Air Force family member-children is delivered within the TRICARE network. TRICARE service delivery is managed by regional contractors who determine the number of network providers of any given type within their region and work to maintain the adequacy and quality of the panel of providers. Family members enjoy the unique benefit of being able to seek mental health care for eight sessions of outpatient behavioral health care without prior approval or a referral. Active duty service members (including activated National Guard/Reserve members) and their families enrolled in TRICARE Prime or TRICARE Prime Remote can get assistance in setting up behavioral health appointments by calling the regional contractors' Behavioral Health Provider Locator and Appointment Assistance Service:

- North Region: 1–877–747–9579 (8:00 a.m.–6:00 p.m.)
- South Region: 1–877–298–3514 (8:00 a.m.–7:00 p.m.)
- West Region: 1–866–651–4970 (24 hours per day)

Family members of the Reserve and Guard have these same benefits when their sponsor is activated and up to 90 days prior. Resources available to Reserve and Guard families are essentially identical to the families of active duty Airmen if their sponsor purchases TRICARE Reserve Select.

There is a nation-wide shortage of qualified mental health providers for children. In many rural locations the situation is worse. This is why the Services' special needs identification programs are so important. Once a family member is identified as having a need for a particular type of specialty care, those needs are reviewed before a family is given a new assignment.

TRICARE has recently expanded its telemental health network and has launched a particularly interesting pilot program known as the TRICARE Assistance Program (TRIAP) web-based counseling and referral initiative, which permits eligible family members to receive counseling services from a licensed professional mental health provider and be referred to formal mental health care if such care is indicated. Parents could use such a service to discuss behavioral problems arising in their children to better understand the need for further care.

Other resources available to families include counseling through Military OneSource, Chaplains, and Military Family Life Consultants—all of whom may refer the family to seek more formal mental health treatment if necessary through consultation with their primary care manager or by contacting a TRICARE mental health provider directly.

Mr. LOEBSACK. What, if any, efforts are being undertaken to address the correlating impact on children when a service member is determined to be suffering from PTSD or when they are recovering from a significant injury?

General FRASER. The Air Force offers a variety of programs and services to meet the needs of children of wounded warriors.

Airman and Family Readiness Centers (A&FRCs) have many resources for families of deployed or injured Airmen and their family members. Information may be delivered in an individual, family or group format and may cover such issues as deployment, grief and loss, daily life issues, marriage and relationship issues and parenting. Through the A&FRCs, Military and Family Life Consultants (MFLCs) meet confidentially with service members, spouses, family members and children.

The Air Reserve Component's Yellow Ribbon Campaign provides informational events and activities for the members of the reserve component, their families, and community members to facilitate access to services supporting their health and well-being through the phases of the deployment cycle.

Depending on the injury or illness, an Airman may have a Family Liaison Officer (Survivor Assistance Program), Recovery Care Coordinator and/or Medical Case Manager; these individuals frequently help the family identify issues and suggest care for a family member.

The Air Force actively collaborates with its sister services and the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (DCoE). One recent initiative of the DCoE has been its project with the Sesame Workshop to produce the "Family Connections" website with Sesame Street-themed resources to help children cope with deployments and injured parents. In addition, DoD-funded websites, such as *afterdeployment.org,* provide specific information and guidance for parents/caregivers to understand and help kids deal with issues related to deployment and its aftermath.

In consultation with parents, a child's physician (primary care manager) frequently is able to identify issues and refer the child for care when necessary. Typically, formal mental health treatment is delivered through the TRICARE network—families can seek up to 8 visits without a referral or the need for prior approval.

Other sources of counseling available that could benefit children of wounded Airmen include support through a chaplain, counseling provided through Military OneSource providers, and the TRICARE Assistance Program, offering online counseling and referral.