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THE INCIDENCE OF SUICIDES OF UNITED STATES SERVICEMEMBERS AND INITIATIVES WITHIN THE DEPARTMENT OF DEFENSE TO PREVENT MILITARY SUICIDES

HEARING

BEFORE THE

SUBCOMMITTEE ON PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

MARCH 18, 2009

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THE INCIDENCE OF SUICIDES OF UNITED STATES SERVICEMEMBERS AND INITIATIVES WITHIN THE DEPARTMENT OF DEFENSE TO PREVENT MILITARY SUICIDES

WEDNESDAY, MARCH 18, 2009

U.S. SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The subcommittee met, pursuant to notice, at 3:34 p.m. in room SH–216, Hart Senate Office Building, Senator E. Benjamin Nelson (chairman of the subcommittee) presiding.

Committee members present: Senators E. Benjamin Nelson, Levin, McCaskill, Hagan, Begich, Graham, Thune, and Collins.

Committee staff members present: Richard D. DeBobes, staff director, and Leah C. Brewer, nominations and hearings clerk.

Majority staff members present: Jonathan D. Clark, counsel; Gabriella Eisen, counsel; Gerald J. Leeling, counsel; and William K. Sutey, professional staff member.

Minority staff members present: Joseph W. Bowab, Republican staff director; Diana G. Tabler, professional staff member; and Richard F. Walsh, minority counsel.

Staff assistants present: Jessica L. Kingston, Christine G. Lang, and Ali Z. Pasha.

Committee members' assistants present: Jay Maroney, assistant to Senator Kennedy; Thomas L. Gonzales, assistant to Senator Byrd; Ann Premer, assistant to Senator Ben Nelson; Gordon I. Peterson, assistant to Senator Webb; Stephen C. Hedger, assistant to Senator McCaskill; and Michael Harney, assistant to Senator Hagan; Clyde A. Taylor IV, assistant to Senator Chambliss; Adam G. Brake, assistant to Senator Graham; Jason Van Beek, assistant to Senator Thune; Brian W. Walsh, assistant to Senator Martinez; and Chip Kennett, assistant to Senator Collins.

OPENING STATEMENT OF SENATOR E. BENJAMIN NELSON, CHAIRMAN

Senator BEN NELSON. Good afternoon. I apologize for the delay. These votes somehow get in the way of the rest of our business. I appreciate everyone's patience. I'm happy to see you all here, and I look forward to the testimony.

As the Personnel Subcommittee hearing comes to order, we meet today to receive testimony on the incidence of suicides among

United States servicemembers and initiatives within the Services and the Department of Defense (DOD) to prevent military suicides.

I'm honored to welcome back Senator Graham as this subcommittee's ranking member. Senator Graham will be joining us shortly. He and I, along with the rest of the subcommittee, intend to do everything we can to ensure that our servicemembers and their families are well taken care of.

We've been alarmed, like the rest of the Country, at the rising rates of suicide by military servicemembers. Between 2007 and 2008, suicide rates per 100,000 personnel have increased in every Service: from 16.8 to an estimated 20.2 in the Army; from 11.1 to 11.6 in the Navy; from 16.5 to 19 in the Marine Corps; and from 10 to 11.5 in the Air Force. These numbers indicate that, despite the Services' best efforts, there's still much work to be done to prevent military suicides.

Each of these deaths marks a life filled with potential but cut short by personal torment. Each marks a family confronted by loss and grief. Each marks the sad end of an American who nobly served our Country and preserved the freedoms we all cherish. Each marks the responsibility we all have to our men and women in uniform today to help those who are troubled so that they don't become the tragedies of tomorrow.

About a year ago, on February 27, 2008, we held a Personnel Subcommittee hearing where the issue of suicide was discussed. I raised several points that I felt needed further explanation, and I asked personnel leaders of the Service branches to discuss their suicide prevention programs, the challenges they face, and successes they had achieved. I was told that there was a focus on removing the stigma associated with seeking mental health support, and that there was no data tracking the high operations tempo with an increase in suicides. So, one purpose of this hearing is to find out where we stand on those issues, what progress has been made, if any, to reduce military suicides, what challenges remain, and to determine whether Congress needs to take any action to reduce these troubling incidents in the future. We know that more is needed, and it's needed now. That's why we're here today because the suicide rates are going up, not down. The question is: What can we do right now to address this problem?

There are several risk factors that experts say may increase a person's risk of committing suicide, regardless of whether they're military or civilian. Financial troubles, marital and relationship issues, and legal or disciplinary problems are all common factors to incidents of suicide. In addition to these common factors, military service adds unique stressors. Undoubtedly, repeated and extended deployments and the intensity of the conflicts in Iraq and Afghanistan are taking a toll on the mental health of our troops and their families. This hearing will help all of us understand what initiatives and programs each Service, as well as the DOD, has in place to prevent suicide among servicemembers, and what improvements can be made.

We know there's a shortage of mental health providers, that a stigma still lingers in the military—and in our culture, for that matter—against seeking mental health help, and that we're not doing enough to treat overall force wellness. Approximately 2 years

ago, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury was created. I want to understand what we can do today to treat and care for our servicemembers to ensure the overall health and wellness of our Armed Forces.

On our first panel, we are pleased to welcome Senator Cornyn, who, while, unfortunately, is no longer a member of the Senate Armed Services Committee, continues to be a tireless advocate for our servicemembers. Senator Cornyn has been closely following the investigations of suicide of four recruiters in the Army's Houston Recruiting Battalion since 2005. In response to our concerns about the stress that our military recruiters deal with on a daily basis, especially in the Army, we have the commanding general of U.S. Army Accessions Command here to discuss these deaths and other aspects of recruiting assignments and duty that may warrant special attention by the services.

Senator Cornyn, thank you for taking the time to be with us today. We look forward to your testimony on this issue and your participation in today's hearing.

For our second panel, the Vice Chiefs of Staff of each service will discuss suicide prevention initiatives and programs in their respective Services. I'll introduce them when the second panel convenes.

On our third panel, we have various representatives from Army leadership who will discuss more specific aspects of suicide policies and programs in the Army, as well as a representative from DOD who will speak to DOD suicide prevention initiatives and research. Also on the final panel, we're honored to have a civilian witness from the Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA). I'll introduce these witnesses when we begin the third panel.

We look forward to learning what policies, programs, and initiatives each of the Services, as well as DOD, has implemented and identified to ensure that our servicemembers in both the Active Duty and Reserve components, and their families, remain resilient, and that our All-Volunteer Force can continue to perform its mission, with the help and support of the services that they need and deserve.

In the National Defense Authorization Act for Fiscal Year 2009, Congress attempted to help open the lines of communication on best practices across the Services and throughout DOD by requiring the Department to establish a suicide task force to address these issues on a larger scale. While we consider the establishment of this task force a priority, and we're eager to hear about the status of that this afternoon, we expect the Services to continue to intervene with urgency to reverse the trend of increasing servicemember suicides. The numbers in every Service have increased in the past 2 years and that trend must not continue. We must pay particular attention to the Army and Marine Corps, as their rates of suicide have increased more than other Services. While these rates are disheartening, the truly distressing factor is that, in the first 2 months of this year, January and February, the Army's actual numbers of suicides have dramatically increased. There are reasons that the Army's numbers are the highest, but the problem is not isolated. Perhaps, today, each of the Services

can share best practices learned thus far in their work on suicide prevention and what actions may be taken at this time to combat the problem.

So, I want to thank all of our witnesses in advance today for being here.

Senator Graham is not here for an opening statement, but the chairman of the Senate Armed Services Committee, Senator Levin, is here, and I would ask him if there are any opening statements he might make.

STATEMENT OF HON. CARL LEVIN, U.S. SENATOR FROM THE STATE OF MICHIGAN

Senator LEVIN. Thank you, Senator Nelson. I will be very brief, and ask that you put my entire statement in the record.

I want to thank you, first, for holding this hearing at your subcommittee. The Personnel Subcommittee is a subcommittee which is critically important to us, focusing on the kind of issues that dramatically impact our personnel.

As you pointed out, the increase in suicides of military personnel in the last few years is alarming. In 2006, 102 Army soldiers committed suicide. That number was 128 in 2008. Twenty-five marines committed suicide in 2006, 41 in 2008. There are a number of additional cases where the Armed Forces medical examiner has not yet concluded whether the deaths are by suicide, so the 2008 numbers will likely be even higher.

We owe maximum efforts to the men and women who wear our uniform who are, tragically, the victims of suicide, their loved ones, and the communities which love them so much.

Senator Cornyn, welcome back to our committee for this hearing. You've been especially concerned about this issue, including that spike of recruiters from the Army's Houston Recruiting Brigade who committed suicide between January 2005 and September 2008.

Congress has recognized the strain on our ground forces and has authorized increases of 65,000 soldiers in the Army and 22,000 in the Marines. It is one way, hopefully, of reducing the stress upon them. It is our intent that these increases will help to relieve the stress on our forces, but we also have to make sure that the Department is able to provide all of the assistance to our troops that they need to cope with the stress that they are facing and have experienced.

We have an increasing number of troops returning from combat with post-traumatic stress disorder (PTSD), a condition that many believe contributes to the increase in the number of suicides. I know that many are reluctant to seek help because they perceive a stigma will attach to them when they receive mental health care. We have to eliminate that stigma.

I was very pleased to learn, recently, that two Army generals have publicly acknowledged that they have sought counseling for the emotional trauma they experienced as a result of deployments to combat areas. One of them, Brigadier General Patton, said, "We need all of our soldiers and leaders to approach mental health like we do physical health. No one would ever question or ever even hesitate in seeking a physician to take care of their broken limb

or gunshot wound or shrapnel or something of that order. We need to take the same approach towards mental health."

Finally, we're here because the American people want us to do everything that we can to support our troops. We're here to learn how we can translate that support and respect of the American people for our troops into the reduction of the number of suicides.

Suicide is, first and foremost, a tragic loss of an individual and a tragedy for the family and friends of the person who took his own life, but it is also a tragedy for our Nation.

Again, I want to thank you and thank our witnesses and, again, welcome our colleague, Senator Cornyn.

[The prepared statement of Senator Levin follows:]

PREPARED STATEMENT BY SENATOR CARL LEVIN

Thank you, Senator Nelson, for holding this very important hearing.

The increase in suicides by military personnel in the last few years is alarming. In 2006, 102 Army soldiers committed suicide; 115 in 2007; and 128 in 2008. This translates to an increase in suicide rates per 100,000 of 15.3 in 2006; 16.8 in 2007; and 20.2 in 2008. Similarly, 25 marines committed suicide in 2006; 33 in 2007; and 41 in 2008. This is a suicide rate per 100,000 of 12.9 in 2006; 16.5 in 2007; and 19 in 2008. I understand that there are a number of additional cases where the Armed Forces Medical Examiner has not yet concluded whether the deaths are by suicide, so the 2008 numbers will likely be even higher. These increases are not acceptable! We must improve our suicide prevention efforts to reverse the number of servicemembers taking their own lives.

Senator Cornyn, welcome back to the committee for this hearing. I know that you have been very concerned about a spike of recruiters from the Army's Houston Recruiting Brigade committing suicide. Four suicides between January 2005 and September 2008 is cause for concern. I thank you for your personal interest in ensuring that these suicides were fully investigated and that measures are taken to prevent additional suicides in the high-stress recruiting field. I understand that Lieutenant General Freakley, the Commander of the United States Army Accessions Command is here as a witness today to discuss his investigation of these recruiter suicides and changes made to prevent additional suicides.

I am also concerned about a recent spike in suicides and suicide gestures by cadets at the United States Military Academy. In 2 months, December 2008 and January 2009, two cadets committed suicide and two more attempted suicide. These are the first suicides at the Academy since 2005. What has changed that caused this spike? Brigadier General Linnington, the Commandant of Cadets at the Academy, is here to share his insights regarding these suicides and suicide attempts.

I am pleased that the Vice Chiefs and Assistant Commandant are here today as witnesses to help us understand what is happening and how to improve suicide prevention in the military. Their presence here says a lot about the importance they attach to this issue.

As military leaders, I know that each of you is very concerned about the recent increase in the number of suicides in your Service. The numbers of suicides have increased in every Service, but significantly more so in the Army and Marine Corps, the two Services most heavily engaged in ground combat in Iraq and Afghanistan.

Congress has recognized the strain on these ground forces and has authorized increases of 65,000 soldiers in the Army and 22,000 in the Marines. It is our intent that these increases will help to relieve the stress on your forces, but we also have to make sure that you are able to provide all of the assistance your troops need to cope with the stress that they are experiencing.

The professionals tell us that common issues leading to suicide include relationship problems, financial problems and legal problems, as well as mental health issues. I know that each of your services have programs to address these as part of your suicide prevention efforts. Undoubtedly, the 15 month deployments have contributed to these underlying problems that are linked with suicides. Perhaps Brigadier General Sutton, the Director of the Defense Center of Excellence for Psychological Health, and Ms. Kathryn Power from the Department of Health and Human Services, can help us to better understand conditions that may lead to suicide and additional efforts that can be taken to prevent suicides.

I am concerned about the increasing number of troops returning from combat with Post-Traumatic Stress Disorder, a condition that many believe contributes to the in-

crease in the number of suicides. I know that many are reluctant to seek help because of the stigma that they perceive attaches when they receive mental health care. We have to eliminate this stigma I was very pleased to learn recently that two Army generals have publicly acknowledged that they have sought counseling for the emotional trauma they experienced as a result of deployments to combat areas. General Carter Ham and Brigadier General Gary Patton have set the example for all soldiers who are experiencing menial issues as a result of their service. I agree with Brigadier General Patton when he said: "We need all our soldiers and leaders to approach mental health like we do physical health. No one would ever question or ever even hesitate in seeking a physician to take care of their broken limb or gunshot wound, or shrapnel or something of that order. We need to take the same approach towards mental health."

I commend the Army for working with the National Institute of Mental Health on a 5-year project to develop intervention and mitigation strategies to help decrease the number of suicides in the Army. While this is an important effort, we cannot wait 5 years for the results. We must identify actions and take them now to reduce suicides.

I am looking forward to hearing more about your suicide prevention programs and learning how we can help you to address the increase in suicides in the military.

Senator BEN NELSON. Senator Cornyn.

STATEMENT OF HON. JOHN CORNYN, U.S. SENATOR FROM THE STATE OF TEXAS

Senator CORNYN. Thank you, Chairman Nelson.

I want to begin by thanking you and Ranking Member Graham for agreeing to hold this important hearing to shed light on an alarming trend of rising suicides in our Armed Forces. I want to thank Chairman Levin and Ranking Member McCain for their leadership on this critical issue and ensuring that it gets the necessary oversight by the Senate Armed Services Committee.

Nearly 2 million U.S. troops have been deployed to Iraq or Afghanistan since September 11, 2001. Many of them, as we know, multiple times. This repeated combat service, combined with the associated separation from loved ones, has taken a great toll on them, as you might expect, both physically and mentally. Undoubtedly, combat-related mental health conditions have emerged as a significant health issue for these troops. Today's hearing is necessary to look at these increased suicide rates and any relationship they may have to these stresses and strains.

Last year, as the committee knows, I learned of a string of suicides at the Army Houston Recruiting Battalion, and I subsequently heard from numerous constituents with direct knowledge of recent events within this unit. Based on their allegations of poor morale, a hostile combat command climate within the unit, and my request, the Army launched a comprehensive investigation into these issues. The investigation confirmed much of the information shared with me by my constituents. I want to commend the Army, particularly Secretary Geren, General Freakley, and General Turner, who actually conducted much of the investigation, for not only their candor, but their diligence in pursuing this inquiry and their commitment, and the Army's commitment, to take care of its soldiers.

I want to highlight, briefly, some of the issues that emerged from the investigation. The geographic isolation of many recruiting stations presents challenges for soldiers trying to access services that are available on most military installations, but may not be available where they are actually located. In addition, the investigation

reported that Army recruiters assigned to these remote locations suffer from a lack of peer support.

The investigation also examined the Army's processes for assigning recently-returned combat veterans to recruiting duty, and found that the Army's selection policies are sound, but they're not consistently applied. Consequently, less than 60 percent of the applicants for recruiting duty are vetted in accordance with the Army's prescribed policy, resulting in many soldiers being sent to Recruiting and Retention School without adequate mental health screening themselves.

I recently visited a local recruiting station in Houston and met with a group of recruiters to hear firsthand about their experiences and their daily challenges. They related to me the tremendous stresses involved in their work. We owe it to them and to their families to put better safeguards in place to prevent future suicides both within the Houston Recruiting Battalion and across our armed services. We must be fully cognizant of the challenges in the recruiting mission, and we must assure ourselves that those who lead our recruiters are both respectful and compassionate towards them while demanding high standards of performance.

We are a Nation at war, and our recruiters are absolutely critical to maintain the All-Volunteer Force and win on all fronts in the global war on terror. It's critical that we honor the memory of these fallen soldiers by taking every possible step to prevent this kind of tragedy from reoccurring in the future. I look forward to participating in this hearing today and learning how the military plans to confront this serious problem.

Again, in closing let me say, Mr. Chairman—Chairman Nelson, Chairman Levin—I appreciate your leadership and support in giving us the opportunity to look more closely at this and, more importantly, listening to the Military Service Vice Chairmen and other leaders as to what their plans are to alleviate this problem and address it in the future.

Thank you very much.

[The prepared statement of Senator Cornyn follows:]

PREPARED STATEMENT BY SENATOR JOHN CORNYN

Mr. Chairman. I would like to start off by thanking you and Ranking Member Graham for agreeing to hold this important hearing to shed additional light on the alarming trend of rising suicides in our Armed Forces. I would also like to thank Chairman Levin and Ranking Member McCain for their leadership on this critical issue and ensuring that it gets the necessary oversight by the Armed Services Committee.

Nearly 2 million U.S. troops have deployed to Iraq or Afghanistan since September 11, 2001. Many of them multiple times. This repeated combat service, combined with the associated separation from loved ones, has taken a great toll on them, both physically and mentally. Undoubtedly, combat-related mental health conditions have emerged as a significant health issue for these troops. Today's hearing is a necessary look at the increased suicide rates in the military.

Last year, I learned of a string of suicides in the Army Houston Recruiting Battalion, and I subsequently heard from numerous constituents with direct knowledge of recent events within this unit. Based on their allegations of poor morale and a hostile command climate within the unit, at my request, the Army launched a broad, comprehensive investigation into these issues. The investigation confirmed much of the information shared by my constituents. I commend the Army for its candor in this inquiry and its commitment to taking care of soldiers.

I would like to highlight some of the issues that emerged from the investigation. The geographic isolation of many recruiting stations presents challenges for soldiers

trying to access services that are available on most military installations. In addition, the report noted that Army recruiters assigned to these remote locations suffer from the lack of a peer support network. The investigation also examined the Army's process for assigning recently returned combat veterans to recruiting duty, and found that the Army's selection policies arc sound, but are not applied consistently. Consequently, less than 60 percent of applicants for recruiting duty are vetted in accordance with the Army's prescribed policy, resulting in many soldiers being sent to Recruiting and Retention School without adequate mental health screening.

I recently visited a local recruiting station in Houston and met with a group of recruiters to hear first-hand about their experience and daily challenges. They related to me the tremendous stresses involved in their work. We owe it to them and their families to put better safeguards in place to prevent future suicides both within the Houston Recruiting Battalion and across our Armed Forces. We must be fully cognizant of the challenges in the recruiting mission, and we must ensure that those who lead our recruiters are both respectful and compassionate towards them while still demanding high standards of performance.

We are a nation at war, and our recruiters are absolutely critical to maintain the All-Volunteer Force and win on all fronts in the war on terror. It is critical that we honor the memory of these fallen soldiers by taking every possible step to prevent this kind of tragedy in the future. I look forward to participating in the hearing today and learning how the military plans to confront this serious problem.

Senator BEN NELSON. Thank you, Senator Cornyn, for your thoughtful testimony. We invite you to join us here at the dais, if you like. We would be honored to have you.

On the second panel, we're honored to have General Peter W. Chiarelli, who is the Vice Chief of Staff of the Army; Admiral Patrick M. Walsh, who's the Vice Chief of Naval Operations (CNO); General James F. Amos, who is the Assistant Commandant of the Marine Corps; and General William M. Fraser, who is the Vice Chief of Staff of the Air Force. If you would, please join us at the table.

We welcome you back, and we look forward to hearing about each of your Service's suicide prevention initiatives and programs, and mental health efforts, especially in light of the fact that, as noted, each of the Services have had increased rates of suicide between calendar years 2007 and 2008.

General Chiarelli?

STATEMENT OF GEN PETER W. CHIARELLI, USA, VICE CHIEF OF STAFF, UNITED STATES ARMY

General CHIARELLI. Mr. Chairman, Ranking Member Senator Graham, Chairman Levin, distinguished members of the committee, I thank you for the opportunity to appear before you today to provide a status on the Army's efforts to reduce the number of suicides across our force.

I have also submitted a statement for the record, and I look forward to answering your questions at the conclusion of my opening remarks.

First, on behalf of our Secretary, the Honorable Pete Geren, and our Chief of Staff, George Casey, I would like 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's been a busy time for our military. We are at war, and we have been at war for the past 7-plus years. That has undeniably put a strain on our people and our equipment. The reality is, we're dealing with a tired and stressed force, and the effect, in the most extreme cases, has been, unfortunately, an increased incidence of suicide. Other senior leaders of the Army

and I recognize that we must find ways to relieve some of this stress, particularly the stress caused by deployments and frequent lengthy periods of separation. However, the level of stress is directly related to demand, and, as you well know, demand is high and not expected to diminish significantly for the foreseeable future. In the meantime, our efforts are focused on mitigating the stress as much as possible. We are also taking steps to eliminate the stigma that has frequently kept soldiers from seeking help.

The reality is, there is no simple solution. In fact, it is going to require a multidisciplinary approach and a team effort at every level of command and across all Army components, all Services and jurisdictions, as well as cooperation with partners outside of our organization. I can assure you, the members of this committee, that this challenge will remain a top priority for our Army's senior leaders.

Chairman, members of the committee, I thank you, again, for your continued generous support of the outstanding men and women of the United States Army and their families, and I look forward to your questions.

[The prepared statement of General Chiarelli follows:]

PREPARED STATEMENT BY GEN PETER W. CHIARELLI, USA

Chairman Nelson, Ranking Member Graham, distinguished members of the Senate Committee on Armed Services; I thank you for the opportunity to appear here today to provide a status on the Army's efforts to reduce the number of suicides across our Force. This is my first occasion to appear before this esteemed committee, and I pledge to always provide you with an honest and forthright assessment.

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

As all of you know, it has been a busy time for our Nation's military. We are at war, and we have been at war for the past 7-plus 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, and deeply patriotic, and they are doing an outstanding job on behalf of the Nation.

As leaders, we have a responsibility to look out for our Soldiers' physical and mental well-being. 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 can assure the members of this committee that we are addressing the issue of suicides across our Army with that same attitude.

CALENDAR YEAR 2008 AND 2009 ARMY SUICIDE REPORTS

On January 29, 2009, the Army released its annual report on suicides for calendar year 2008. The statistics cover active duty soldiers, including activated members of the National Guard and U.S. Army Reserve. There were 140 suicides of soldiers on active duty over the 12-month period (this figure includes 7 unconfirmed cases still under review); the confirmed rate was 20.2 per 100,000. This is an all-time high for the Army.

For the first time in history, the number of suicides in calendar year 2008 (19.5 per 100,000) also exceeded the national average (11.0 per 100,000). However, it should be noted that the most recent data from Centers for Disease Control and Prevention (CDC) is for 2005, so a true side-by-side comparison cannot be made. The CDC figures, for example, do not yet reflect the impact of the financial downturn that occurred in the latter half of 2008.

Unfortunately, this alarming trend has continued in calendar year 2009. The number of suicides for calendar year 2009 by active duty Soldiers, including activated members of the National Guard and Reserves is currently 48 (out of a total population of 700,000) (includes 29 pending, but not yet confirmed); and, the corresponding number of suicides for calendar year 2009 by Reserve component and

Army National Guard soldiers not on active duty is currently 18 (out of a total population of 400,000) (includes 11 pending, but not yet confirmed).

I, and the other senior leaders of our Army, readily acknowledge that these current figures are unacceptable.

REASONS FOR SUICIDES

Individuals who make the decision to commit suicide usually do so based upon a combination of factors. For example: investigations have concluded that the vast majority of Soldiers who committed suicide in calendar year 2008 were dealing with some type of relationship problem (i.e., marital discord, break-up, divorce, family disagreements); and, many of the soldiers were also experiencing legal, financial, and occupational difficulties. On their own, each problem may be manageable—or even avoidable—but, problems are often exacerbated by the added stress and helplessness a soldier can feel when deployed.

The reality is we are dealing with a tired and stretched force. In calendar year 2008, over two-thirds of the soldiers who committed suicide were either deployed or had deployed in the past. In this era of—what I like to 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 contributes significantly to their level of stress and anxiety.

Looking ahead, I—and, the other senior leaders of the Army—recognize that we must find ways to relieve some of the stress on our Force, particularly the stress caused by deployments and frequent, lengthy periods of separation. However, the level of stress is directly related to demand—and, as you well know, demand is high and not expected to diminish significantly for the foreseeable future. In the meantime, our efforts are focused on mitigating the stress as much as possible. Shortening the length of deployments from 15 to 12 months will help, but even that is going to take time. We are still dealing with the impact of the Surge. The Army will not get our last Combat Brigade off of a 15-month deployment until June 2009, and our last Combat Support (CS)/Combat Service Support (CSS) unit off of 15-month deployment until September 2009.

ADDRESSING THE CHALLENGE OF SOLDIER SUICIDES

As you all know, I was given the mission by Secretary Geren and the Chief, General Casey, to develop a plan to significantly reduce the high number of suicides across the Army. I can assure the members of this committee—this is not business as usual. I am conducting weekly meetings and VTCs with many of the Army's senior leaders, Army Service Component Commands, and Direct Reporting Units around the globe. Beginning next week, I plan to travel to seven Army installations to assess implementation of our strategy.

The increased trend in soldier suicides is impacting every segment of the Army—Active, Reserve, and National Guard; officer and enlisted; male and female; deployed, nondeployed, and never deployed. The reality is there is no simple solution. In fact, it is going to require a multi-disciplinary approach; and, the Army is taking a hard look at every single facet of our organization to make a determination on what can and should be done to address this problem. We are also reviewing and reemphasizing those basic practices that were so effective in the past at keeping our suicide numbers down, such as asking a buddy if he or she needs help and making sure he or she is linked up with a chaplain or mental health provider.

In January, Secretary Geren directed an Army-wide stand-down to address the problem of suicides. During the 30-day window between February 15 and March 15, unit commanders took a 2- to 4-hour period to conduct a training session with their soldiers and Army civilians. A standardized training support package was provided to each unit, including a DVD, "Beyond the Front." This interactive learning video was developed in conjunction with Lincoln University, WILL Interactive, Inc., and the Army Research Institute, and it presents soldiers with two very realistic scenarios that address some common stresses and hardships that can lead to thoughts of suicide. Unit leaders were onhand at the training sessions to answer questions and to help soldiers work through the issues presented.

Also as part of the stand-down, unit commanders conducted training on one of the Army's primary programs—the Ask, Care, Escort program, commonly referred to as ACE. In some cases, a soldier may be struggling with a problem, but he is not willing to talk about it because of potential stigmas or fear of ridicule from fellow soldiers. The ACE program reminds soldiers that they have a responsibility to look out for one another and help—not deride or ostracize—a buddy who is having problems.

This stand-down is being followed by a chain-teaching program focused on suicide prevention that will allow leaders to communicate with every soldier. This chain-

teach will be conducted during a 120-day period that began on March 15, 2009. The intent is to inform and educate soldiers and DA civilians about the resources and services available; motivate soldiers to maintain both physical and mental health wellness; engage leaders at all levels of the Army to foster an environment of reduced stigma associated with seeking mental health care; and, enhance the capability of soldiers, DA civilians, Army leaders, family members, and others to take necessary action to help individuals at risk.

A TEAM APPROACH

Effectively addressing the challenge of soldier suicides is going to require a 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 the National Institute of Mental Health (NIMH).

The Army signed a Memorandum of Agreement with NIMH in October 2008, and the Institute is currently conducting long-term research aimed at helping to identify those soldiers most at risk, as well as developing intervention and mitigation strategies that will help decrease the number of suicides across the Army. This is the largest single study on the subject of suicide that NIMH has ever undertaken. It is expected to last 5 years, and will include soldiers from every component of the Force—Active Army, Army National Guard, and Army Reserve. Intermediate data will also be available throughout the study period to inform the Army's ongoing intervention strategies. The findings will benefit the Army, the other military Services, as well as the U.S. population overall, and may lead to more effective interventions for both soldiers and civilians.

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 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.

The Army is also in the process of hiring more mental health care practitioners, including psychiatrists, psychologists, and marriage and family therapists. We are educating more primary care providers on the symptoms and courses of action for depression and post-traumatic stress disorder. What we discovered is that soldiers who are unwilling to seek help from a mental health care professional will oftentimes 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.

COMPREHENSIVE SOLDIER FITNESS

The Army is in the process of developing its Comprehensive Soldier Fitness Program. The objective is to raise mental fitness up to the same level of attention as we have historically given only to physical health and fitness. 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. We recognize that people come into the Army with a very diverse range of experiences, strengths, and vulnerabilities in their mental as well as physical condition. So we will start with an assessment at accession, and provide training and education as needed.

As part of this effort, the Army has instituted Battlemind training, 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. To date, Battlemind is the only mental health and resilience training program demonstrated to reduce symptoms of post-traumatic stress upon redeployment. People who participated in Battlemind also have reported fewer stigmas attached to getting mental health care if needed than people who had not had the training.

CHANGING THE ARMY CULTURE

Today, there is a wide range of programs and services available. However, soldiers are frequently reluctant to seek help. This is the other piece we recognize needs work; we need to change the culture of our Army. 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.

In 2008, the Department of Defense revised question number 21 on the questionnaire for national security positions regarding mental and emotional health. The revised question now excludes non-court ordered counseling related to marital, family, or grief issues, unless related to violence by members; and counseling for adjustments from service in a military combat environment. Seeking professional care for these mental health issues should not be perceived to jeopardize an individual's professional career or security clearance. On the contrary, failure to seek care actually increases the likelihood that psychological distress could escalate to a more serious mental condition, which could preclude an individual from performing sensitive duties.

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.

CLOSING

In my 36-year career in the Army, I have never dealt with a more difficult or critical mission than the current charge to reduce the number of soldier suicides. Any time an individual makes the decision to commit suicide; the loss affects family and friends, fellow soldiers, and the Army.

Stress, anxiety, or depression affecting a soldier can be caused by a variety of factors, including relationship problems and financial, legal, and occupational difficulties. One at a time or in certain situations each factor may be manageable—or even avoidable. But, when they happen in some combination or all at once, and especially when a soldier's anxiety is further compounded by the stress of a deployment—he (or she) can reach a point of desperation. If left unaided, this individual could make the fateful decision to end his or her own life.

The reality is every suicide is unique, and there is no simple solution. In fact, to significantly reduce the number of suicides will require a team effort across the Army by soldiers of every rank and at every level of command. Long-term, the Army's senior leaders recognize that we need to find ways to relieve some of the stress on our force, particularly the stress caused by deployments and frequent, lengthy periods of separation. We also acknowledge that this stress is an effect of increased demand on the force, and the reality is this demand is not expected to diminish in the foreseeable future. In the meantime, we are taking immediate steps to mitigate some of the stress on our soldiers and their families by helping them to better cope with difficult situations. We are also in the process of changing the culture of the Army to ensure Soldiers are aware of available programs and services; and are willing to seek help whenever necessary—for themselves or for a buddy.

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

Chairman, 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.

Senator BEN NELSON. Admiral Walsh?

STATEMENT OF ADM PATRICK M. WALSH, USN, VICE CHIEF OF NAVAL OPERATIONS, UNITED STATES NAVY

Admiral WALSH. Chairman Nelson, Chairman Levin, distinguished members of the subcommittee, thank you for this opportunity to testify about the command and organizational level of efforts that are underway to prevent suicides in the Navy.

Suicide ranks as the third-leading cause of death in the Navy. It's a loss that destroys families, devastates communities, 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, 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. This means that leaders must look for, and connect to those individuals challenged by seemingly intractable troubles, with relationships and work, financial and legal matters, deteriorating physical 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 our more important policy and programmatic initiatives are directed by the CNO to establish the Navy Preparedness Alliance, a consortium led by our Chief of Naval Personnel, our Reserve Chief, Bureau of Medicine, and our Shore Installation Commander 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's a program led by operational leadership, supported by the naval medical community, and provides practical decisionmaking 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 warrants.

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 of 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, sir.

[The prepared statement of Admiral Walsh follows:]

PREPARED STATEMENT BY ADM PATRICK M. WALSH, USN

Chairman Nelson, Senator Graham, 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 11.6 per 100,000 sailors in 2008, for a total of 41 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 5 years show a weak correlation between suicide and deployment history. From 2003–2008, the Navy suffered 240 suicides. Approximately half (48 percent) of suicides had not deployed at all in the previous 3 years; most (64 percent) of suicides had not deployed specifically in support of Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF); one-third (31 percent) had previously deployed for OIF/OEF; eight (3.3 percent) 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 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 tempo of operations 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 decisionmaking 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 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 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 servicemembers 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 com-

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

[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 servicemember from disclosing psychological services obtained for combat related stress or family difficulties.

mand climate, as well as sailor and family satisfaction with the Navy. The Navy conducts a BHNAS for targeted groups of deployed sailors.

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 350. 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 Office of the Chief of Naval Operations (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 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 percent of Navy spouses rate the training and services as "low" experienced by their military spouse for deployment related stress. A novel program developed by the University of California, Los Angeles, and partnered with the Navy, Project Families Overcoming Under Stress (FOCUS) 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 servicemembers, 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 Web site

[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.

(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 3-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 North Atlantic Treaty Organization countries) as Third Location Decompression. Conducted by counselors, chaplains, and peers, sailors spend 2 to 3 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 fiscal year 2008, the program has contacted 719 Reserve sailors and provided 314 clinical assessments. The RPHO coordinators have also played a critical part in helping 2,078 reservists and their spouses attend 20 mental health retreats called "Returning Warrior Weekends" where sailors and their spouses are provided a chance to share deployment experiences with fellow servicemembers 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 servicemembers 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 are improving how commands report active-duty suicide attempts (or Reserve in drill or activated status). In these situations, the military treatment facility responsible for the individual's assessment, care, or referral also has responsibility for completing the DODSER within 30 days of the event.

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. New policy will also gather data on sailor suicide attempts. Nevertheless, 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.

Senator BEN NELSON. Thank you, Admiral.

General Amos?

STATEMENT OF GEN. JAMES F. AMOS, USMC, ASSISTANT COMMANDANT OF THE UNITED STATES MARINE CORPS

General AMOS. Thank you, Chairman Nelson, Ranking Member Graham, and Chairman Levin, who just departed, and distinguished members of this committee, for this opportunity to report on the Marine Corps suicide-prevention efforts.

On behalf of more than 239,000 Active and Reserve marines and their families, I'd like to extend my appreciation for the sustained support Congress has faithfully provided its Corps. As we begin this hearing, I would like to highlight a few points from my written statement.

The tragic loss of a marine to suicide is deeply felt by all of us who remain behind. We lost 41 marines to suicide in 2008, up from 33 in 2007, and up from 25 in 2006. That is unacceptable. We are taking action to turn this around. I care deeply about this, and I am committed to work with the leadership of the Marine Corps to fix it.

The data shows that the most likely marine to die by suicide corresponds to our institutional demographics. He is a young Caucasian male, 18 to 24 years old, between the ranks of private and sergeant, E1 through E5. The most likely cause is a failed relationship with a woman. Male marines are at a greater risk of suicide than are female marines. The most common methods of suicide are gunshot or hanging, similar to our civilian counterparts. Suicide prevention is required training for recruits in boot camp and for all of our new officers at the basic school. It is part of the curriculum at our staff noncommissioned officer (NCO) academies, our commanding officer courses, and all other professional military education courses. Simply put, suicide prevention training is incorporated into our education and training at all levels of professional development and throughout the marine's entire career.

At a planning session this past November, some of our Corps' very best NCOs came to Quantico and asked us to provide them with additional training such that they could take ownership of the suicide prevention effort for their peers and for their marines. Our NCOs have the day-to-day contact with marines, and therefore, the best opportunity to see changes in behavior and other problems that can identify marines in need of further assistance. As a result, we are developing a high-impact leadership training program focused on our NCOs and our corpsmen, and giving them additional tools to identify and assist marines at risk for suicide.

With great support from the United States Navy, we are increasing the number of our mental health professionals and embedding more of them in our operational units, where they can develop close relationship with our marines as they deploy forward. This helps to reduce the stigma of seeking help and identify potentially affected individuals early.

While there is no single answer that will solve this crisis of rising suicides, we are committed to exploring every potential solution and using every resource we have available. We will not rest until we have turned this around.

I thank each of you for your continued faithfulness to our Nation and your confidence in the leadership and the commitment of your Corps. I request that my written testimony be accepted for the record, and I look forward to your questions.

Senator BEN NELSON. It will be accepted.

[The prepared statement of General Amos follows:]

PREPARED STATEMENT BY GEN. JAMES F. AMOS, USMC

I. INTRODUCTION

Chairman Nelson, Senator Graham, and distinguished members of the subcommittee: On behalf of your Marine Corps, I would like to thank you for your generous and faithful support 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 painful questions of why and how. Why did this happen? How can we avert a future tragedy? What lessons can be learned that can be used to prevent another loss? 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? 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 2 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 41 confirmed or suspected suicides. Our preliminary suicide rate in 2008 of 19.0 suicides per 100,000 marines approaches the national civilian rate of 19.8 per 100,000 when that rate is adjusted to match the demographics of the Marine Corps. 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 likely cause is a failed relationship with a woman. 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 (OEF)/Operation Iraqi Freedom (OIF), which is almost ex-

actly the same as the percentage of all marines with deployment experience (69 percent). Marines with multiple deployments are similarly not over-represented in the suicide population. For the 6-year period of 2003–2008, 16 percent of marine suicides occurred in the OEF or OIF area of operations, 32 percent were marines with a deployment history, and 52 percent were marines with no OIF/OEF deployment history. Taken together, this data suggests that while the continuing stress resulting from overall tempo of operations 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.

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 aarine 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 when available in such a manner that will not compound their loss. A comprehensive survey tool, the Department of Defense Suicide Event Report, is required for all marine suicides and suspected suicides. We are currently determining the best approach to facilitate the use of that survey tool for all marine suicide attempts as well.

From our analysis, the most common risk factors associated with suicides include a history of 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 10 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 Noncommissioned 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 all levels of professional development and throughout a marine's career.

One of our relatively new initiatives is Frontline Supervisors Training, a 3- to 4-hour gatekeeper-type training for marines in leadership positions. The training reinforces the leadership skills all NCO and SNCO marines have learned and further teaches these leaders how to recognize the signs of distress, engage their marines in a discussion about suicide related thoughts and risk, effectively refer them to local support resources, and recognize the importance of sustained effort even after a marine has received professional assistance. We have trainers at all marine installations who are actively training NCOs, SNCOs, and junior officers with this course.

Last November, I met with our two- and three-star commanding generals, their sergeants major, and representative noncommissioned officers (NCOs) to review our

suicide awareness and prevention program in depth. At that meeting, 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 noncommissioned officer leaders by providing them marine relevant information to assist them in identifying and responding to distress in their marines. To accomplish this, we are developing a mandatory high-impact leadership training program, focused on our noncommissioned 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 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 training program will be ready for use across the Marine Corps this summer.

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 commanders, colonel and above. 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, all marines will receive additional training on suicide prevention this month. We will complete this all hands training by 31 March. The training package will be delivered by Marine leaders and will educate all marines on warning signs, engagement with their buddies, and how to access the variety of local and national support resources.

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. By embedding OSCAR teams in our operating force units, we make it easier for marines to develop a relationship with and seek help from mental health professionals. We are in the process of growing the program and providing those resources to units at home as well as when deployed. In addition, Navy Medicine has increased the number of mental health providers in Deployment Health Clinics and in the TRICARE network over the past 2 years.

We coordinate our suicide prevention efforts with other experts from across the Federal Government, civilian expertise, 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 the 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 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 in 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.

Senator BEN NELSON. Thank you, General Amos.

General Fraser?

STATEMENT OF GEN. WILLIAM M. FRASER III, USAF, VICE CHIEF OF STAFF, UNITED STATES AIR FORCE

General FRASER. Mr. Chairman and Senator Graham, members of the committee, I want to thank you for the opportunity to be here today and to address this very serious issue.

It's a privilege to join with the other Vice Chiefs of our sister Services in addressing this tremendously important issue with members of this committee. I echo their sentiments on the need to further advance our work in preventing suicides among our servicemembers.

In the Air Force, we believe that when an airman raises their hand and takes the oath, their lives are forever changed in the name of service. As they do so, they incur a commitment; and likewise, we have a reciprocal commitment to them and to their families. Part of that commitment means ensuring that we have programs in place that adequately address the stresses of a military life. Whether deployed in combat or at home station, there are immense pressures on our men and women in uniform. Through a total-force approach, we are doing all we can to focus on suicide prevention while heightening awareness and exploring new approaches on this issue affecting our Air Force and our airmen.

With our sustained operations tempo and expeditionary culture, we are taking important steps to ensure airmen are as mentally prepared for deployments and redeployments as they are physically and professionally, yet, at the same time, we are providing the full support to those military families that are left behind.

We continue to make strides in implementing our Air Force Suicide Prevention Program and further enhancing our psychological health treatment and our management programs, and in strengthening our continued partnerships with our sister Services and our interagency colleagues. It is, indeed, a team effort.

While we recognize the successes that our programs are yielding, we also know that a single suicide is one too many. So, we remain committed to these programs, individually and collectively, as a

part of a larger effort to take care of our Air Force's most valuable assets: its people.

I want to thank you again for your continued support of America's airmen. I look forward to your questions and to our ongoing dialogue as how best we can serve those who serve our Nation.

Thank you, Mr. Chairman.

[The prepared statement of General Fraser follows:]

PREPARED STATEMENT BY GEN. WILLIAM M. FRASER III, USAF

1. INTRODUCTION

America's Air Force provides critical capabilities across the spectrum of conflict for the joint team and the Nation. The Air Force mission to "fly, fight, and win . . . in air, space, and cyberspace" has never been more vital to the Nation's defense. The ability to think and act globally; ready to deliver humanitarian relief or hold targets at risk within hours; provide unrivaled global positioning. navigation and timing through advanced space infrastructure; or defend our Nation's net-centric information architectures are just a portion of what the United States Air Force contributes as part of the Joint. Coalition and interageney collaboration that protect and defend the United States and its global interests.

Our airmen are proud to provide these contributions to our Nation's defense. After 18 years of continual presence in the Middle East, our current force is the most battle-tested group of airmen in our history. Yet this era of increasing demands continues to place a heavy burden on our airmen and their families. These airmen have responded magnificently to their Nation's call. Nevertheless, we see evidence of the strain on personal and family relationships from frequent deployments, increased workload, and other environmental factors such as economic pressures, and are witnessing an increase in some negative behaviors and in the physical and psychological injuries home by our force from the current conflicts.

The Air Force is dedicated to supplying, training, and equipping our airmen with the best means possible in our Nation's defense. As part of our key priority to develop and care for airman and their families, we are also dedicated to the well-being of our airmen and their overall physical and mental health. The tragedy that is suicide has the potential to strike across our Air Force. It is not limited only to those airmen who have deployed or will deploy, nor is it bound by rank, gender, ethnicity, or geography. Any attempted or successful suicide receives the highest attention from Air Force leadership.

Today I would like to share with the committee data pertaining to suicide rates in the Air Force and address what steps we are taking to combat such trends, as well as report on the policies and support programs we have in place to deal with suicides. In a broader sense, the Air Force is making progress in treating psychological injuries to include Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). The Air Force is using modern tools to address the total mental health of our airmen. In conjunction with our Department of Defense (DOD) and Department of Veterans Affairs (VA) counterparts, we are making significant progress in the quality of medical care that our Airmen receive and deserve.

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 RATES AND PREVENTION PROGRAMS

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 further ripples through family, friends, co-workers, and the community.

The Air Force has experienced a slight increase in the suicide rate for calendar year 2008 of 11.5 suicides per 100,000 people when compared to its 10 year average of 9.7 suicides per 100,000. Since the beginning of major combat operations in Iraq, the 5 year average (calendar years 2003–2008) for Air Force suicides is 11 per 100,000.

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. The Air Force experienced 38 suicides by active duty members in calendar year 2008,

with some observable patterns. Thirty-six of the suicide victims were male (95 percent), while there were two female victims (5 percent). Officers accounted for 4 suicides (11 percent), while the other 34 were spread across the enlisted ranks. Over half of the victims were married (55 percent). For comparison, of the active duty Air Force population, nearly 20 percent are women, 20 percent are officers, and 60 percent are married. Another identifiable trend is the presence of firearms in 58 percent of the incidents. Medical record reviews of recent victims also indicate that a majority of victims had utilized some form of mental health services for issues ranging from alcohol abuse to marriage counseling. 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. From 2003 to 2008, 39 suicide victims had deployed in the previous 12 months but 150 victims had never deployed. 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 (AFSPP) with a renewed focus on 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 high risk for a poor hand-off.
- 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.

We are giving renewed attention to the 11 initiatives in our AFSPP with a leadership emphasis on help-seeking behaviors, stigma reduction, and managing personnel in distress. Our wingman concept develops a culture of looking out for fellow airmen. 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.

2.1 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 this field. The AFSPP is defined in Air Force Pamphlet 44–160. This program was initiated in 1996 with the purpose of reducing the number of lives lost to suicide. 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, resulting in a 28 percent rate reduction. The AFSPP centers on effective education, detection and treatment for persons at risk. Since its inception, the AFSPP has heightened community awareness of suicide and suicide risk factors. Additionally, it has created a safety net that provides protection and adds support for those in trouble. The AFSPP is a nationally recognized program and was one among the first three suicide prevention programs to he listed on the Substance Abuse and Mental Health Services Administration National Registry.

There is no easy solution to preventing suicides: it requires a total community effort using the full range of tools at our disposal. However, we have seen a marked difference through the AFSPP. Going forward, the Air Force is committed to continued emphasis on the proven AFSPP as the best approach to dealing with those at risk of suicide.

The AFSPP is a commander's program, and thus it is the responsibility of every commander to ensure the AFSPP is fully implemented as we continue to develop effective tools to assist potential victims.

2.2 Air Force Suicide Prevention Program Initiatives

The AFSPP consists of 11 specific policy and training initiatives which collectively comprise our approach to taking care of our airmen in this critical area. These initiatives include:

Leadership Involvement

Air Force leaders actively support the entire spectrum 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 menial 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 was updated to effectively track both direct patient care activities and prevention services.

Community Education and Training

Annual suicide prevention training is provided 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 me individual's emotional state and contacting a menial 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 learns help personnel deal with their reactions to traumatic incidents.

Integrated Delivery System (IDS) and Community Action Information Board (CAIB)

At the 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 UCMJ 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 Staffs 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 a new tool for leadership known as the Frontline Supervisors Training. This half-day class enhances supervisor skills for assisting airmen in distress.

3. AIR FORCE SUPPORT PROGRAMS

In support of our AFSPP initiatives, we have also 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 equipping them with 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 the unique situations that our airmen and their families face as part of the military lifestyle, we offer military family life consultants to provide individual, marriage and family counseling: special needs families assistance: financial education services; and education, advocacy, and intervention for domestic violence and new parent issues. Additionally, 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 into the mental health system. These programs provide the necessary support networks, education, skill-building services and counseling to help airmen at risk successfully adapt to their current environment.

Another key source of support available to all airmen is found in our 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.

4. DEPLOYMENT AND PSYCHOLOGICAL HEALTH

The current environment for many of our airmen is one of increased operational tempo and includes more frequent and longer deployments. With this heightened operations tempo, we remain mindful of the increased stresses and requirements placed 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 menial 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 and 90 to 180 days after returning from deployment complete the Post-Deployment Health Reassessment (PDHRA). At an enterprise level, the PDHA identifies airmen exposed to trauma in theater. The Air Force tracks symptoms from all airmen exposed to trauma in theater 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. Additionally, the PHA/PDHA/PDHRA screen also identifies depression, alcohol abuse, and family problems that are all warning signs of at-risk airmen.

The PDHRA completion rate for Active Duty airmen is 89 percent, with the remaining 11 percent past due, or over the 180 day window. Nearly half of the PDHRA participants screened positive for physical or emotional symptoms. Of these screened positive, 80 percent receive medical follow-up within 30 days, with the remaining 20 percent that have not received treatment within the 30-day window contacted regarding their extenuating circumstances. The PDHRA is a survey with a positive algorithm that is intentionally overly sensitive to act as an initial filter for possible medical assistance. We continue to closely monitor these metrics, working to ensure all airmen receive the screenings, and if necessary, the follow-on medical attention within a timely window.

4.1 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 is centered on effective risk recognition and help-seeking for airmen during these difficult times of adjustment. Landing Gear serves as a bridge to care 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.

Twenty percent of airmen in theater are exposed to traumatic events. 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. While less than 2 percent of deploying airmen develop PTSD, the brief training developed for 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.

5. PSYCHOLOGICAL HEALTH TREATMENT AND MANAGEMENT

The signature injury to our airmen and troops in the current conflicts may be TBI. We are training, our medical professionals to recognize and effectively deal with TBI. Flight Nurse, Aeromedical Evacuation Technician, and Critical Care Air Transport Team courses all now provide training on TBI. We are making significant progress in training these first responders to injured warriors by updating our training objective thus year to accomplish an in-theater TBI assessment.

We have also made psychological health treatment more accessible to our airmen. Since 2007. the Air Force has hired 91 contract mental health providers. Our standard of access for routine appointments is 7 days. We have trained an additional 400 mental health providers on optimal PTSD treatment solutions to better deal with an increasing number of airmen suffering from PTSD.

Finally, we have made significant progress in decreasing the stigmas attached for airmen seeking help with mental issues. Our mental health providers have been placed in primary care clinics to emphasize the similarities of treatment for mental and physical conditions, and working to reach these airmen for treatment when they exhibit signs of Post-Traumatic Stress, and before their stresses reach the Disorder diagnosis. Air Force leaders advocate for help-seeking behavior in multiple forums and we are emphasizing a culture where seeking help is seen as a virtue rather than a failure.

6. PARTICIPATION IN DOD AND VA PROGRAMS

While we are making 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. Other military Services have enjoyed successes with recent programs. The Air Force collaborates with our sister service suicide prevention offices to share and adopt best practices. The Army has recently developed a series of interactive videos that we are exploring to determine adoption into our own suicide prevention efforts.

The Air Force is completely engaged with the Defense Center of Excellence to address psychological health and TBI issues that are experienced across the Joint Force. We are fully committed to participating in the medical advances and groundbreaking work that occurs in this area.

One of our priorities is to work closely with the VA to perform smooth transitions for returning OIF/OEF veterans and ensure their continued healthcare. When a deployed airman is ill or injured, we respond rapidly 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 duly 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 learn. In fact we have recently formalized policies that will afford our wounded airmen opportunities for retention, priority retraining, and promotions. If airmen are separated from active duty, they are covered by the TRICARE Transitional Health Care Program until their transition to VA is completed.

It is our solemn pledge that all combat wounded and other disabled veterans will receive complete information and assistance in obtaining all services from DOD, the VA. and the Department of Labor to which they are entitled by virtue of their service to their country.

7. 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 necessary tool to commanders and Air Force leadership to assist airmen in distress.

Airmen serving in the current conflicts are not immune from psychological injuries. The Air Force is proceeding deliberately with programs and policies designed to improve our airmen's total mental 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.

Senator BEN NELSON. Thank you.

Senator Graham has arrived, so I now recognize him for an opening statement.

STATEMENT OF SENATOR LINDSEY GRAHAM

Senator GRAHAM. Very briefly, Mr. Chairman.

One, I look forward to working with you in this Congress as we've done in the past. This is one subcommittee, I think, that has really gotten the spirit of what we're all about here and tried to be as nonpartisan as possible, and I think we've been very good at that.

This issue, obviously, is something that the Country is concerned with. What I want to know is: When we exceed the civilian population, in terms of military suicides, what's going on? The prevention programs you've described seem to be very aggressive.

Being part of the military for a long time, I know there is a conflict here and a bit of a tension. If you step out and say, "I'm having a problem," people worry that it's going to affect their ability to be promoted. I know that is something that everyone at the table is sensitive about, to make sure that our folks can self-identify, that one buddy can help the next.

I look forward to learning about what you're trying to do to control this problem, and I appreciate the hearing. Hopefully, we can come up with some constructive solutions.

[The prepared statement of Senator Graham follows:]

PREPARED STATEMENT BY SENATOR LINDSEY GRAHAM

Good afternoon Mr. Chairman. Senator Cornyn, welcome. You served for years on the Committee on Armed Services; it is great to have you back with us today.

Senator Nelson, it is a great pleasure for me to serve with you in the 111th Congress and especially again as ranking member on the Personnel Subcommittee. I have to point out that with 16 members assigned to our subcommittee, we are not only the largest subcommittee, but I think we are larger than some committees in the Senate—so we must be doing something right!

We are also doing something that is important—starting with our hearing today on the difficult subject of suicides by servicemembers.

We know that statistically suicide is rare yet it remains one of the leading causes of death among young adults, and when a suicide occurs, it affects a part of every family, every military unit, every commander and citizen that it touches.

Tragically, we have seen a steady rise in the number of suicides within the Army and Marine Corps since 2003, and for the first time, the suicide rate in the Army exceeds comparable civilian rates.

I believe that the military has made progress on many fronts in confronting the issue of stigma, in improving training and awareness about suicide risks at all levels. But we need to know more, and achieve a better result.

I hope that this hearing will lead us to a better understanding of the factors that military organizations and families can positively influence in order to prevent the terrible and irreversible consequences of suicide by members of the military.

I thank all of our witnesses today, and especially the Vice Chiefs of Staff of each of our armed services. I know you are working hard to protect our servicemembers and their families, using every resource available to prevent the often unpredictable and universally tragic act of suicide. I believe I speak for every member on our subcommittee when I say that we are committed to supporting you in those efforts.

Senator BEN NELSON. General Chiarelli, last year during a Personnel Subcommittee hearing, General Rochelle testified that the Army was focused on removing the stigma of receiving mental healthcare, and that the Army had a task force in place to provide greater oversight in this area. As you and I have discussed, progress is being made. Can you tell us what the latest findings or actions are from the task force?

General CHIARELLI. Well, Senator, as you well know, the problem is not solved, but I think we are headed in the right direction. I think that the most important thing we've done in a long time, and a product of that task force, was an interactive video that we're using as the centerpiece of our stand-downs for the Active component force starting on March 15, called "Beyond the Front." It is an interactive piece that goes right to attacking that issue of stigma and helping soldiers and leaders work through that problem.

In addition to that, the Chief of Staff of the Army and the Secretary of the Army have asked me to take on this particular issue. I'm spending a great deal of my time concentrating on this. I've stood up a task force that's working with me, under Brigadier General Colleen McGuire, who are looking at all aspects of this problem and collecting data.

In addition to that, every single suicide that we have in 2009, once confirmed, will be briefed to me. I held that first session with the leaders 2 weeks ago. During a 2½ hour session, 15 different suicides were briefed to me, and it was one of the most intense 2-hour periods that I've ever spent. I think this goes a long way in allowing everyone to learn about the lessons of each one, rather than only the lesson of the suicide that's closer to home, and I think it's going to pay huge dividends for the United States Army.

Senator BEN NELSON. General Amos, the Marine Corps has an ongoing pilot program, the Operational Stress Control and Readiness (OSCAR) Program, embedding health professionals in units at the regimental level. You mentioned that you're getting support from the Navy in the areas of mental health professionals. Is there any evidence that embedding mental health professionals in units reduces suicides or suicide attempts by making mental healthcare more available? Has the Marine Corps concluded that this is, indeed, an efficient use of mental health providers?

General AMOS. Sir, we have 3 OSCAR teams currently deployed in Iraq right now, and one with the 2,000 marines that are deployed in Afghanistan, so we have a total of 4 forward-deployed. It's too soon to tell the real benefit of these. Anecdotally, we believe that this is going to be a significant force multiplier, reducing the stigma and allowing us to be able to actually look young marines in the eye with a mental health professional while they are deployed. That way, the mental health professional is part of the shared adversity and shared sacrifice of those marines that are forward, and therefore, identifies with them. So, we think it's going to work. It's too soon to tell. The Navy has come forward—and I think we have the numbers—55 mental health professionals forward-deployed in the U.S. Central Command right now, with marines.

The real issue, and challenge across all of DOD, is that it's not a function of an unwillingness, it's a function of a shortage of mental health providers across our great Country, both in civilian life and in the military. So, I think it's too soon to tell. My anticipation and expectations are, Mr. Chairman, that it's going to pay rich dividends, and we intend to fully staff this out and push these mental health providers forward.

Senator BEN NELSON. Now, you have the embedding when they're deployed. Is there an embedding when they return, in-between deployments?

General AMOS. Sir, the embedding right now begins in the predeployment training, during the 3- or 4-month workup, so that they begin to develop a relationship, so it's not a cold start in theater. When they come back, there will be the continued habitual relationships with those mental health providers. As you might imagine, it's a function of numbers right now; we just don't have enough to be able to provide all the ones that are working up and all the ones that have come back. We will get there, and that's where we're headed.

Senator BEN NELSON. General Chiarelli, I understand you have an embedding program, as well. Maybe you can give us some indication of how this is working with the Army.

General CHIARELLI. Well, I would have to fully agree with General Amos; it's too early to tell. But, all anecdotal indications from units returning indicate that this is a great help to them. But, I think as you know, Senator, we rely on Professional Filler System (PROFIS) doctors. I want to lay it all out here. I have found that, because those PROFIS doctors were turned back, those are doctors—a mental healthcare provider would be the same—that come from the military treatment facility someplace, deploy with that unit, they deploy for that year or 15 months, but then, when they come back, if we're not watching it, they are immediately reassigned back to that medical facility, and we have a problem because that continuity is important when they're deployed, but the continuity is also needed when they come back and begin to go through many of the problems that they have when they come back to their units in their hometowns. It's just as important to have that continuity. We have to find a way to provide that continuity much better than we are today.

Senator BEN NELSON. To the other Vice Chiefs, do you have any program similar to that, or are you considering programs similar to the embedding ones that the other services are using?

We'll start with you, General Fraser.

General FRASER. Sir, we, too, are experiencing a shortage of mental healthcare providers because of the shortage across the country. However, this last year, we took action to bring on more. In fact, within the last 12 months, we hired 97 new mental healthcare providers to place them with our units, so that, across all of our installations, we have our units covered.

Now, we are also deploying a large number of our mental healthcare providers. I've talked with General Chiarelli, and I've talked with the other Vice Chiefs, too. When you have a lack of mental health providers in the other Services, then, as General Chiarelli just talked about, PROFIS have to go forward to fill the gap. What we want to make sure that we do, though, for those who support those types of taskings, is to ensure that we have a good handoff. We don't want providers to fall through the cracks. That is something that our healthcare providers are very intent on fixing because you can see how that would happen when they come back and they're no longer attached to those units, or they are deployed for less time than that unit. We know that the Army is on longer

deployments. We are getting longer deployments of mental health providers in there, but yet, at the same time, we also realize there are other things that we have to do.

The other thing that we're noticing, and that we want to do with these 97 mental healthcare providers, for instance, is when we started building our budget, we're taking a look at very seriously converting these to civilian positions so they become a part of the Air Force. These are other types of things that we're doing.

Another thing that we're doing, not just with the embeds, sir, but we're finding great utility in the health assessments, not only the Periodic Health Assessments that folks do on an annual basis, but the pre- and post-deployment screening. The reassessment that occurs 90 to 180 days after a troop has returned is more important. What we're finding in that assessment, because it is a very sensitive assessment, is that a large number of the folks begin to exhibit stress. It's necessary, then, that we get them the care that they need to have. We're batting about 80 percent of getting those individuals in to see healthcare providers within a 30-day period. That additional 20 percent does not go unnoticed. We then follow up with them to get eyes on them and talk to them to see what else we can do to make sure. So, the Post-Deployment Health Reassessment Program is actually yielding great benefits after that deployment and being forward in the theater.

Thank you, sir.

Senator BEN NELSON. Admiral Walsh.

Admiral WALSH. The concept of an embed here is a very important part of our deployment pattern; it's part of our force generation. So, if you were to look at the construct that we use for deploying carriers and carrier strike groups, you will find all the key elements of what you've described in the OSCAR team as part of our deploying units. You'll find medical help for mental health professionals, medical professionals, as well as chaplain support.

I will point out that, statistically, where we find areas of vulnerability is when we step away from that coherent, cohesive construct. This is on the redeployment of troops when they come back. So, in the first 6-month period and in the period from 12 to 18 months, we see empirical evidence that focuses our attention, and it's not only suicide, but it's also other safety-related issues.

So, these are areas where people have stepped away from the checks and balances, the lines of accountability, and the clear oversight that comes from a deploying unit, creating our areas of vulnerability.

Senator BEN NELSON. Thank you. My time has expired.

What we didn't talk about were the Guard and Reserve units' members who have come back, and how we will continue to provide for them, but we can get to that later.

Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I think Senator Cornyn has to leave. Would you like to make a statement before you leave?

Senator BEN NELSON. Oh, sure. Senator Cornyn.

Senator CORNYN. Thank you very much, Senator Graham and Senator Nelson, for your courtesy. I do, like all of us, have multiple hearings and obligations at one time.

But, I want to say again, General Chiarelli, how much I appreciate General Freakley, General Turner, and Secretary Geren for the seriousness with which the Army has taken the concerns that I first raised last September about what happened here. We can all see the concern because, of course, we've had many hearings and a lot of efforts have been undertaken to try to deal with everything from traumatic brain injury (TBI) to post-traumatic stress syndrome. We recognize the strains on families, with lengthy and multiple deployments, and a military, as far as the Army and Marine Corps are concerned, that is too small for our current obligations, on a worldwide basis.

I say all that to say that it's hard, I think, to draw any grand conclusions, other than that we don't really know exactly what causes an individual to take his or her own life. That's what I hope comes out of this. I know Secretary Geren has entered into arrangements with the National Institute of Mental Health that, I think, with a lot of these tragedies, will perhaps allow us to save more lives, but certainly apply that science and that learning more broadly across the population, generally, to save a lot of families from this same tragedy that confronted these four families out of the Houston Recruiting Battalion.

But, it doesn't seem to me that taking one's life is what you would call a normal response. In other words, we have an awful lot of soldiers, sailors, airmen, and marines, and others, who undergo the same or similar stresses and strains, and they don't take their lives. I'd be pleased if we could just go down the line and get your reaction: Is this something you think we need to try to do a better job identifying on the front end, when someone is recruited into the military? Is it something we need to do a better job of once they return from deployments, let's say, abroad in Afghanistan and Iraq? Where do you think that the key point in time is where we are most likely to identify an individual like this and intervene in a way that saves them and their family from this tragedy?

General Chiarelli, do you have a thought about that?

General CHIARELLI. Well, Senator, that is a tough question. There is no doubt about it; we need to do everything we can to try to identify this on the front end. But, even if we were 100-percent successful on the front end—and I think you know that—at least we're seeing in the Army, that 70 percent of our suicides that we had last year, 133 that we've confirmed so far, with another 7 pending, 70 percent of those, or a little bit greater than that, had some kind of relationship problem. But, it was normally not just a relationship problem, it was a relationship problem that was compounded with something else. It could have been a deployment, it could have been multiple deployments. I'm looking at a group of suicides now, nine suicides, where I have six out of nine soldiers who have deployment history. That about fits the statistics we're looking at: one-third deployed, one-third not deployed, and one-third, when they were deployed, committed the act. Of those six soldiers who have deployment history, four of them have multiple deployments. That doesn't normally fit. But, I think we have to attack this from a multidisciplinary approach and understand that we have to be able, at all points of a soldier's career, to have people ready to intervene and help that soldier, should that single event,

like a relationship, compounded with a legal problem, financial problem, or a peer, cause an individual to contemplate suicide. It's going to take a multidisciplinary approach across the entire career of a soldier.

Senator CORNYN. Admiral Walsh?

Admiral WALSH. The benefit of these sorts of conversations is that we share among the Services because we have a very common set of problems here that we're trying to address, even though we have cultural differences and maybe deployment patterns that are different. What we have learned from this is that it is the shipmate, it is the battle buddy, it is the person that comes to the assistance of someone in need through programs that help to reduce the glamorization of alcohol, the stigma associated with asking for help, that a battle buddy or a shipmate can come forward and say he feels comfortable in either reporting his friend or bringing his friend to the kind of resource.

We don't come before the committee today to say that we are resource-limited. We are attacking this on many different fronts. The committee has been very supportive, in terms of supporting us with everything that we've ever asked for. The challenge that we have is really getting to a climate that allows, in a command organization, for people to feel comfortable being vulnerable, that they are comfortable, both on a professional level, that they won't be hurt, and on a personal level, that they won't be stigmatized, that they can come forward and ask for help.

What we have learned is the importance of demanding feedback, to demand a dialogue. For our particular Service, what that means is, I'm going to get one set of answers if I survey the member, but if I survey the family, I'm going to get a different set of answers. That to me is the way we go out, proactively, to look for these problems before they present themselves to us.

Senator CORNYN. General Amos, do you have anything you'd like to add in that regard?

General AMOS. Sir, I echo what Admiral Walsh and General Chiarelli have said. You asked, is there anything we could do early on during recruiting with an assessment of the young recruit, maybe before they actually become, in our Service, a U.S. marine? We've been fortunate because we are the smallest Service, we have a niche of society that we recruit, and it has gone quite well. With the help of Congress, we've grown the Marine Corps, as you said, Mr. Chairman, 22,000 up to almost 202,000, as of today.

The quality has not decreased; in fact, the quality has increased. The numbers of high school graduates have increased. The numbers of waivers have decreased. So, you would think, intuitively, that you were getting a higher-quality product, and we are. We put them through 12 weeks of boot camp, and our boot camp is legendary, and is designed to do a whole lot of things, in addition to imbuing the DNA of being a U.S. marine. But, one of the things it's designed to do is to put that young recruit through as stressful an environment, to look for those areas where he or she needs improvements or where he or she needs our help. We're pretty good at that. Those drill instructors are pretty good.

So at the end of 12 weeks at Parris Island or San Diego, on that Friday morning, I would say that we've probably done a pretty

good job of filtering out those that we might otherwise cut. You and I might think that there's probably not a potential candidate here for making a decision to take their own life. It's a mystery.

I will tell you that the next part for us is the resilience training, and that's what we are working on right now. How do you build a young man or a woman and make them strong enough so that, when a relationship fails or when something happens at home, that person has the ability to withstand that? So, we're working on that right now, sir, through our training.

Finally, the last thing I would say in my list is that we don't, and marines don't, leave marines on the battlefield. That theme needs to be carried over to everything we do in taking care of our young marines. We are not going to leave them behind.

Senator CORNYN. General Fraser?

General FRASER. Senator, thank you very much.

I, too, would echo the comments of my colleagues here. There's no one suicide that's exactly the same as another, and that's why we, as a Service, investigate every single one, to try and understand, Is there something that we can learn from this?

Through the Air Force Suicide Prevention Program, we have 11 initiatives within that program because we think it is multifaceted, since no one is exactly the same. As we learn from each suicide, we then take that into account across those 11 initiatives; but, moreover, we take into account the community where they live. Every community is different, whether it's in North Dakota, Texas, Florida, or Alaska. The other thing that we've done, through the Community Action Information Board, is to get that information out there. These meet, not only at the wing level, but they meet at the major command level. These are outbriefed at the major command level so that they can understand. We, in the Pentagon, even at the Air Staff level, hold a Community Action Information Board so that we can better understand what we can do with our processes, procedures, or resources given the needs of our troops out there to provide that support for them, but also for their families.

The other program that I think has yielded some dividends is our Wingman Program. It's the battle buddies because, as they begin, from the day of accession, as we go through education and training, through detection, all the way up to getting them help, we have found that the Wingman Program has been very beneficial. It helps break down that stigma. The stigma is no longer there, so that maybe they can get them the care that they need. It's that person that knows them better. In fact, we have gone so far as to move those mental healthcare providers who used to be in a different organization. We, ourselves, reorganized, and they are in our military treatment facilities now. If you come in for some other kind of care, then you can be looked at in that area, and it's not like you're going someplace else that's going to stand out, that they see your vehicle, they see you're going in there. It's a part of our military treatment facilities.

These are some of the things that we're learning. We continue to go back and look over those 11 initiatives, based on the cases that we have.

The other thing, sir, that we're doing is partnering with our sister Services here. We, right now, are taking a look at the video that General Chiarelli talked about. We think there's something that we can learn from that, in that interaction in today's high-risk youth. We see the same things that the other Services do. We think there's some utility there, and so, we're looking at adapting that, because that's another tool in our kit that we can use to help our young airmen out. It's multifaceted.

Senator CORNYN. Thank you very much. My time has expired.

Senator BEN NELSON. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I would request that Senator McCain's opening statement be placed in the record, if that's appropriate.

Senator BEN NELSON. It will be accepted.

Senator GRAHAM. Okay.

[The prepared statement of Senator McCain follows:]

PREPARED STATEMENT BY SENATOR JOHN MCCAIN

I thank Senator Cornyn for requesting this hearing, and Senators Nelson and Graham for promptly scheduling this hearing aimed at finding ways to prevent suicide by members of the Armed Forces.

Because the response to this problem relies so heavily on leadership and the military chain of command, we have asked the Vice Chiefs of Staff of the Services to testify today.

I hope this hearing will lead us all to a better understanding of why suicides occur in the Armed Forces, and who may be at risk. We seek assurances from the senior military leadership that resources and actions are being directed effectively and urgently to address any factor which has been shown to place a servicemember, his or her military unit and family at risk for the consequences of suicide. We need to understand what lessons have been learned by each of the Services when, at various points in their history—during peace and war—suicide rates have unpredictably risen or fallen in response to specific interventions.

There has been speculation about the impact of wartime operations on suicide rates. I want to hear more about the facts relating to suicide and military operations, and make sure that we are directing our efforts in the right direction. I have seen evidence of the dedication and resilience of our military personnel a thousand times over throughout the world—and that has not changed. We mourn the loss of every servicemember who falls in the defense of freedom, including by his own hand.

The bond of military Service is a strength like none other, based not on pursuit of individual achievement but on the performance and cohesion of military units. We must build on that strength to protect each member who commits his or her life to the defense of our Nation. I am confident that is what we will do.

Thank you Mr. Chairman, Senator Nelson, Senator Graham, Senator Cornyn and my colleagues on the Senate Armed Services Committee.

I look forward to your statements and to the testimony of our witnesses today.

Senator GRAHAM. What brings us here is the spike in suicides. I mean, there's a reason for this hearing, there's a reason you're doing all the preventive action and that we're all-hands-on-deck, so to speak. The Army's suicide rate has doubled from 2004 to now, from 9.6 per 100,000 to 20.2. Any indication as to why, General Chiarelli?

General CHIARELLI. Senator, I'm amazed every day at the resiliency of the Force, but I also know that it is a stressed and tired Force. You can look at the numbers and try to make yourself feel it's not totally dependent on that stress, by looking and saying that one-third of those individuals don't have any deployment history at all.

Senator GRAHAM. Right.

General CHIARELLI. But, I just don't think that's the case. I think it's a cumulative effect of deployments that run from 12 months to 15 months. I think most of America thinks that we are off the 15-month deployment; we will not get our last brigade back off of 15-month deployment until June of this year, and our last combat service support unit, those enablers you often hear about, until September 2009. We can do a lot, but we can't control the demand, and we expect the demand to continue for all of 2009 and into 2010.

So, if you were to ask me to identify one thing that I think has caused that spike, that is, in fact, it.

Senator GRAHAM. Sure. On the Air Force side, from 2004 until 2008, the suicide rate has been reduced in half in 2005 and, this year, is still a third less than 2004. How do you account for that? How has the deployment activity in the Air Force been from 2004 to 2008?

General FRASER. Sir, we've actually not seen a direct correlation to deployments.

Senator GRAHAM. Have you been deployed substantially from 2004 to 2008?

General FRASER. Yes, sir. In fact, if you take into account Operations Northern Watch and Southern Watch, we have actually been engaged for over 18 years in a rotation and in a cycle.

We think that the most positive thing that we did was our Air Force Suicide Prevention Program, in those 11 initiatives, and the fact that we continue to review those and bring in other things that we can do to take care of our airmen and to take care of their families. However we're not resting on that, because we have seen, as the chairman pointed out in his opening remarks, a bit of a tick up, if you please. We have to stay on top of this.

Senator GRAHAM. From the 30,000-foot level here, for the 4-year period I just described, Air Force deployments have not come down. Is that a fair statement?

General FRASER. That's correct, sir.

Senator GRAHAM. They probably have gone up, I would imagine. But, your suicide rates have come down. We just need to know more about the Air Force program, I suppose.

Now, on the Navy/Marine Corps side, I may be wrong, but it seems like you've had a pretty consistent suicide rate from 2004 to 2008. Is that correct?

Admiral WALSH. For Navy, that's correct, sir.

Senator GRAHAM. Okay. What about the Marine Corps?

General?

General AMOS. Sir, we've gone up. Since 2006, 2007, and 2008, we've gone up at a rate that's unacceptable.

Senator GRAHAM. Okay. Now, what do you attribute that to, General?

General AMOS. Sir, I think it's a lot of what General Chiarelli talked about. I mean, it's the reality of where we are with the stress on the Force, and it's exacerbated by deployments. We are a very deploying force. Senator, many of our units are right around the one-to-one deployment-to-dwell ratio. So, that's the reality of the demand side of it right now. But, in our Service, the thing that exacerbates this is, we are the youngest Service. Not only are we

the smallest Service, but we are the youngest. For instance, today we have a little over 201,000 marines on Active Duty; 160,000 of those are on their first 4-year enlistment. So the typical age of our marines is very, very young. So they fit this model of 18- to 24-year-old male and, again, on his first enlistment, or hers, that become the prime candidate to take their life. I think it's a host of things that are stressors on our young marines. The answer is the resilience, and the answer, I think, from our perspective, is going to be the NCO.

Senator GRAHAM. Finally, as to the Navy, what would be your view of fairly level rates?

Admiral WALSH. This is very difficult to penetrate with a program. I'm from a generation of naval officers who remembers exactly where they were when Admiral Boorda committed suicide as the CNO in May 1996.

This has been difficult to penetrate. We started our program in 1998.

Senator GRAHAM. Have your deployment schedules gone up or down from 2004 to 2008?

Admiral WALSH. Our deployment rates have increased. Our dwell time has been preserved. Our most vulnerable population is the individual augmentees who come outside of the typical deployment patterns for Navy.

Senator GRAHAM. Have they had a higher suicide rate than the Service as a whole?

Admiral WALSH. No, sir. One individual augmentee and one who returned from individual augmentee status about 18 months later.

Senator GRAHAM. Okay.

Mr. Chairman, I'd like to put these charts into the record. I think they're pretty informative.

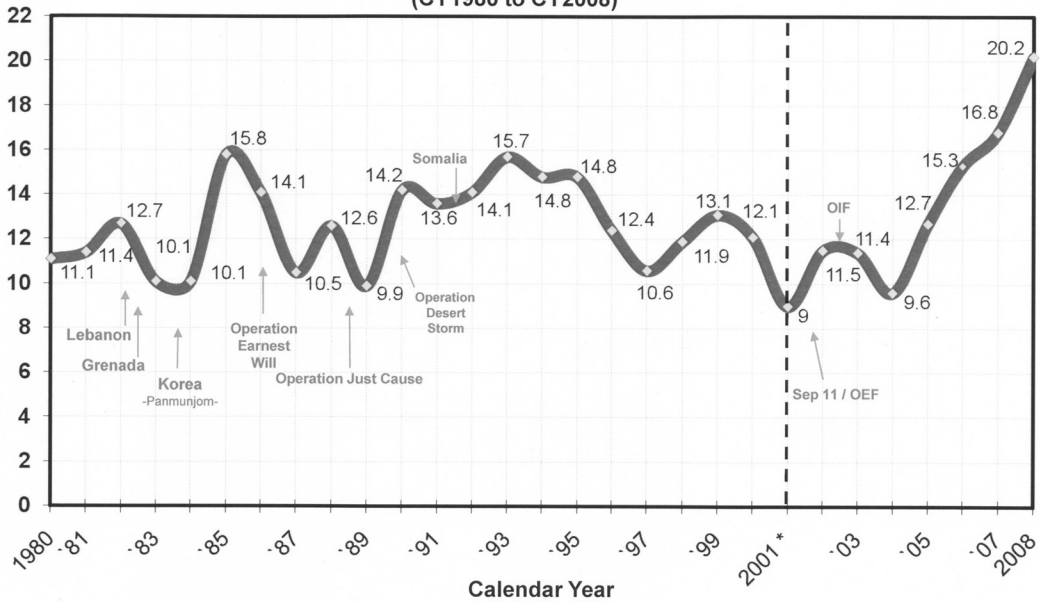
Senator BEN NELSON. Without objection.

[The information referred to follows:]

ARMY SUICIDES

Supporting Soldiers, Civilians & Families – Active, Guard, Reserve and Retired

Suicide Rates per 100K - Contingency Operations (CY1980 to CY2008)



Source: AFME, Defense Manpower Data Center (DMDC)
* CY1980-CY2000 depict Active Army Rates; CY2001-CY2008 depict Active Duty Rates (includes USAR and ARNG on Active Duty, and Active Army)

*** Data as of 2 Mar 09**

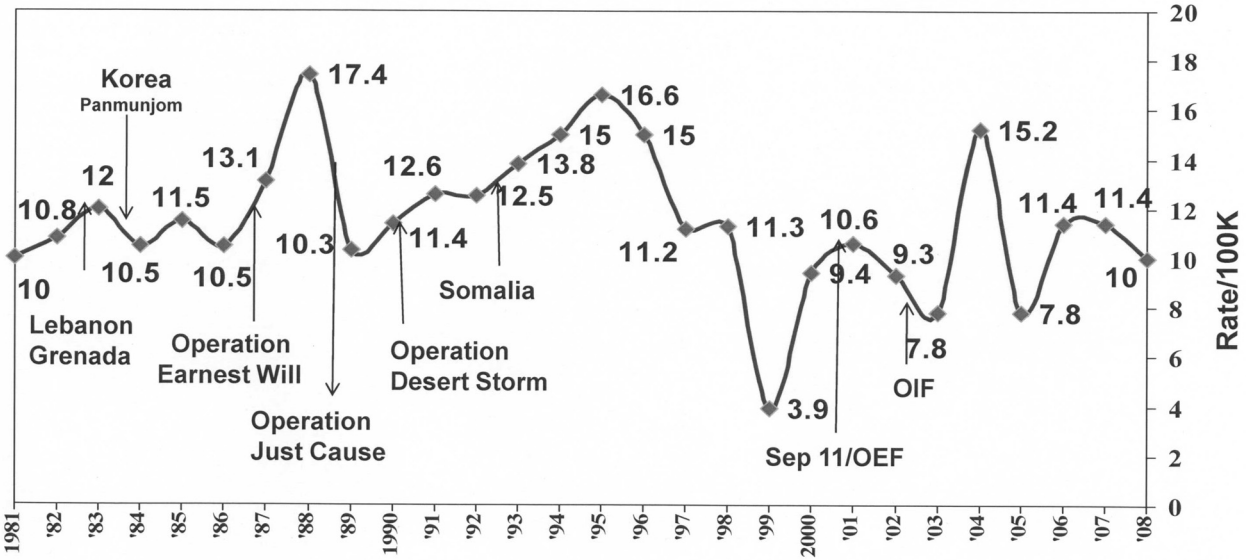
G-1, Human Resources Policy Directorate

U.S. AIR FORCE

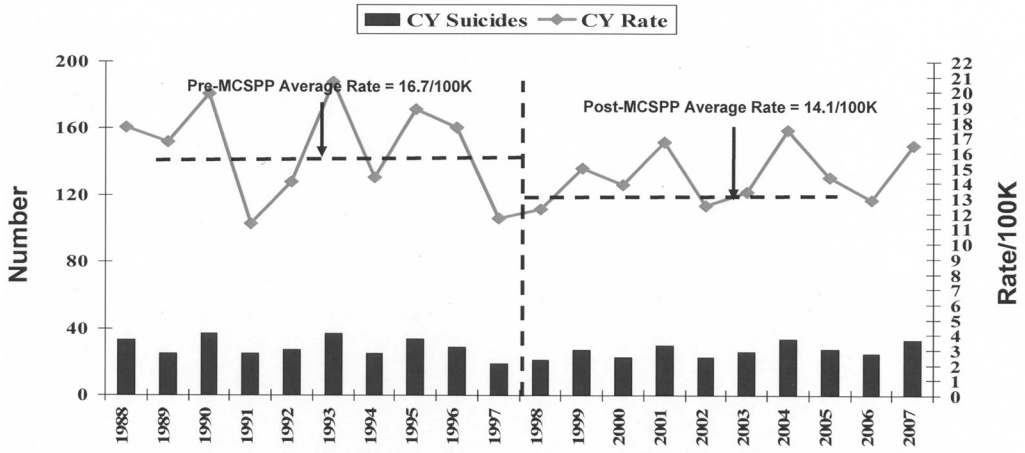
UNCLASSIFIED

Active AF Suicides

Contingency Operations



Program Efficacy

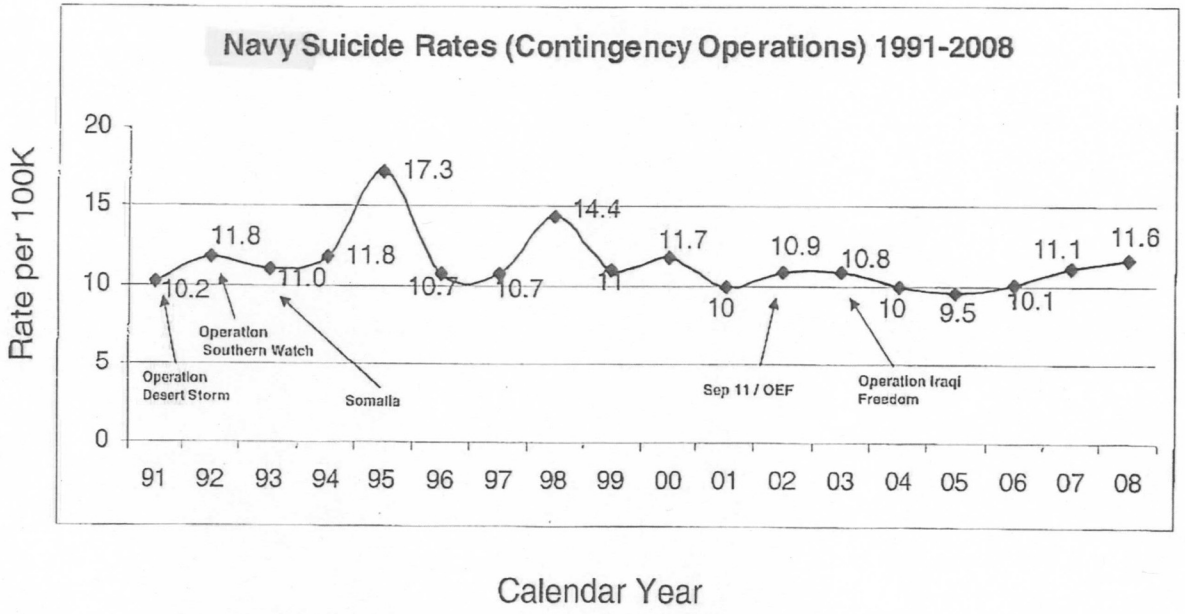


Rate is available for 9 years prior to MCSPP and was significantly higher than the rate after the program was formalized by MCO 6200.4A: T-test: $P<.05$

MCO 6200.4A required 1-hour suicide awareness training for all Marines
Average suicide rate dropped 16% after the initiation of required training

SASC: Suicide Hearing Graph

(Tab A to CIMS tasker 10123C1)



SERVICE SUICIDE STATISTICS

Basic Statistics

Active Duty Suicides (includes Reserve Component on Active Duty)

	USA	USN	USMC	USAF
CY08	128* (includes 6 USAR & 13 ARNG)	41 (includes 2 USNR)	41 (includes 2 USMCR)	38 (# does not include 6 ANG/AFRC)
CY07	115 (includes 3 USAR & 9 ARNG)	40 (includes 3 USNR)	33 (includes 0 USMCR)	34 (# does not include 3 ANG/AFRC)
CY06	102 (includes 10 USAR & 4 ARNG)	38 (includes 6 USNR)	25 (includes 0 USMCR)	42 (# does not include 4 ANG/AFRC)
CY05	87 (includes 6 USAR & 18 ARNG)	37 (includes 1 USNR)	28 (includes 3 USMCR)	31 (# does not include 7 ANG/AFRC)
CY04	67 (includes 3 USAR & 10 ARNG)	40 (includes 2 USNR)	34 (includes 1 USMCR)	49 (# does not include 6 ANG/AFRC)
CY03	79 (includes 6 USAR & 11 ARNG)	44 (includes 2 USNR)	26 (includes 8 USMCR)	38 (# does not include 2 ANG/AFRC)

*(As of 26 JAN 2009 w/15 cases pending final determination by the Armed Forces Medical Examiner.)

Suicide Rates per 100,000 Personnel (includes Reserve Component on Active Duty)

	USA	USN	USMC	USAF
CY08	20.2*	11.6**	19**	11.5
CY07	16.8	11.1	16.5	10
CY06	15.3	10.1	12.9	12.1
CY05	12.7	9.5	14.4	8.9
CY04	9.6	10	17.5	13.1
CY03	11.4	10.8	13.4	10.2

*(Estimated rate; final rate will be provided once all pending cases receive a final manner of death determination by the Armed Forces Medical Examiner.)
**(Preliminary rate; final rate will be calculated in APRIL 2009 per USD (P&R) memo dated 16 JUNE 2006.)

Risk Factors

Deployment History (CY03 – CY08 TOTALS)

Status at Time of Death	USA	USN	USMC	USAF
Deployed	129*	8	30	1
Post Deployment	173*	75	59	39
No Deployment History	133*	153	98	150

*(Does not include statistics from CY03 – CY04.)

Associated Stressors (NOTE: more than one reason may apply in any given case)

	USA*	USN**	USMC***	USAF****
Financial	9%	16.3%	13%	29%
Legal/Disciplinary	23%	36.8%	33%	44%
Marital/Relationship	65%	61.3%	49%	45% / 70%
Substance Abuse	18%	31.5%	25% (in last yr.)	39%

*(Army data is based on 2007 ASER Report.)
**(Navy percentages reflect suicides statistics from CY03 to CY08.)
***(Marine Corps percentages reflect suicides statistics from 1999 to 2007.)
****(Air Force percentages reflect Active Duty suicides statistics from 2003 to 2008.)

Demographics

Rank

	USA*	USN**	USMC***	USAF****
E1 – E4	80	96	134 (E1-E9)	111
E5 – E9	47	121		97
Officers	12	20	9	24

*(Information reflects CY08 Active Duty suicide statistics only, including pending cases.)
**(Suicide statistics from CY03 to CY08.)
***(Suicide statistics from CY03 to CY08.)
****(Active Duty suicide statistics from 2003 to 2008.)

Age

	USA*	USN**	USMC***	USAF****
17-24	65	97	129	96
25-34	37	88	40	73
35+	40	55	18	63

*(#s reflect CY08 Active Duty suicide statistics only, including pending cases.)
**(Suicide statistics from CY03 to CY08.)
***(Suicide statistics from CY03 to CY08.)
****(Active Duty suicide statistics from 2003 to 2008.)

Race

	USA*	USN**	USMC***	USAF****
White	110	166	141	176
African American	17	29	12	31
Hispanic	4	17	16	7
Asian/Pacific Islander	5	16	1	8
Native American	4	11	4	? – USAF did not provide information.
Other	3	1	13	? – USAF did not provide information.

*(#s reflect CY08 Active Duty suicide statistics only, including pending cases.)
**(Suicide statistics from CY03 to CY08.)
***(Suicide statistics from CY03 to CY08.)
****(Active Duty suicide statistics from 2003 to 2008.)

Gender

	USA*	USN**	USMC***	USAF****
Male	134	228	184	219
Female	9	12	3	13

*(#s reflect CY08 Active Duty suicide statistics only, including pending cases.)
**(Suicide statistics from CY03 to CY08.)
***(Suicide statistics from CY03 to CY08.)
****(Active Duty suicide statistics from 2003 to 2008.)

Senator BEN NELSON. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

Mr. Chairman, let me first thank you, Senator Graham, and Senator Cornyn for your leadership on this extraordinarily troubling issue.

I want to commend the members of our panel for the actions that you're taking in each of the Services to address this issue in a forthright manner. I think the kinds of tapes, videos, publications,

cards, and guidance that you're providing are excellent, and they'll be extremely helpful as they're used more widely.

I am concerned, however, about the problems that occur after the men and women come home from deployment or after they have been discharged. When I look at the cases that we have had in Maine, they involve soldiers who have come back home and do not have the kind of support system that you have described today as being potentially effective.

For example, I remember well a young soldier who came home from Iraq missing a limb, was discharged from the Service, went back to his small community in Maine, was very isolated and no longer getting the support that he needed, and attempted to commit suicide after a number of months. In another case, a National Guard member who came back home, back to his civilian life, did successfully commit suicide.

What struck me in hearing your testimony today is, it's evident that the military Services are taking this problem very seriously and are developing good programs and procedures. But, I'd like each of you to discuss how you're coordinating with the Department of Veterans Affairs (VA), for example, and the National Guard, because the problems I'm seeing in Maine involve the members of the Guard who have come back home to resume their civilian lives or, in some cases, it's people who have gotten out of the Services. So, what kind of aftercare, if you will, or coordination, is being provided for those who have been recently discharged but have serious problems and need mental health services?

General, we'll start with you and go down the table.

General CHIARELLI. Well, this is a real issue for us. When you get psychologists and psychiatrists in a room, you can get them to agree on little, but most of them will agree that those that are found in geographically isolated areas have a higher incident of suicide. The Army Science Board, who did a study for us, proved that to be the fact. They said it was statistically provable that that is, in fact, a true statement. When you realize that over half of the Army, in our National Guard and Reserve components, go on Active Duty and then do exactly what you described, Senator, return to their communities, we have to find a way to deliver those services to them.

One of the things that I think is having a big benefit today is the Yellow Ribbon Program, where National Guard and Reserve units come back at the 30-, 60-, and 90-day period and go through some reintegration training, much the same as the Active component does for 10 days when they come back. I think you know that the desire has always been to demobilize the National Guard and the Reserves as fast as you possibly can, and I think that is sometimes to their detriment. I think the Yellow Ribbon Program goes a long way in getting us to where we need to be in providing them those services.

But, we're also looking for innovative ways to provide mental healthcare online. In the National Defense Authorization Act, there was some language put in by Representative Dicks, who asked us to go out and look at the possibility of doing this. I think it shows great promise. It's not without problems. The credentialing of a doctor that lives in North Dakota giving advice to a soldier that's

in California, across State lines, raises some problems that we're working our way through. There are also problems in finding the way to pay for this and to work it into the overall TRICARE plan. But, these are the kinds of things we're doing to try to deliver these things to the majority of our population that do return, many times to geographically isolated locations away from the support of our posts, camps, and stations.

Senator COLLINS. Thank you.

Admiral Walsh?

Admiral WALSH. Senator, while we don't have the Guard issue, I would apply it to our Reserves.

Senator COLLINS. Right.

Admiral WALSH. The issue in the Reserves is having visibility on reservists. So, those who affiliate, those who serve, are part of our database. We've had success with programs for our severely wounded, ill, and injured who are transitioning out of DOD and through the VA system. That Safe Harbor Program today has about 250 or so personnel. We've had no incidence of suicide in that kind of framework, where we have good control over, and maintain contact with, people as they make their transition from DOD through the nonmedical sorts of services that they need. It's a support system, and one that's accountable to the active line.

Where we are less visible, where we have less control, are those reservists who no longer affiliate and move on into the civilian population. We do not have visibility on them. So we have less programmatic impact on them.

Senator COLLINS. Is there coordination with the VA healthcare system to try to help in that area?

Admiral WALSH. I know there are initiatives underway, ma'am, in order to do that, but I can take that for the record and get back to you. [Refer to the questions for the record section for a variety of programs, coordination, and treatment explanations.]

Senator COLLINS. Okay.

General Amos?

General AMOS. Senator, we don't have a Guard; we have Reserves.

Senator COLLINS. Right.

General AMOS. But, we are a total force, and all our Reserves, for the most part, are deployed at least twice in the Reserves. So, we are actually integrated, and we track them very carefully. When we talk about programs, whether it be mental health programs, tracking wounded, or care for families, we really talk about everybody, together—the 239,000 Active and Reserve marines. We bring them together, and they are an integral part of that.

The Wounded Warrior Regiment (WWR), when it has stood up by our Commandant 2 years ago, was designed to provide the continuity of care and attention that marines want to provide for those that are wounded. Right now, we have a little over 8,800 marines that have been wounded, many of whom stayed on active duty, but a large percentage of them have moved on into the VA and on to the next parts of their life. We track all 8,800 through the WWR. We have the call center that was established a year and a half ago and made over 37,000 phone calls. They call the wounded marines, they call their mothers, and they call their wives. The idea is to

ask, "How are you doing?" You get a lot simply by talking to mothers, sometimes, because the marine himself may not give you the straight scoop, but we've found, over time, moms will and wives will. So, we track that.

Where I think there's work to be done, in our case, is with those marines that perhaps would qualify or be classified as someone that has a mental health issue and otherwise are perfectly fine; their bodies are healthy and whole, maybe something happened that caused them to seek a mental health provider, and then they finish their enlistment and they move on to the next part of their lives. We don't track them, because they're not a wounded marine, necessarily. They're wounded if it's PTSD, and we track some of those that are more severe. But, I would say, if there's work to be done, it's probably in this area, where we take a young marine that's faithfully served and has some type of mental health issue, and we do the battle handover to the VA. I don't think we're doing that right now, and I think it's something that we need to do.

Senator COLLINS. Thank you.

General Fraser?

General FRASER. Senator, we too are a total force, and all the tools that are available to the Active Duty, the Guard, and the Reserve both participate in. So they're a part of our Suicide Prevention Program, and have access, and we utilize all of those tools to help them.

But, once they go home, there are issues that come up. One of the things, though we've not hesitated to do, and we've worked through this, is that, if they need help, we will immediately help assist them, the Guard or the Reserve, to get them back on orders and get them the help they need.

Senator COLLINS. Good.

General FRASER. There's no time lost if it's identified that someone needs help. We're part of the Yellow Ribbon Program, and we're doing all kinds of other things. The Landing Gear, which I've not talked about, is another program where we think that that's beginning to pay dividends, too. That program is across all of the Active Duty, the Guard, and the Reserve now, which helps, both in the predeployment, on expectations and an understanding of the individual and where they are, but post, when they come home and then—if they need some follow-on—because we are seeing a large increase in PTSD. Ensuring, as General Amos was talking about, that we take care of them and continue to follow on is a key thing that we're doing. But, that's just an example of some of the things.

Senator COLLINS. Thank you.

Mr. Chairman, I know my time has expired. Just a suggestion for our panel. I realize my time has expired, so I won't ask for a response today, but in your response to the record, and that is, as a result of work that many of us on this committee have done, there now is screening for TBI, both pre- and post-deployment. I wonder if that could be expanded to also be a screen for mental health problems. If you did it predeployment, and that's the concept to identify TBI, then you'd have a baseline that you could compare with post-deployment screening. If you did it as part of the screening for TBI, there would not be any stigma attached to it, and yet, you might be able—I mean, we all want to eliminate that

stigma, but we have to recognize that it exists—as part of that review, identify those with problems or at risk. That's just something I'd like the panel to consider.

Senator COLLINS. Finally, Mr. Chairman, I really think the issue of the handoff to the VA is absolutely critical because that's the case of the young soldier who lost his leg, who tried to commit suicide; he was living in rural Maine, in a very small community, very far from the VA hospital. He was having problems with this prosthesis. He couldn't get the answers he needed. He became depressed and frustrated. We just have to find a way to reach people like that, and the VA system has to be part of the solution.

Thank you for your indulgence.

Senator BEN NELSON. Thank you, Senator. The effort to make the transition from Active Duty or from Guard/Reserve deployment to the VA, to make that as seamless as possible, is a wonderful exercise and recognizes the importance of having it be a continuum, as opposed to dropping off the cliff. Obviously, it's very difficult to make it happen in rural areas, as much as we would like, but it's obviously very important to have it extended into the rural areas, as well. So, I would agree with you and I hope that the panel would look for that, as well as the pre- and post-screening. I think there's a great deal of benefit to be gained from doing it that way.

Thank you, Senator.

Senator COLLINS. Thank you.

Senator BEN NELSON. General Fraser, I have a question. It was in your written testimony, you indicated that the medical record reviews of many of the recent victims indicate that a majority of the suicide victims had utilized some form of mental health services for issues ranging from alcohol abuse to marriage counseling.

While it's clear that they reached out for some help, as their medical records would indicate, they still committed suicide. I suppose it's easy to say that the mental health services are ineffective even, as a result, that's what happened. But, I don't know that that's a conclusion we want to draw, necessarily. What are your thoughts on that fact? Prior use of mental health services, and yet, it was not or may not have been sufficient; it also could be something else that came along.

General FRASER. Thank you, Sir. That is something that we are trying to understand better. Because of that, anyone who was participating or receiving any kind of help, mental health assistance, counseling, or things of that nature, is reviewed after suicide. We have instituted and that we are now doing, is also a medical incident investigation. So, there's a follow-on investigation that's going to take place, so that our mental healthcare providers can understand that better. Was there something that happened in their care, in the runup to it, or other things that they may have missed, was there a seam? So, we are working this, not only when there's a suicide that's actually committed; there's the normal investigations that we do—normal, in the sense that we bring in a team, it's investigated. Our Office of Special Investigations and our security forces do that and give feedback to the commander. If it is found that they've had some care given, we also launch off on one of these other investigations to better understand that so that we can then input that into the system to try and shore that up even

better. So, we're continuing to work it, sir. There's no one seam through that, either.

Senator BEN NELSON. It's obvious that we've gotten pretty good at following the physical health of individuals, being able to document injuries, recovery, with complete medical records. We don't have the capability yet to be able to do that on the mental health side, for a variety of reasons. We've already indicated, stigma and identification, and perhaps even the identification by the soldier, by the airman, by the marine, by the sailor. So, hopefully we'll be able to be as effective with mental health records and support to be able to do that as we are on the physical side, ultimately.

One other question I have is—I think it was General Chiarelli, you said "learning to cope," trying to identify, at the time that you bring individuals in, that you identify, in your own minds, the ability of that person to cope with the strains, the stress, and everything that would come along in their military career. Are the other branches focused more on mental health upfront to determine the ability of the recruit to cope, not just simply with basic training, but to just cope with life's challenges that are obviously going to affect them: the breakup of a romantic relationship or financial problems that might develop?

Admiral Walsh?

Admiral WALSH. Coping for the recruits is a very important part of the program; however, empirically the data suggests to us that the 63 percent of those who commit suicide in the Navy are in the E4 to E6 category. These are our mid-grade petty officers. When we look further at it, what this suggests to us is that, what we really need to be looking at is, Who's looking after supervisors, who's looking after leaders, who's giving them the outlet that they need? We look at this by rating; we find corpsmen have a statistically high number, an unacceptable number. When we talk about mental health professionals, we also have to think about their dwell time and how much stress is on them because who looks after the providers is not a common question, and it's one that leaders need to ask.

Senator BEN NELSON. General Amos?

General AMOS. Sir, General Chiarelli and I were meeting last week on TBI with General Sutton, working our way through how we can continue to provide a focus on that. One of the things that came out of that was the reality of most of the referrals and most of the folks that actually can put their fingerprints on a young man or young woman in distress really aren't necessarily the front-line mental health providers. Now, we say that, but really, in many cases, I think somewhere around 60 percent are the standard primary healthcare folks. In other words, it's your battalion surgeon, it's your doctor, your corpsman or medic, it's the chaplain. So, for us, our focus for the next little bit is going to make sure it's the whole body, it's everybody paying attention, taking care of one another, understanding that we don't leave anybody behind. Everybody plays an important part in this. That's where we're headed, sir.

Senator BEN NELSON. General Fraser?

General FRASER. Sir, we think that it begins at the accession, and we begin, right away, assessing those young airmen and un-

derstanding where they are. We also are institutionalizing our Wingman Program from the very beginning, even in the basic military training. We see that down there nowadays, even as we've expanded basic military training. They're working more together as a team. As you see them out running, as you see them out running the obstacle course, doing things, if one gets ahead, they're falling back, they're helping the others along. So, institutionalizing that from the beginning in those wingmen, and helping each other, we think that's going to pay great dividends.

These assessments that we're doing are telling us a lot, though. The annual Physical Health Assessments, but also the pre-, the post-, and then the follow-on reassessments that are going on, we're learning a lot from that, and that's how we're able to follow up. Then we begin to get a history, and then you can understand the individual and where they are.

The other thing is working with the families, working with the families through a key spouse program, working through the issues that they may have, to help us understand where they are because maybe we'll be able to see that there's a relationship problem there that we are able to address and help earlier on.

The other thing is training the supervisors, the leaders, the flight commanders at every single level to understand and look for indicators. We've formalized that training, also, so that they have the tools in their kitbag that they can utilize to take care of their airmen. So, it's a holistic approach, again. But, it does begin on day one with the accession.

Thank you, sir.

Senator BEN NELSON. Senator Graham?

Senator GRAHAM. I know we want to get to the next panel. Gentlemen, just one quick question. I want to make sure I have your testimony right. Do you believe there's a shortage of mental health counselors in the military?

General CHIARELLI. There is in the Army, sir. Senator, there is in the Army, both on mental healthcare providers—although we have raised that number by some 250, there's no doubt in my mind we are short—and also substance-abuse counselors.

Senator GRAHAM. Right.

Admiral Walsh?

Admiral WALSH. Yes, sir. For the Navy, we're asking for more.

Senator GRAHAM. Okay.

Admiral WALSH. We are at 88 percent of the fill that we need.

Senator GRAHAM. Okay.

General AMOS. Senator, you know we don't have medical in our Corps, but we rely on the Navy, and we are significantly short.

Senator GRAHAM. Right. You have the Navy folks.

General FRASER. Sir, we are short in our active duty authorizations. We do not have them all filled.

Senator GRAHAM. My question is, is there anything this subcommittee can do, in terms of bonuses, you name it, to help recruit more people into this area?

General CHIARELLI. I can't tell you that at this time. I can tell you that we have a rough time. We have the resources out there to hire right now, but when you go to places like Fort Drum, Fort Campbell, Fort Hood, TX, in a specialty that is short already across

the country, it is difficult, even with the money, to hire what you need.

Admiral WALSH. Sir, we're aware of the nationwide shortage in mental health professionals, but the concept that we think works, in terms of operations with mental health, is to have them deploy with us. So, they need to come along and preferably serve in uniform the way the Assistant Commandant of the Marine Corps, General Amos, described.

Senator GRAHAM. Yes, well, we stand ready, if you think of something down the road, General. What I've gotten from this, it seems like the deployment activity of the Marine Corps and the Army obviously are putting more stress on servicemembers. I mean, that makes sense when you think about the missions of the Marine Corps and the Army in this particular war, and the Navy and the Air Force have done things never envisioned for the Navy and the Air Force, in terms of ground commitments. I can understand why the numbers are higher for the Army and the Marine Corps because deployments are longer and it's the nature of your work. So, I know you're on top of it, doing the best you can. All I can say is that, where this subcommittee can help inform the committee, as a whole, about how to make up for the shortage, we stand ready. If it's money, and that will help, I think we're ready to help with money.

Thank you.

Senator BEN NELSON. Thank you, gentlemen. Thank you, particularly, for waiting and being patient with the delayed start. Thank you for your service to our country. For the men and women who serve under you, we thank them as well.

In our final panel, we welcome Lieutenant General Benjamin C. Freakley, who is the Commanding General of the United States Army Accessions Command. We all appreciate that recruiting is one of the most demanding, challenging jobs in any military service. In addition to the long hours, many recruiters work in remote areas, without the traditional support structures in place to help deal with stress, including the residual effects of prior deployments. General Freakley is charged with overseeing all Army recruiters and is here to discuss the results of his investigation into the recent suicides in the Houston Recruiting Battalion and actions taken throughout the entire Army to reduce the risk of suicide among recruiters.

We welcome you.

We also have with us Major General David A. Rubenstein, Deputy Surgeon General of the Army. He's here to discuss the role of the Army Medical Command in suicide, mental health, and substance abuse prevention, research, and treatment.

Brigadier General Loree K. Sutton is the Director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. She'll discuss the role of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury in suicide prevention, and, as a piece of that, will address the status of DOD's establishment of the task force to examine matters relating to prevention of suicide by members of the Armed Forces required by the National Defense Authorization Act for Fiscal Year 2009.

Also with us today is Brigadier General Michael S. Linnington. He is the Commandant, U.S. Corps of Cadets at the United States Military Academy. He's here to address the recent suicides and suicide attempts at West Point and specific actions that have been directed to prevent suicide at the Academy.

Finally, we are honored to have a representative from the civilian sector, Ms. A. Kathryn Power, who is the director of the Center of Mental Health Services within the SAMHSA, which is under the HHS. Ms. Power has a long career of outstanding public service, including participation in the DOD Task Force on Mental Health, whose report we all consider a valuable resource. She will share views from the public health perspective. Her testimony will address suicide rates and causal factors in comparable U.S. civilian population groups. She'll also discuss best practices in suicide prevention from the civilian community that could be effectively applied in a military environment and ongoing and potential Federal agency collaboration efforts that could prevent suicides among members of the Armed Forces.

We thank you all for taking time to be here today, and we look forward to hearing from you. Thank you.

General Freakley?

STATEMENT OF LTG BENJAMIN C. FREAKLEY, USA, COMMANDING GENERAL, U.S. ARMY ACCESSIONS COMMAND, DEPUTY COMMANDING GENERAL, INITIAL MILITARY TRAINING

General FREAKLEY. Chairman Nelson, Ranking Member Graham, and distinguished members of the subcommittee, thank you for the opportunity to appear before you today.

The subject we address is a tragic one. Suicide is a national problem, one to which the Army is not immune. When a soldier, civilian, or family member commits suicide, we, the Army at large, lose a brother or sister, a comrade in arms, a member of our Army family. Each loss is a tragedy, with any number of people asking how they could have done something differently to prevent this death.

The motivation to commit suicide is rarely simple and often complicated by medical issues, family and personal relationships, job stress, and financial concerns. Army recruiters have particularly stressful jobs, and we are looking at their circumstances to determine how we provide them additional support.

Between January 2005 and September 2008, there were four suicides within the United States Army Recruiting Battalion at Houston, TX. I directed an Army regulation 15–6 investigation to look into the factors existing with each suicide, and I appointed Brigadier General Frank D. Turner III, U.S. Army Accessions Command, Deputy Commanding General and Chief of Staff, to conduct this external investigation. The investigation thoroughly examined personal, organizational, and institutional factors that might have impacted the four soldiers.

General Turner's investigation concluded that there was no single cause for these deaths. Relevant factors included stress, personal matters, and medical problems. Additionally, a poor command climate was perpetuated by a few individuals within the battalion, compounded by an artificially inflated mission placed on

each recruiter. The command climate and inflated mission manifested in long hours and unpredictable schedules.

United States Army Recruiting Command leads over 7,000 full-time soldiers to recruit for the regular Army and over 1,700 Reserve soldiers to recruit for the United States Army Reserve. Maintaining the All-Volunteer Force is a challenging task. Engaged, caring, and compassionate leadership is necessary to maintain the proper balance between mission accomplishment and ensuring the well-being of our recruiters and their families.

Approximately 70 percent of the United States Army Recruiting Command personnel live in areas that are considered geographically dispersed. That means they live away from military installations and do not have ready access to care and peer support networks that they have come to expect, to include military medical facilities. Peer support networks are often difficult to maintain in recruiting, as most personnel live in surrounding communities, not on installations where soldiers can easily socialize.

The investigation made several recommendations that we are addressing across Recruiting Command, Accessions Command, and the United States Army. General Turner's investigation found that there is nothing inherently problematic with combat veterans being assigned to recruiting duty after returning from a deployment, as compared to a wide range of other challenging Army assignments. Although post-deployment screening was not found to be a factor for any of the suicides in the Houston Battalion, improvements are required in reintegration policy compliance, post-deployment continuity of care, and ensuring assignment policies consider the special needs of soldiers and families, especially those assigned to communities away from military installations.

In addition to the actions that we're taking, Accessions Command, the Army G–1, the Surgeon General, have adopted procedures to ensure compliance with recruiter screening and the selection process, the provisions of care for soldiers who require mental healthcare, Army-wide suicide training, and access to care in peer-support networks for geographically dispersed soldiers. The Army and the Command are taking very specific action to prevent future suicides. Leadership has changed in the Houston Battalion, and Recruiting Command has conducted an initial inspection that showed the command climate and morale is much improved. A formal Inspector General investigation will be conducted in the Houston Battalion in June of this year.

At my request, the Department of the Army Inspector General is conducting a command-wide inspection of the recruiting work environment. The Secretary of the Army, the Honorable Pete Geren, directed a stand-down day, and this one was conducted across Recruiting Command on February 13, to address the complex issue of suicide and leadership to enforce a positive climate for our soldiers and their families.

Additional suicide prevention training is being conducted across the Army as we work to change perceptions regarding mental health, increase awareness of suicide, and improve leadership.

The Army G–1, through the Human Resources Command, is adapting screening and selection processes for prospective recruiters. The Army's Office of the Surgeon General and the Recruiting

Command are developing recruiter-specific mental-health screening tools to be used in those processes.

The Recruiting Command is revising its regulation to remove any ambiguity about mission assignment procedures. Additionally, we are implementing training programs at the Recruiting and Retention School to improve recruiter resiliency.

Additionally, across Cadet Command over 4,600 gun cadets, who will be this year's new lieutenants, are being trained in suicide awareness so that they reduce the stigma and are aware of the young soldiers joining their formations.

To address care and peer network support, we are developing a pilot program to assess the feasibility of mobilizing Reserve soldiers in their hometown as regular Army recruiters, under the premise that Reserve soldiers are already actively engaged in their community and have a well-established support network.

We have received significant support from the Army leadership. The Secretary of the Army, the Honorable Pete Geren, has taken personal interest in this matter at every step, and offered support within his authority, as has the Chief of Staff of the Army and the Vice Chief of Staff. Losing soldiers to suicide is intolerable. Army senior leaders have acted swiftly to support recruiters and soldiers Armywide in laying the groundwork for understanding that there is no stigma attached to seeking mental healthcare and improving the education to all of our soldiers to be self-aware and aware of their buddies with suicide awareness. We expect that our focus on these issues, along with additional training and concerned leadership throughout our command, that our soldiers will seek the help they need before considering a tragic act.

We thank you, sir, and the committee, for all of your attention to this matter, your continuing support to our Army, our command, and to our soldiers and their families.

[The prepared statement of General Freakley follows:]

PREPARED STATEMENT BY LTG BENJAMIN C. FREAKLEY, USA

INTRODUCTION

Chairman Nelson, distinguished members of the subcommittee, thank you for the opportunity to appear before you today. The subject we address today is a tragic one. Suicide is a national problem, one to which the Army is not immune. When a soldier, civilian, or family member commits suicide, we—the Army at large—lose a brother or sister, a comrade in arms, a member of our Army family. Each loss is a tragedy, with any number of people asking how they could have done something differently to prevent this death. The motivation to commit suicide is rarely simple and often complicated by medical issues, family and personal relationships, job stress, and financial concerns. Army recruiters have particularly stressful jobs, and we are looking at their circumstances to determine how we provide them additional support.

HOUSTON SUICIDES

Between January 2005 and September 2008, there were four suicides within the U.S. Army Recruiting Battalion at Houston, TX. I directed an Army Regulation 15–6 investigation to look into the factors existing at the time of each suicide, and I appointed Brigadier General Frank D. Turner III, U.S. Army Accessions Command Deputy Commanding General and Chief of Staff, to conduct the investigation. The investigation thoroughly examined personal, organizational, and institutional factors that might have impacted the four soldiers. General Turner's investigation concluded that there was no single cause for these deaths. Relevant factors included stress, personal matters, and medical problems. None were diagnosed with Post-Traumatic Stress Disorder. Additionally, a poor command climate was perpetuated

by a few individuals within the battalion, compounded by an artificially inflated mission placed on each recruiter. This command climate and inflated mission manifested in long hours and unpredictable schedules.

RECRUITING COMMAND

The U.S. Army Recruiting Command employs over 7,000 full-time soldiers to recruit for the Regular Army and approximately 1,700 Reserve soldiers to recruit for the U.S. Army Reserve. Maintaining the All-Volunteer Force is a challenging task. Engaged, caring, and compassionate leadership is necessary to maintain the proper balance between mission accomplishment and ensuring the well-being of our recruiters and their families.

Approximately 70 percent of the U.S. Army Recruiting Command personnel live in areas that are considered "geographically dispersed." That means they live away from military installations and ready access to the care and peer support networks they have come to expect, to include military medical facilities. Peer support networks are often difficult to maintain in recruiting, as most personnel live in surrounding communities, not on an installation where soldiers can easily socialize.

LESSONS LEARNED

The investigation made several recommendations that we are addressing across the Recruiting Command and the Army. General Turner's investigation found there is nothing inherently problematic with combat veterans being assigned to recruiting duty after returning from a deployment, as compared to a wide range of other challenging Army assignments. Although post-deployment screening was not found to be a factor for any of the suicides in Houston Battalion, improvements are required in reintegration policy compliance, post-deployment continuity of care, and ensuring assignment policies consider the special needs of soldiers and families, especially those assigned to communities away from military installations.

In addition to the actions that we are taking, Accessions Command, the Army G1, and the Surgeon General have adopted procedures to ensure compliance with the recruiter screening and selection process, the provisions of care for soldiers who require mental health care, Army-wide suicide training, and access to care and peer support networks for geographically dispersed soldiers.

WAY AHEAD

The Army and the command are taking very specific action to prevent future suicides. Leadership has changed in Houston Battalion, and the Recruiting Command has conducted an initial inspection that showed command climate and morale is much improved. A formal Inspector General inspection will be conducted in the Houston Battalion in June of this year. At my request, the Department of the Army Inspector General is conducting a command-wide inspection of the recruiting work environment. The Secretary of the Army-directed "stand-down day" was conducted across the Recruiting Command on February 13 to address the complex issues of suicide. Additional suicide prevention training is being conducted across the Army, as we work to change perceptions regarding mental health.

The Army G1, through its Human Resources Command, is adapting screening and selection processes for prospective recruiters. The Army's Office of the Surgeon General and the Recruiting Command are developing a recruiting-specific mental health screening tool to be used in those processes.

The Recruiting Command is revising its regulation to remove any ambiguity about mission assignment procedures. Additionally, we are implementing training programs at the Recruiting and Retention School to improve recruiter resiliency.

To address access to care and peer network support, we are developing a pilot program to assess the feasibility of mobilizing Reserve soldiers in their hometown as Regular Army recruiters, under the premise that Reserve soldiers are already actively engaged in their community and have a well-established support network.

We have received significant support from Army leadership. The Secretary of the Army, the Honorable Pete Geren, has taken a personal interest in this matter at every step and offered all support within his authority.

CONCLUSION

Losing soldiers to suicide is intolerable. Army senior leaders have acted swiftly to support recruiters and soldiers Army-wide in laying the groundwork for understanding that there is no stigma attached to seeking mental health care. We hope with our focus on these issues, along with the additional training and concerned leadership from all levels, all soldiers will seek the help they need before consid-

ering a tragic act. Thank you for your attention to this matter and your continuing support to the Army.

Senator BEN NELSON. Thank you.

General Rubenstein?

STATEMENT OF MG DAVID A. RUBENSTEIN, USA, DEPUTY SURGEON GENERAL, UNITED STATES ARMY

General RUBENSTEIN. Chairman Nelson, Senator Graham, Senator Thune, thank you for bringing us together to discuss this very complex and very difficult issue of suicide in our ranks.

I'd like to tell you a story about a 33-year-old soldier at one our largest Army posts. He's married. He lives at home with his wife and his three children. He's assigned to the Warrior Transition Unit (WTU) of his post because of a motorcycle accident 2½ years ago that left him with a TBI. He is a model patient in every regard.

He's been treated by the same psychiatrist for the past 2 years and 1 month. He saw that psychiatrist on Friday of last week. On Monday, he saw his primary care doctor. He also saw his nurse case manager, and he had a group life-skills appointment. On Tuesday, he apparently committed suicide.

We lost a soldier yesterday. We have a hole in our formations. We have a devastated family. We have a devastated unit. We have a TBI Clinic which is absolutely devastated. This soldier was used as a motivational speaker once a week in the TBI Clinic, talking to other soldiers for the past 2 years. Of course, we have individual healthcare providers who are devastated.

This soldier was treated, was compliant, and was supported in every way, and yet, he's dead today.

Thank you, again, for bringing us together to talk about this very complex, very difficult problem that causes all of us to scratch our heads and wonder how we stop the next one.

I look forward to your questions, sir.

[The prepared statement of General Rubenstein follows:]

PREPARED STATEMENT BY MG DAVID A. RUBENSTEIN, USA

Chairman Nelson, Senator Graham, and distinguished members of the Personnel Subcommittee, thank you for the opportunity to discuss the Army Medical Department's efforts to support suicide prevention efforts across the Army. The increased operational demand of our military force to fight overseas contingency operations has stressed our Army and our aamilies. Despite our varied efforts over the last several years, suicide rates continue to rise. The Army and the Army Medical Department (AMEDD) are extremely concerned about this trend and we are committed to doing whatever it takes to prevent suicide. The AMEDD is contributing medical expertise to the suicide prevention task force recently established by the Army Vice Chief of Staff, General Pete Chiarelli, to address suicide and suicide prevention. This multi-disciplinary task force, led by Brigadier General Colleen McGuire, will integrate all of the diverse suicide efforts ongoing across the Army; build on these efforts; and develop a comprehensive strategy for suicide prevention that involves screening/surveillance, suicide prevention training, risk assessments, and treatment.

The Army Medical Department supports the Army's multidisciplinary approach in many ways. Our most significant contributions are in the arenas of surveillance and treatment. We have made recent improvement in each of these areas.

SURVEILLANCE IN THEATER

The Army's groundbreaking Mental Health Advisory Teams (MHATs) have shown that longer deployment, multiple deployments, greater time away from base camps, and combat frequency and intensity all contribute to higher rates of post-traumatic stress disorder, depression, and marital problems. All of these factors can contribute

to increasing suicide rates. MHAT V findings show that rates of mental health problems rose significantly with each deployment, reaching nearly 30 percent among soldiers on their third deployment to Iraq. The 2007 effort also showed that soldiers in brigade combat teams deployed to Afghanistan are now experiencing levels of combat exposure equivalent to levels in Iraq, and that the rate of mental health problems is comparable between these two countries as well.

The data from all the MHAT assessments have led to a number of important policy changes. The data have been used to improve the training and distribution of behavioral health personnel in theater. They have assured that sufficient mental health personnel (credentialed providers and mental health technicians) are deployed in theater and are providing support to soldiers at remote locations. The MHAT findings were the impetus for revising the Combat and Operational Stress Control doctrine and training for behavioral health personnel. All behavioral health professionals deploying to theater are now mandated to take the new Army Medical Department Combat and Operational Stress Control Course. Additionally, MHAT findings have resulted in improved training in battlefield ethics and suicide prevention.

The MHAT assessments further led to the implementation of Army-wide mental health training, called Battlemind, for all soldiers and leaders. Prior to the conflicts in Iraq and Afghanistan, there were no empirically-validated training strategies to mitigate combat-related mental health problems. Our behavioral health professionals at Walter Reed Army Institute of Research used their MHAT experiences to develop the Battlemind training program, a strengths-based approach highlighting the skills that helped soldiers survive in combat instead of focusing on the negative effects of combat. The Army incorporated Battlemind training into the Deployment Cycle Support program in 2006 and is integrating it into the new Comprehensive Soldier Fitness program led by Brigadier General (Dr.) Rhonda Cornum. The intent of the Comprehensive Soldier Fitness Program is to increase the resiliency of soldiers and families by developing the five dimensions of strength—physical, emotional, social, spiritual, and family.

SURVEILLANCE ARMY-WIDE

Before 2004, the Army collected data on completed suicides using a variety of methods which were not always consistent. Beginning in 2004 we began the Army Suicide Event Report, where we collected data on both completed suicides and serious suicide attempts. This report has yielded valuable data which we issue every year in an annual report. Now all the Services are using this format, which is called a DOD Suicide Event Report (DODSER).

We have experienced difficulty integrating all of the different data sources and providing useful information to commanders. For this reason, in the fall 2008, we stood up the Strategic Analysis Cell under the Army's Center for Health Promotion and Preventive Medicine (CHPPM) to provide actionable intelligence to the Army G–1, the General Officer Steering Committee, and leaders Army-wide in an effort to reduce suicidal behavior in the Army. CHPPM will obtain non-medical data such as command investigations, Criminal Investigation Command reports, and Line of Duty reports to integrate with the DODSER and other medical data. In addition, they will evaluate nontraditional social outcomes data from Army installations (such as incidence of domestic violence, behavioral health diagnoses, utilization of mental health resources and substance abuse data, as well as other outcomes) for utility in generating a broader assessment of community health and resiliency.

The Post-Deployment Health Reassessment, which does surveillance of individual soldiers following deployment, is identifying but failing to refer soldiers with alcohol problems to the Army Substance Abuse Program; this is something we are seeking to improve, because multiple studies have identified alcohol and depression as the major medical risk factors for suicide. In an effort to increase early intervention in soldiers with alcohol problems, Army senior leadership is examining all possible options to increase soldier self-identification and referral for alcohol treatment by ensuring confidentiality while maintaining good order and discipline in the force.

TREATMENT

In the area of treatment we have instituted post-traumatic stress training for our healthcare providers so that they can accurately diagnose and treat combat stress injuries; we are dedicating time and energy toward provider resiliency training; and we have hired 250 more behavioral healthcare providers and over 40 marriage and family therapists to work in our military treatment facilities. We also have numerous longer-term efforts to enhance recruitment and retention of uniformed behavioral health providers.

In an effort to provide far-forward treatment, the Services collectively deploy 200 behavioral health personnel in support of Operation Iraqi Freedom, and about 30 in support of Operation Enduring Freedom. We are also seeking to leverage the front end of the medical system. The medical asset which knows the average soldier best is the platoon medic; the medic is in a position to notice changes in an individual Soldier even before he or she presents for medical care. We have incorporated a CPR-like training for behavioral health issues into every medic's initial training and ongoing certification. Although suicides in theater rose from 2003 to 2007, they declined in 2008, we believe due in part to implementation of MHAT recommendations and the aggressive efforts of medics, providers, and leaders.

Some experts feel that the best way of reducing population suicide rates is better recognition and treatment of depression/anxiety in primary care. On average, Soldiers visit primary care about 3.4 times annually (not counting specialty visits, vaccines, or dental visits), presenting an opportunity for screening. Studies of civilian suicides show that more than half of the individuals who commit suicide see a primary care provider in the month before taking their life. In 2006 the Army Medical Command piloted a program at Fort Bragg, intended to reduce the stigma associated with seeking mental health care. The RESPECT-Mil pilot program integrates behavioral healthcare into the primary care setting, providing education, screening tools, and treatment guidelines to primary care providers. RESPECT-Mil leads to early contact and low stigma intervention options for soldiers concerned about the ramifications of seeing a mental health professional. Finally, RESPECT-Mil insures that screening and recognition occur in a health care context where acceptable and effective assistance can be expected and obtained. Based on the success of the program at Fort Bragg, the AMEDD expanded implementation of this program to 15 sites last year and plans to implement at an additional 17 sites in 2009.

CONCLUSION

The challenge in addressing suicide is that, unlike other medical problems, those who are suicidal often do not present for care at the time when care is most needed.

Our own data show that once a soldier has a behavioral health problem, he is twice as likely as other soldiers to have concerns about seeking behavioral health care. That is why our current approaches (Battlemind training, Comprehensive Soldier Fitness) educate the soldier and other key people in a soldier's life (such as junior leaders, buddies, and spouses) to recognize a soldier in need and take appropriate action to assist. It is also why efforts to bring the medical system to the soldier at key junctures (Post-Deployment Health Assessment, Post-Deployment Health Reassesment) and taking full advantage of the soldier's contact with primary care for routine health care (RESPECT-Mil) also make sense.

There is no scientifically proven way of preventing suicide except in people who have attempted suicide in the past. Unfortunately there are multiple risk factors for suicide and no simple solutions. However, the Army is moving out on multiple fronts in a coherent and integrated approach with General Chiarelli and Brigadier General McGuire leading the way. We appreciate the support of Congress and this subcommittee as we aggressively work through this difficult problem. Thank you for holding this hearing and for your enduring support of our soldiers and families.

Senator BEN NELSON. Thank you.

General Sutton?

STATEMENT OF BG LOREE K. SUTTON, USA, DIRECTOR, DEFENSE CENTERS OF EXCELLENCE FOR PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY

General SUTTON. Chairman Nelson, Ranking Member Graham, and other distinguished members of the committee, thank you so much for the opportunity to bring you up to date on what DOD is doing to address the increase in suicides in such cases as Major General Rubenstein and General Freakley have described and to discuss our current initiatives to support the Services in reducing suicides and saving lives.

We are committed to ensuring that every warrior receives standard-of-care treatment across the continuum of resilience, prevention, diagnosis, treatment, recovery, and reintegration. Our overarching goal is to do whatever it takes to prevent individuals from

ever reaching that point of helpless and hopeless despair that can lead to suicide. It's about strengthening the connections, connections to one's selves, one's buddies, one's families, one's leaders, one's community, one's nation—mind, body, heart, and spirit.

To enhance outreach and coordination among DOD, Federal agencies, and civilian partners, Centers of Excellence were created, thanks to Congress, to address psychological health issues and TBI for DOD. In coordination with the VA, academia, and many others, DOD established the Defense Centers of Excellence for Psychological Health and TBI in November 2007. Today, this is better known as DCOE, serving as DOD's open front door for all issues related to psychological health and TBI, including suicide prevention.

I would like to tell you about several of our initiatives as they relate to preventing the tragedy of suicide.

In August 2008, we established AfterDeployment.org, an interactive Web site for servicemembers and their families to explore behavioral health information and to readjust successfully to life, returning from deployment. This tool is being developed with Web 2.0, 3.0 interactive tools. It's currently getting 6,000 hits per month and that is continuing to grow. We will build on that tool.

In November 2008, DCOE sponsored the first Warrior Resilience Conference, attended by 300 line warriors and health professionals. We brought in former Vietnam veterans, like Sergeant Andy Brandy, from New Mexico, who has continued to reach out to our warriors, marines, soldiers. He addressed, 2 weeks ago, 4,000 returning soldiers at Fort Polk. Three sergeants in that formation came up to him after the presentation and said, "Sarge, thanks so much for sharing your story. I was there. I'm returning from three tours. I thought it was me. I thought I was alone. I was going to kill myself this weekend."

We also brought in Lieutenant Colonel Dave Grossman, introduced an innovative community-immersion Philoctetes Project, which brings to light the lessons from 2,500 years ago, the Trojan Wars, the writings of Sophocles, as well as rolled out the resilience-stress continuum, a tool developed by warriors—marines, soldiers, Canadian armed-force soldiers—for marines, for leaders.

We also, in January of this year, opened an outreach center to answer questions about psychological health and TBI, 24 hours a day, with members of the military Services, veterans, families, healthcare providers, military leaders, and employers. We have already received numerous desperate calls. We've coordinated closely with the SAMHSA–VA Lifeline to ensure that we keep our arms around everyone who contacts us, wherever they happen to contact us from. The center can be reached at 1–866–966–1020 or by e-mail, at DCOEoutreach.org.

DCOE recently spearheaded the historic joint effort between DOD and VA in cosponsoring the 2009 Suicide Prevention Conference, in part to align the efforts of the Suicide Prevention Programs across government agencies, healthcare professions, and communities. We also, thanks to Bonnie Carroll, Executive Director of the Tragedy Assistance Program for Survivors, we were able to connect with those families of suicide victims and learn from their experiences, to ensure that their losses are not in vain.

The DOD Suicide Prevention and Risk Reduction Committee (SPARRC) provides expert support for DOD systemwide initiatives, including suicide surveillance, metrics, and common nomenclature. Timely, accurate reporting, monitoring, and analysis of suicide data is vital. DCOE and SPARRC rely on two complementary data sources for this: the Mortality Surveillance Division of the Office of the Armed Forces Medical Examiner (OAFME) and the National Center for TeleHealth and Technology (T2). By standardizing data and reporting, OAFME and T2 allow the Services to track and analyze suicide data and contributing risk factors to improve prevention, intervention, and treatment services. We will also be working very closely with the National Institute for Mental Health as they begin their study this coming year.

DOD is committed to transforming its culture by emphasizing that seeking treatment is an act of courage and strength. To this end, with the support from the service Vice Chiefs and the surgeons general, we are formally launching the Real Warriors, Real Battles, Real Strength Campaign, a public-health educational campaign nationwide to be formally launched this next month promoting the vital message that stigma is an unacceptable, deadly, toxic workplace hazard, and to harness the power of individual stories, family members, warriors, communities, scientists, faith leaders, employers, members of our Nation, and members of generations of warriors that extend beyond our current generation.

To help prevent combat operational stress injuries, DOD is working with the Services to implement psychological resilience programs that better prepare servicemembers for the stresses of combat in all stages of deployment. Further, we are implementing programs that embed mental health consultation and treatment services in the primary care setting. In addition, DOD is supporting ongoing studies that evaluate programs to identify best practices, innovative resources, and practical tools.

In accordance with the National Defense Authorization Act for Fiscal Year 2009, as you mentioned, Mr. Chairman, DOD recognizes that opinions from multiple disciplines foster innovation. Thus, we are working to establish the DOD Suicide Prevention Task Force that will report to the Defense Health Board and the Secretary of Defense. Currently, we have fielded 34 nominations from leading experts across the country. We have suicide prevention program managers who have selected these leaders for consideration and final selection from Dr. Cassells that will be announced later this month. That group then will move forward, without delay, to come up, within 6 months, with a set of recommendations, a report, and then a plan to follow. Time is not our friend.

Finally, we must embolden leaders and the entire military community to foster a strength-based, holistic strategy. Through our continued and relentless efforts, we can make a change for the better, provide our warriors and families immediate care when they need it, intervene early, and prevent tragic losses. It takes a nation to embrace our warriors and to help them heal and reintegrate as they return from the adversity of combat.

DOD greatly appreciates the committee's strong support of America's Armed Forces and your concern for their health and well-

being. Thank you for the opportunity to address these vital issues. I look forward to your questions, Mr. Chairman.

[The prepared statement of General Sutton follows:]

PREPARED STATEMENT BY BG LOREE K. SUTTON, M.D., USA

Mr. Chairman, members of the committee, thank you for the opportunity to bring you up to date on what the Department of Defense (DOD) is doing to address the increase in suicide rates among servicemembers, and to discuss our initiatives to reduce suicides and save lives. We share your sense of urgency to take swift and effective action on this critical problem.

In the military, the unprecedented pace of deployments to Iraq and Afghanistan has put pressure on servicemembers, particularly in the Army and Marines, sent to war zones in multiple deployments to defend our Nation under harsh and stressful conditions. Sustained high operational demands may be diminishing the breadth of psychological health resources and social supports that mitigate suicide. However, there is insufficient evidence at this time to identify a conclusive relationship between operational tempo and suicides. Only careful longitudinal studies of these factors will be able to reliably assess this relationship. Existing research suggests that there are common strains that many servicemembers who commit suicide face. Common issues are: relationship problems, marital problems, legal and/or disciplinary, substance abuse, and financial problems. Suicide expert Thomas Joiner, PhD, demonstrates in his book, Why People Die by Suicide, that there are three fundamental factors: feeling ineffectual and burdensome to others, lack of belongingness and sense of isolation, and hardening to self-deprivations, injuries, and learned ability to hurt oneself. These factors may come into play for servicemembers resulting in isolation and hopelessness. Increasing sensitivity to such signs is critical to identify and refer those who need help.

Building resilient communities and looking out for our servicemembers and families is our sacred privilege and responsibility. The Department is actively engaged in providing and improving care, tools, and resources for all, while simultaneously addressing cultural barriers that prevent individuals from seeking care.

We are firmly committed to ensuring that every warrior receives excellent care across the continuum of resilience, prevention, diagnosis, treatment, recovery, and reintegration. The programs in place also span the education and deployment lifecycle to ensure warriors and leaders are able to help themselves and others. In addition, the DOD provides tools and resources for families and communities. No individual, family, leader, or community is omitted from the suicide prevention equation; it is only through a holistic and comprehensive strategy that we will be optimally successful.

DEFENSE CENTERS OF EXCELLENCE

In an effort to enhance outreach and coordination among DOD, Federal agencies, and civilian partners, a center of excellence was created by Congress to address psychological health issues and traumatic brain injury (TBI) for the DOD. In collaboration with the Department of Veterans Affairs (VA), academia, and others, DOD established the Defense Centers of Excellence (DCoE) for Psychological Health and TBI in November 2007.

DCoE's mission focuses on the full continuum of care and prevention for psychological health concerns and TBI. In this effort, we strive to provide opportunities for warriors and families to thrive through collaborative global networks promoting resilience, recovery, and reintegration.

Today's society is immersed in social media tools and interactive Web sites. In an effort to leverage technology, Congress mandated an interactive Web site for servicemembers and their families to explore behavioral health information. An important DCoE initiative, afterdeployment.org, is a mental wellness resource for servicemembers, veterans, and military families—and can help warriors in their successful readjustment to life after returning from deployment. Through a user-friendly platform, entrants may find videos by veterans, spouses, and others about their real-life stories of overcoming the stresses of war. In addition, links on different educational topics are provided for those interested in more information. Afterdeployment.org has been well received due to the privacy afforded to the user. Visitors to the site can benefit from the wide variety of available resources without registering or providing any identifying information.

The DCoE also opened an Outreach Center this year to answer questions about psychological health and traumatic brain injury, 24 hours a day, from members of all the military Services, veterans, families, health care providers, military leaders,

and employers. The Outreach Center can be reached at 1–866–966–1020 toll-free and via email at resources@dcoeoutreach.org. We work in coordination with the National Suicide Prevention Lifeline (1–800–273–TALK) as well as Military OneSource, the National Resource Directory, and the Service-specific hotlines.

The DCoE recently organized the joint effort between DOD and VA in cosponsoring the 2009 Suicide Prevention Conference. This was the first time that the two Departments had officially co-sponsored this event, and the conference was aptly titled, "Building Community Connections: Suicide Prevention for the 21st Century." An important goal of the conference was to align the efforts of suicide prevention across government agencies, healthcare professions, and communities. Psychological health and TBI experts, representatives of nongovernmental organizations, community leaders, mental health clinicians, military officers and noncommissioned officers, chaplains, relatives of servicemembers who had committed suicide and others participated in the conference. Plenary sessions featured powerful contributions from suicide-attempt survivors and family members of individuals who took their own lives. The conference provided four focused tracks: Clinical Intervention; Multi-Disciplinary Approaches; Practical Applications and Tools; and Research and Academics.

Another critical type of collaboration in suicide prevention is the DOD Suicide Prevention and Risk Reduction Committee (SPARRC). This committee, which meets monthly and is chaired by a DCoE leader, includes a wide range of critical stakeholders. The membership includes the Suicide Prevention Program Managers from each Service and representatives from the National Guard Bureau, Reserve Affairs, Office of Armed Forces Medical Examiner (OAFME), National Center for TeleHealth and Technology, VA, Substance Abuse and Mental Health Services Administration, and others. This membership provides both expert and comprehensive support for the committee's goals of addressing DOD system-wide policy initiatives consistent with DOD readiness requirements and the Military Health System Strategic Plan of a "Fit and Ready Force," program and implementation instructions, suicide surveillance metrics, and use of common nomenclature in suicide reports.

It is especially important to highlight timely and accurate monitoring and analysis of suicide data across the DOD. DCoE and SPARRC rely on two complementary data sources in this effort. For the number of suicides and suicide rates, the Mortality Surveillance Division of the Office of the Armed Forces Medical Examiner and the Service Suicide Prevention Program Managers aggressively scrutinize suicides and suspected suicides in real time. Similar to the protocol of the Centers for Disease Control and Prevention which reports when there is 90 percent of cause-of-death determinations completed. DOD makes estimates of suicides after 90 days utilizing standing DOD resources of the Medical Examiner and Service investigative services. It requires 2–3 years for 90 percent of cause-of-death determinations to be completed in the civilian sector.

The second source is the National Center for TeleHealth and Technology (T2), which is one of DCoE's six component centers. T2 manages the DOD Suicide Event Report (DODSER) system, which provides over 250 data-points per suicide with details, summaries and analysis of a wide range of potential factors contributing to suicide attempts and completions. The DODSER data includes specific demographics, suicide event details, treatment and military history. The variables are designed to map directly to the Centers for Disease Control and Prevention's National Violent Death Reporting System to support direct comparisons between military and civilian populations. T2 is responsible for integrating and maintaining DODSER data, as input by the Services, and for preparing an annual DOD suicide report. The annual report, accomplished no later than July 31 each year, will include aggregated DODSER data. Services will produce corresponding standardized and comparable Service Suicide Event Reports resulting from their inputs.

By standardizing data and reporting in the near future, the SPARRC, OAFME, and T2, will allow the Services to track and analyze suicide data and contributing risk factors proactively to improve prevention, intervention, and treatment services. No other organization or mechanism other than the SPARRC has existed to develop, formally require and monitor compliance across DOD for standardized suicide data (via diligently-developed collaborations). In addition, the data will facilitate the review and evaluation of the effectiveness of suicide prevention initiatives and their execution over time.

DOD is actively committed to transforming its culture by emphasizing that seeking treatment is an act of courage and strength. This endeavor requires the direct engagement of leaders at all levels to provide leadership characterized by transparency, accountability, candor, respect and strength. To this end, DCoE, with the support from the Service Vice Chiefs, is formally launching the "Real Warriors, Real Battles, Real Strengths" campaign this spring. The campaign will catalyze construc-

tive dialogue by harnessing the power of individual, family, unit, and community stories around the Nation.

SUICIDE PREVENTION EFFORTS ACROSS THE DOD

We know that preventing suicide in the Armed Services requires an integrated and united effort. In addition, a more resilient force must be established. To prevent the onset of combat operational stress injuries, DOD is implementing psychological resilience programs that better prepare servicemembers for the stresses of combat and all stages of deployment, as well as for the sustained increased demands ingarrison that occur during periods of conflict.

It is essential for DOD to continually evaluate its current efforts and continue to deliver the most timely and relevant information to best inform our decisionmakers, families, and warriors. As such, DOD has many ongoing studies that evaluate programs to identify best practices, innovative resources, and practical tools. Multiple research studies on suicide prevention and resilience programs focus on reviewing, cataloguing, and identifying potential enhancements for current programs, while others are conducting longitudinal analyses. DOD-wide initiatives address stigma, provide guidelines for leaders, and ensure that psychological health issues are integrated throughout a warrior's career.

DOD also recognizes that bringing together different opinions from multiple disciplines fosters innovation in program implementation and problem solving. The DOD Suicide Prevention Task Force, under the Defense Health Board, is a 14-member panel that will include representation from the Services, family advocates, civilian communities, and academic advisors. They will provide advice and recommendations on matters relating to operational programs, health policy development, and health research programs. The mission objectives of this group focus on promotion of health, treatment, and prevention of disease and injury.

We must embolden leaders and the entire military culture to encourage help-seeking behaviors. The many programs and efforts across the DOD and throughout the Services will continue to provide critical solutions to help our servicemembers and families overcome the many stressors associated with service in a war time environment.

Finally, we are in a position where, through our united and concerted efforts, we can make a change for the better; provide our warriors and families immediate care when they need it, to intervene early and prevent unnecessary losses. We are all devoted to this effort and will not leave any one behind.

DOD greatly appreciates the committee's strong support of America's Armed Forces and your concern for their health and well being. We have made great progress thus far in meeting the challenges related to the stressors of waging war in this era of persistent conflict. With the committee's continued help and support, we will do even more.

Thank you for the opportunity to address these vital issues. I look forward to your questions.

Senator BEN NELSON. Thank you.

Commandant?

STATEMENT OF BG MICHAEL S. LINNINGTON, USA, COMMANDANT, U.S. CORPS OF CADETS, UNITED STATES MILITARY ACADEMY

General LINNINGTON. Chairman Nelson, Ranking Member Graham, and Senator Thune, thank you for the opportunity to testify today representing the United States Military Academy at West Point on the important topic of suicide.

West Point remains one of the world's preeminent leader-development institutions and a top-tier college. The young men and women that attend West Point are the best our Country has to offer, and our staff and faculty are dedicated to developing them into effective leaders of character upon graduation as lieutenants in the United States Army.

West Point is not easy. It requires dedication, discipline, and a thorough commitment to excellence in order to be successful. Cadets also require support from a variety of sources; most impor-

tantly, our staff and faculty and from parents and loved ones back home. Unfortunately, over the past year, two cadets and two members of our staff and faculty committed suicide, and we've had two suicide gestures. Although the circumstances of these deaths were all different, these suicides were largely the result of significant personal challenges in the soldiers' and cadets' lives, such as stress from broken relationships, and, in the case of one of the cadets, a pre-existing mental condition traced back many years which Academy officials did not know about at the time of his admission. None of those soldiers or cadets that committed suicide at West Point over the past year had deployed to a combat zone. Given that suicides at the U.S. Military Academy over the past several decades have been rare, these four suicides are not only troubling, they are unacceptable. The loss of any soldier is a tragedy, and West Point remains absolutely dedicated to the safety, health, welfare, and well-being of all of our cadets, as well as our staff and faculty.

As the Commandant of Cadets, I am the steward of the United States Corps of Cadets, and I take that responsibility very seriously. Based on these incidents, we have reenergized our preventative measures and are doing everything in our power to preclude their reoccurrence.

West Point has always had a robust mental health education and treatment program that includes mental health professionals in the Cadet Counseling Center located right in the cadet living area, assigned chaplains and tactical officers who are directly responsible for cadet well-being, and mental health professionals available from the on-post hospital for everyone's use. We are working hard to encourage everyone to take advantage of these resources and eliminate any stigma that may be present with anyone seeking professional help. Based on the significant increase in the number of cadets, staff and faculty, and family members seeking help in recent years, we think we are making progress in this important area.

The superintendent addressed the issue of suicide head-on shortly before the December holidays, and, as a result of these suicide episodes, he directed all units complete suicide prevention training by the end of January and directed participation by all personnel in the Army's Suicide Prevention Stand-down, which you've heard about this afternoon. We also ordered suicide prevention handouts for every cadet, soldier, and civilian employee on post, which were received and distributed in mid-January.

The superintendent reiterated to all leaders that suicide prevention and response is clearly a command program. Our overarching goal is educating soldiers, families, and civilians about the world-class suicide prevention programs, training, and resources available to create greater awareness about the warning signs of suicide and the appropriate responses that can save a person's life.

We are committed to providing these resources to help our cadets, soldiers, civilians, and their families overcome difficult times. We are equally committed to training and educating America's future leaders to deal with these issues in their units when they graduate. By showing cadets what "right" looks like, removing the stigma of seeking help, and understanding the individual unit and

environmental factors contributing to suicide, West Point continues to provide leaders of character for our Nation.

I would like to emphasize that your tremendous support continues to prove absolutely essential in taking care of our soldiers in the Academy. You continue to nominate to West Point great young men and women of the highest caliber whose willingness to serve portends another great American century. With your continued leadership and support for the Army and West Point, we look forward to meeting the challenges ahead. Together we will continue to make a difference.

Thank you, Mr. Chairman.

[The prepared statement of General Linnington follows:]

PREPARED STATEMENT BY BG MICHAEL LINNINGTON, USA

Chairman Nelson, distinguished members of this committee, thank you for the opportunity to testify today on behalf of West Point. West Point remains the world's preeminent leader-development institution and a top tier college. Recent independent rankings have named West Point as the best public college in the country. We are proud of that, and of the record of our graduates, the Long Gray Line. However, this winter, two cadets committed suicide, and last summer we lost a faculty member and a staff noncommissioned officer to suicide. Although the circumstances of these deaths were all different, and suicides at the United States Military Academy over the past several decades have been rare, this is very troubling. The loss of any soldier is a tragedy, and we remain dedicated to suicide prevention. We are committed to the well-being of all the soldiers.

I am the steward of our cadets—sons and daughters of America—and I take that responsibility very seriously. Let me assure you that everyone at West Point is re-energizing our preventive measures, and investigating any patterns regarding these incidents.

West Point is, of course, a college, not an Infantry Division, and we have found that none of these soldiers or cadets had deployed to a combat zone. Furthermore, we found that one of the cadets who committed suicide had a pre-existing mental health condition that he did not reveal during his medical screening for entrance to the U.S. Military Academy.

The Department of Defense accessions screening process has remained relatively unchanged over the last two decades. The candidate completes a medical history that asks specific medical questions, including questions about the candidate's mental condition. Throughout the medical exam, the examining physician conducts a mental health assessment evaluating the individual's affect; orientation to time, space, and event; mood; anxiousness; and any other markers of abnormal behavior.

We do believe that every candidate deserves an opportunity to be fully considered for admission—and prior mental health conditions often turn out to be a transient reaction to a stressful situation, for example, parents' divorce. However, our medical community as well as the admissions committee, is scrutinizing waivers for these conditions more closely, and we are less likely to grant a waiver for a mood or anxiety disorder than we have in previous years. For the class of 2013, we approved waivers for only three candidates in comparison to previous years in which we approved approximately eight such waivers each year.

One data point we use as we analyze our situation is how we compare to other colleges and universities across America. An American College Health Association (ACHA) survey showed that 9.5 percent of college students have seriously contemplated suicide and 1.5 percent have made a suicide attempt. About 95 percent of students who commit suicide are clinically depressed.

Data also shows that the national college student suicide rate is 7.5 per 100,000 students. We are well below that—we have had only seven cadet suicides in the past 3 decades. This works out to about 6 suicides per 100,000. Of course, those numbers are no comfort to us because our goal is to prevent all suicides.

To that end, West Point has, and has had, a robust mental health program that includes Mental health professionals in the cadet counseling center, the Center for Personal Development (CPD), located directly in the cadet area. The CPD, a personal counseling and leadership center for cadets, is staffed by trained professional counselors and psychologists who operate under very strict confidentiality policies.

Mental Health Professionals at Keller Army Community Hospital, on post. It is interesting to note that the number of cadet appointments with a psychiatrist has

increased significantly in the past 5 years. We do not believe this means we have an increase in cadet psychopathology, but, rather, a reduction in the stigma associated with seeking help and a greater willingness to do so.

An academy-wide focus on intellectual, physical, ethical, social, and spiritual well-being.

A voluntary and rich religious program of all faiths that includes involved chaplains; several chapels, including a mosque; and religiously-oriented organizations and clubs, such as the Gospel, Jewish, and Catholic choirs and cadet-led Sunday School for our families.

Close supervision of and interaction with all cadets by their tactical officers and NCOs, their cadet chain of command, their professors and coaches, and their sponsors. This personal coaching, teaching and mentorship is one of the hallmarks of West Point, and it is what separates us from all other universities and colleges in America.

As you can see, we make every effort to maintain a robust mental health program, but after the second cadet committed suicide while he was on a medical leave of absence and under psychological care, we quickly redoubled our efforts. Immediately upon their return from winter leave, I spoke to all cadets about suicide prevention and ensured all of them received a formal suicide prevention briefing.

The superintendent also addressed the issue of suicide head on. He directed all units to complete suicide prevention training by the end of January. In addition, we convened a multi-functional Mental Health Team from organizations across the post to address this issue, specifically the issue of information-sharing between mental health professionals and unit chains of command. We also ordered suicide prevention handouts for every cadet, soldier, and civilian employee on post, which were received and distributed by mid-January.

General Hagenbeck also re-iterated to all leaders that suicide prevention and response is clearly a command program, and there should be no stigma associated with seeking help. His commentary was published in our post newspaper, as a reminder to everyone to seek help when it is needed.

We also requested assistance from the Department of the Army Office of the Surgeon General (OSTG). We believed, and this was confirmed by the OTSG team's initial review, that our programs were sound and there is not a significant stigma associated with seeking help when it is needed among our cadets. Specifically, the OTSG team found that our mental health professionals have been providing appropriate treatment; and, aside from a friendship between a cadet who had committed suicide and another who later made a suicide gesture, there is no evidence of suicide contagion. Despite these positive findings, we remain concerned that, after 10 years without a cadet suicide, two occurred just a month apart. As a result, we are continuing to improve our program, and participate fully in the Army's education and information programs over the coming months.

As directed by the Vice Chief of Staff of the Army to all Army units, we conducted a suicide prevention stand-down day and training between February 15 and March 15. Additionally, we will complete the chain-teaching program focused on suicide prevention that allows leaders to communicate with every soldier by 15 June.

I also would like to address an allegation in a recent Washington Post story. The reporter inaccurately used the term "hazing" to describe what she later called "teasing." Hazing is specifically prohibited by Army regulation, and the days of hazing are long gone at West Point. If a cadet is found to have engaged in inappropriate behavior, appropriate disciplinary action will be taken against the cadet based on the facts and circumstances of the cadet's individual case. West Point is, and should be stressful, but there is no hazing.

The Superintendent has emphasized that leaders must vigilantly watch for suicide indicators. Leaders must communicate to those under our charge that there is no problem we cannot help them through, and no problem that should result in their not seeing the sun rise the next day.

The over-arching goal is educating soldiers, families, and civilians about the world-class suicide prevention programs, training, and resources available to create greater awareness about the warning signs of suicide and the appropriate responses that can save a person's life. We are committed to providing the resources for awareness, intervention, prevention, and follow-up necessary to help our cadets, soldiers, civilians, and their families overcome difficult times.

I would like to emphasize that your tremendous support has proven, and will continue to prove, absolutely essential to taking care of soldiers. You continue to nominate to West Point young men and women of the highest caliber whose willingness to serve portends another great American century. With your continued leadership and support for the Army and West Point, we look forward to meeting the challenges ahead. Together, we will continue to make a difference.

Senator BEN NELSON. Thank you.
Ms. Power?

STATEMENT OF A. KATHRYN POWER, M.ED. DIRECTOR, CENTER FOR MENTAL HEALTH SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. POWER. Mr. Chairman, Mr. Ranking Member, and members of the subcommittee, good afternoon. I'm pleased to offer testimony today on behalf of Dr. Eric Broderick, Assistant Surgeon General and Acting Administrator of SAMHSA, an agency of the U.S. HHS.

This topic has a very special meaning for me. As a retired captain in the United States Navy Reserve, I'm intimately familiar with the duty, the courage, and the commitment that our servicemembers exhibit even under the most extreme conditions. We owe these men and women a debt of gratitude for their service to our country, but we owe them much more than that.

As a mental health professional, I am keenly aware of the tragedy of suicide among all segments of our population. Every day in this country, there is one suicide every 16 minutes. Clearly, suicide is a public health crisis in America, and it demands a public health response. Within the public health context, all individuals in a community, whether that community is a school, a neighborhood, a military unit, or an entire base, are affected by the health of its individual members. Our mission at SAMHSA is to promote mental health, to prevent and treat mental and substance-use conditions, and to build resilience in individuals and communities throughout our Nation. We provide national leadership for suicide prevention, leading a broad group of Federal partners, including the DOD and VA, to implement the National Strategy for Suicide Prevention within the transformation of our Nation's health system.

SAMHSA has three major suicide initiatives. Number one, our Garrett Lee Smith Youth Suicide Prevention Grant Program has funded more than 43 States and 18 tribes and tribal organizations, as well as more than 68 colleges and universities, on youth suicide prevention activities. We encourage all of our campus suicide prevention grantees to welcome active duty military and veterans onto their campuses and to provide specialized services.

Number two, we support the Suicide Prevention Resource Center.

Number three, our third major initiative is the National Suicide Prevention Hotline and Lifeline, which is a network of 137 crisis centers throughout 48 States that receives calls from the national toll-free suicide prevention number, 1–800–273–TALK. All calls are free, confidential, answered 24/7. Today, the Lifeline averages 1,500 calls every day.

As a result of the collaboration between SAMHSA and the VA, the Lifeline now serves as the front end for the Veterans Suicide Prevention Hotline. Today, when an individual calls the Lifeline number, they hear, "If you are a U.S. military veteran or if you calling about a veteran, please press 1 now." Callers are immediately routed to the VA Call Center in Canandaigua, New York. In its first year of operation, the Call Center in Canandaigua responded to more than 67,000 callers; calls from veterans led to

nearly 6,000 referrals to the VA suicide prevention coordinators and more than 1,700 rescues—that is, actual calls to police and emergency personnel—for immediate responses to those individuals who were judged to be at immediate risk.

Of special interest to this committee: In fiscal year 2008, 780 callers identified themselves as active duty military. They received the same expert services as any veteran or family member who called. Thus far this fiscal year, 434 callers to the hotline, nearly 3 a day, identified themselves as being on active duty.

Our soldiers, sailors, airmen, and marines deserve the best knowledge and practice we have to offer in suicide prevention. Several effective suicide prevention practices can be, and may already have been, adopted for use with Active Duty personnel. They include, first, gatekeeper training. This trains community members to understand the warning signs of suicide, talk about it, and how to arrange for a person who needs help who might be at risk. A second approach involves systematic followup in the critical time following an acute suicidal crisis. SAMHSA has awarded six grants to implement and evaluate effective followup to individuals who call the National Suicide Prevention Lifeline.

Finally, "postvention" is the term for a promising approach that helps suicide survivors cope with the difficult feelings that follow such a sudden catastrophic loss. Postvention has been recognized by the Center for Disease Control (CDC) as an important strategy for preventing suicides among those who are left behind. In collaboration with our Garrett Lee Smith grantees, this approach is currently being used at Fort Campbell, KY, and by the New Hampshire National Guard.

To promote the success of these and other suicide prevention programs, we work very closely with CDC and the National Institute of Mental Health (NIMH), our sister agencies in HHS. The data that CDC collects and the research that NIMH conducts help shape the suicide prevention initiatives that SAMHSA promotes and manage. In turn, our programs provide the field with critical science-to-service data and key research questions.

At SAMHSA, we have ongoing partnerships with DOD and VA in two large Federal workgroups. One, on returning veterans and their families, and the other on suicide prevention. Those collaborative relationships and partnerships are not codified in law, nor do they receive any special funding. We meet together as concerned citizens, as mental health professionals, as members of the Armed Forces, all supporters of our Nation's military. Our goal is to improve the health and well-being of all Americans, particularly those who fight and die for us.

The poet John Donne wrote, "Any man's death diminishes me because I am involved in mankind." We must build on the esprit de corps in the military that can serve as a source of strength, resilience, and hope to protect the members of our Armed Forces from psychological distress, from substance abuse, and from suicide. We look forward to continued collaborations with Members of Congress, with DOD and VA, and the American people as we stem the tide of suicides among the brave men and women in our Armed Forces.

Thank you very much for the opportunity to address you, and I look forward to your questions.

[The prepared statement of Ms. Power follows:]

PREPARED STATEMENT BY A. KATHRYN POWER, M.ED.

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

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

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

But we owe them much more than that. As a mental health professional, I am keenly aware of the tragedy of suicide among all segments of our population. In 2005, the most recent year for which we have national data, suicide resulted in 32,637 deaths, according to HHS's Centers for Disease Control and Prevention (CDC). Sadly, suicide was the third leading cause of death among young people aged 15 to 24. Rates of suicide are higher among males than among females, but studies indicate females have higher rates of suicidal thoughts and nonfatal suicidal behaviors than males. Although suicide is problematic throughout the lifespan, overall rates of death from suicide are highest among those aged 80 or older, followed by those aged 45 to 49.

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

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

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

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

Within the CMHS, we have three major suicide prevention initiatives. One of these initiatives is the Garrett Lee Smith Youth Suicide Prevention grant program. As of October 1, 2008, 43 States and 18 Tribes and Tribal organizations, as well

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

as more than 68 colleges and universities, are receiving funding for youth suicide prevention through this program.

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

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

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

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

In fiscal year 2008, the Call Center in Canandaigua responded to more than 67,000 callers. Calls from veterans led to more than 6,000 referrals to VA Suicide Prevention Coordinators and more than 1,700 rescues—calls to police or emergency medical personnel for immediate responses for callers judged to be at imminent risk. There have been only 2 known suicides among the 6,000 referrals.

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

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

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

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

Because people who die by suicide have often communicated about it with others, or might be willing to talk about it if asked, a promising approach to suicide prevention is called gatekeeper training. In this type of program, community members are taught the warning signs of suicide, along with instruction on how to arrange help for a person who is at risk for suicide. The best evidence suggests that suicide pre-

vention is most likely to be effective when everyone in a community is involved and when everyone knows what to do when encountering this kind of crisis. The first step, which is at once simple and agonizingly difficult, is asking "Are you thinking of killing yourself?"

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

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

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

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

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

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

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

Leadership at the top is critical, as evidenced by the witnesses at this hearing. But no one individual, agency, or military branch can solve this problem alone. As

former Surgeon General Dr. David Satcher said, "Because its effects are societal in scope and tragic in their consequences, suicide prevention is everyone's business."

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

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

NIMH and the U.S. Army have entered into a memorandum of agreement to conduct research that will help the Army reduce the rate of suicides. This research study will: (1) examine the mental and behavioral health of soldiers, with particular focus on the multiple determinants of suicidal behavior; (2) identify modifiable risk and protective factors and moderators of suicide-related behaviors; and (3) identify specific interventions for reducing suicide risk by addressing empirically identified risk and protective factors. The Funding Opportunity Announcement, "Collaborative Study of Suicidality and Mental Health in the U.S. Army," was released on January 5 at http://grants.nih.gov/grants/guide/rfa-files/RFA–MH–09–140.html.

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

The poet John Donne once wrote, ". . . any man's death diminishes me, because I am involved in mankind." So, too, is each and every one of us here today. We must do all that we can, individually and collectively, to restore a sense of community that helps protect individuals from psychological distress, substance abuse, and suicide. In many ways, America is losing the spirit of community that was previously fostered by extended families, religious organizations, and community centers. Today, we are more likely to eat alone, study alone, and even, as author Robert Putnam pointed out, to bowl alone.

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

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

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

Senator BEN NELSON. Thank you.

Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. I'll be brief.

I appreciate the information you provided the committee about ongoing programs. Major General Rubenstein, I think your example shows that there are some things that you just can't prevent, no matter how much you stay on top of it. This example you gave is one where I don't know what more you could have done. But, what you're telling us, Ms. Power, is that there are a lot of people that, if we get early enough, we can turn it around.

If an active duty member calls this hotline, is the military commander notified?

Ms. POWER. I'm sorry, if the active duty member calls the hotline?

Senator GRAHAM. Right.

Ms. POWER. They have just identified themselves as an active duty member, and they get the same service from either the crisis center locally or we can, in fact, connect them to the VA, if they want. But when they identify themselves as active duty members, it's generally in the conversation with the local crisis center with whom they've been connected.

Senator GRAHAM. But do we, as a matter of routine, inform the military, "You have a problem here"?

Ms. POWER. A matter of routine for when we talk to them?

Senator GRAHAM. Yes. When you talk to the person, when the person calls the hotline, are they identified?

Ms. POWER. It depends on the conversation. Some individuals voluntarily put forward the fact that they are on active duty; and generally either those individuals will say that they do not want to talk to anyone else other than the local crisis center with whom they are connected.

Senator GRAHAM. Okay. So, there is no way to get that person's name and contact the military?

Ms. POWER. Well, we're having some conversations with DOD, actually, as we've garnered these statistics and we've become more knowledgeable about how individuals who are back in their local communities are connecting with those crisis centers, we're starting some conversations with DOD about how we may be able to make some connections, similarly to what we've done with the VA.

Senator GRAHAM. Ms. Powell, how many active duty people identified themselves when they called the hotline?

Ms. POWER. Last year?

Senator GRAHAM. Yes.

Ms. POWER. It was 780 callers, and thus far this year, 3 per day.

Senator GRAHAM. Okay. Major General Rubenstein and Brigadier General Sutton, is that disturbing?

General SUTTON. In one sense, it is, Senator Graham.

In another sense, it's heartening to know that folks who are having difficulties are calling. What's disturbing about it is, as our Outreach Center coaches work with the National Lifeline coaches we've established a network that is used daily.

Senator GRAHAM. How many people contacted your system about suicidal thoughts?

General SUTTON. I don't have an exact number for you, at this point. I will tell you, we just started our Outreach Center in January. It is not a lifeline, which is why, when they call us, if they

need the services of the National Lifeline, we make sure that we have a warm handoff.

What is disturbing about the individuals that we speak with is the proportion of active duty callers who say, "I don't want my chain of command to know about this." It points to the issues that still linger, in terms of stigma and transforming the culture.

We have identified this issue in our work with the Service Vice Chiefs, and we have currently developed standard operating procedures which will be formalized into a memorandum of agreement with the VA and with SAMHSA to ensure that anyone that can develop a relationship of trust that will then enable us to link them back to their home community or their chain of command, we absolutely are committed to doing that. But, we cannot violate the confidence, if an individual prefers that that not be the case.

Senator GRAHAM. Major General Rubenstein, do we have any numbers to compare to, how many active duty people are on base and calling?

General RUBENSTEIN. We'll get you the numbers for the record, Senator.

General RUBENSTEIN. It is disturbing, if those active duty soldiers who live on or in the immediate vicinity of a military base feel they have to call a third party.

Senator GRAHAM. That's the point. I mean that is an astonishing number, to me, if you had 780 contacts last year.

General RUBENSTEIN. The issue of stigma is not normally the issue of the relationship between the caller or the soldier and his healthcare provider, but rather the relationship with the soldier and his leadership. It's the leadership that we have to work with so hard in order to ensure the leadership is taking the issue seriously.

Senator GRAHAM. Right. I know this is hard, but that's the most overwhelming evidence I've heard that there is a real stigma problem here, if 780 people have to go outside the military chain. I understand. I mean, this is not easy. I've been a judge advocate most of my life, and I understand exactly how reluctant people are to identify themselves with having any problem because you're worried about being promoted, not eligible for a particular career path. If you could talk, that would be helpful. Find out exactly what's going on here, all I can say, that's just a big number. I've heard your testimony about what you're trying to do in the Recruiting Command. You had a cultural problem there. At West Point, it's an aberration, and I know you're on top of it. But, this is the first evidence I've heard, from both panels, that there's a systematic problem here, there is a large number of people apparently going outside of all the programs that you've created. The programs seem to be very robust, and you're doing a lot with a limited resource. But, this stigma problem now is put in perspective for me.

One last question, and I'll have to leave. In terms of mental health counselors, the resource problem the other panel testified to, what can we do, from a committee point of view, to help find more people to go into mental health counseling in the military?

General RUBENSTEIN. From the Army's perspective, there are two things. One is to continue the resources that we do need in order to hire our military and civilian and contract providers; but, num-

ber two is our delegated hiring authority, which is an action, not from this committee, but is an action from Congress that allows us to very rapidly hire someone when they show up and say, "I'd like to apply for a job." It allows the hospital commander, the clinic commander, to hire the person without going through the long and laborious processes in place.

So, continue the resources, as the committee has done, and as Congress has done for hiring actions.

Senator GRAHAM. General Sutton?

General SUTTON. I would just add to the points that General Chiarelli brought up earlier, in terms of the importance of establishing a robust T2 network, which we are in the process of doing, working with the VA, working with the National Guard, and working with the States. We know that even if we were able to have perfect ease in hiring the individuals that we need and want to bring onto our team, we still have individuals in remote locations who will not benefit from those services unless we can connect them.

We are also working very closely right now on what we're calling a SimCoach. This is a project linking up with DARPA and the Institute for Creative Technology, which will harness the best of artificial intelligence, with voice recognition technology, with expert learning and neuroscience and simulated conversation. These technologies all exist at this point; they haven't been put together in a single tool that will allow our servicemembers and their loved ones to access, in the privacy of their own home, their own smart phone, or their laptop.

Senator GRAHAM. Well, can this committee help? I mean, do you need something from this committee?

General SUTTON. Sir, you've already gotten us launched, so we'll keep you posted on the progress.

Senator GRAHAM. Okay. Mr. Chairman, thank you for letting me go first, and thank you for having this hearing. I think it's been very instructive in sort of putting the puzzle together, and I think what we have is a resource problem, but, more than anything else, we have a holdover of stigma that we're going to have to keep fighting because the proof is in the pudding, here. When you have this many people feeling they can't talk to someone within the system, then that's a problem. I know you're all on top of it the best you can be.

Thank you.

Senator BEN NELSON. Thank you.

In that regard, assuming that we had enough mental health providers within the system, do they become part of the problem, in terms of the person not wanting to talk to them for fear that will get communicated to their chain of command, which would raise the question of whether or not maintaining a civilian relationship for these providers would that give them an independence that would be outside the chain of command to overcome the stigma and the fear of reprisal and fear of nonpromotion?

Dr. Rubenstein?

General RUBENSTEIN. Mr. Chairman, the soldier who doesn't want to see the psychological health provider on post, for fear of his command finding out about it, is the same soldier who doesn't

want to be seen downtown, for the very same reason, the concern that somehow he or she is going to be found out as needing psychiatric help for a stress-related issue, and because of that, will fear for the ability to advance in his job in the military. I don't think this is limited to our providers who are on post versus our providers who might be downtown. We have 2,500 psychologists, psychiatrists, and social workers in the military. We use a network of 54,000 civilian providers that are under the TRICARE networks in our communities around the United States. The patient who doesn't want to go on post is the same patient who's not going to want to be seen downtown, although they may sneak downtown in order to pay out of their pocket to receive care.

Senator BEN NELSON. Or they call the hotline to avoid detection, perhaps.

General RUBENSTEIN. Perhaps so.

Senator BEN NELSON. General Rubenstein, if you had to look at the example that you gave us today of the soldier who committed suicide this week, and you look back over everything that was done, and you could recreate the situation to try to get a different result, is there anything that you could see there that would stand out to you that was missed or perhaps was done ineffectively?

General RUBENSTEIN. Yeah, that's a fascinating question. As a private pilot, I read aviation safety magazines, and if there's an accident, they start going backwards through time and they start to find something that started to go amiss. This soldier was a low-risk soldier, had been seen by the same psychiatrist for over 2 years, and was being used as a motivational speaker for other patients in the area of TBI. The question comes down to how closely the healthcare team and the leadership team work together. What makes the military community unique from the general population, and the reason we're concerned that 20.2 suicides per 100,000 is larger than 19.5 in the civilian sector, in the military we pride ourselves on putting our arms around our soldiers and looking into our eyes and having battle buddies. We don't have the same thing in the civilian sector. So when you ask about, "Could we have done something?"—we could always do something.

Senator BEN NELSON. Sure.

General RUBENSTEIN. The question is, with this soldier who has 2½ years of history under his belt in the WTU, being used as a motivational speaker, gets a piece of bad news and, to everyone's surprise, reacts by putting a pistol to his chest.

Senator BEN NELSON. Ms. Power, in your prepared statement you discuss a phenomenon that you referred to as "cluster suicides," and you state that this is what happened in Houston, where the four Army recruiters from one battalion died over that 3-year period. Can you give us a little bit more information about what you call "cluster suicides"?

Ms. POWER. I think in the testimony we were trying to get out the point, Senator, that the deaths by suicide are always very complex cases, and there are typically a variety of risk factors that play a role in each death. SAMHSA, of course, has not conducted any review of any of the deaths that were mentioned, and I certainly wouldn't presume to identify any one specific cause for those particular tragic deaths, but certainly we know that overwhelming

stress and pressure can play a role in suicide, and, in combination with other risk factors, it can become quite fatal.

SAMHSA's intent, in my written testimony, was basically to highlight the potential role for the strategy of postvention, where you can bring in appropriate support and assistance to those who were close to, or who knew, the individual who died by suicide, and thus, helping to prevent other future suicides. That was really the intent, to emphasize the fact that, when there are commands or communities in which there are multiple suicides, we've found that the postvention strategies can be very effective in reducing that potential.

Senator BEN NELSON. Commandant Linnington, did you, in response to what has occurred at the Academy, take that approach, to try to get ahead of it with other individuals through post-counseling?

General LINNINGTON. Yes, sir. In fact, one of the things we did well before the Army's program was, when we had the two suicides earlier in the year, we started an aggressive education program, and we really worked hard on the reduction in stigma required to go seek help. Of course, in a young population, a college population, that's the battle buddies, the peers, are the ones that really are the first line of defense, in terms of identifying those at risk. So, we really went after that aspect of it hard. As we've looked at it over the last several months, our numbers have really gone up, significantly up, in terms of the number of cadets that are seeking help. So, we look at that as good news. Unfortunately, when that happens, you identify more folks that are at risk than you originally thought, which then leads to follow-on treatment, and, in some cases, inpatient treatment. But, that's good news, also, I think, in that we identified them before it takes place.

Senator BEN NELSON. So, do you believe there was a reduction of the stigma concerns?

General LINNINGTON. Yes, sir, I do. In fact, we were so concerned about that, that in January we asked the Army, the Office of the Surgeon General, to send a team to West Point to look at our program comprehensively and look specifically look at the stigma aspect of it, to see if we had a stigma. Their findings were quite the opposite, that there was not a large stigma at the Academy. I think that goes to what we do with our cadets from when they first enter the Academy. They start as freshman in college. We talk to them about the facilities available, and we talk to them about seeking help. We also have cadet peer counselors identified for them in their first summer, so they see them all the time, they see chaplains at all the training events. We have full-time tactical officers responsible for their health and welfare; they speak to them, required, quarterly. So, because they have those multiple opportunities to engage with other folks, we think the stigma is low compared with the rest of the Army and those where seeking help may be viewed negatively.

Senator BEN NELSON. Thank you.

Senator McCaskill.

Senator MCCASKILL. In my background, I worked with substance abuse significantly, as the prosecutor in Kansas City. We had a local tax that allowed us to spend significant monies on prevention

and treatment, and I was very involved in the drug court movement in this country. So, I'm pretty well versed on the issues of substance abuse, based on my background.

I went over to Walter Reed after the scandal. First, let me compliment you on the changes and the improvements that have been made at Walter Reed; they're significant, and I acknowledge that, and I think you have done well in addressing many of them. But, one of the things that struck me as I went over there, at that point in time, as I walked around, was in every room I looked in there were bottles and bottles of pills, and bottles and bottles of liquor, and a whole lot of brave, wonderful men and women who were there and kind of in limbo, in terms of what their future held. Many of them were waiting for a variety of reasons. I saw nothing anywhere about substance abuse. There was a bar you could go in, and drink, but there was nothing anywhere about substance abuse counseling. Then you add to that what we have had, in terms of the problems that we've seen at Fort Leonard Wood, as it's related to the substance abuse program there. I don't know how aware you all are that I've introduced a piece of legislation dealing with substance abuse in the military, to try to look at this more carefully. I don't need to tell you that we have some challenges here, in terms of culture.

I would like you all to take a moment and address your view of confidentiality as it relates to someone stepping forward and wanting treatment, versus the culture that exists now, which is more focused on the discipline of the unit and combat readiness, and whether or not, if someone steps forward and wants treatment, whether that's something that their commander needs to know about.

I think it's a real challenge in the military, and I know all of you, as medical professionals, and certainly, Ms. Power, you understand. I'm willing to bet that just about all of those suicide cases, if you look, probably had some kind of substance abuse issue that was also going on there at the same time. It's just highly unusual that people don't try to self-medicate, that are suffering from a mental illness, and that alcohol, and particularly now with all the injuries we're having, the prevalence of a lot of the drugs that are out there. If you all would address that, I would appreciate it.

Ms. POWER. I'll start with the issue, since I can't address the military issues, but I can certainly address the fact that substance abuse is one of the conditions. We certainly talk about co-occurring conditions and co-occurring disorders. In those co-occurring conditions, the presence of substance use and substance abuse is quite high, relative to the presence in completed suicides. So we are aware of the very deep and very serious connection between mental health status and substance use and substance abuse.

In fact, the combination of trauma, the combination of depression, and the combination with substances often are some of the present and triggering factors for suicide. So, from the perspective of SAMHSA, we know that we have to address both mental health status and substance use, and substance use environment, and substance abuse. If we don't address them—that's why we actually promote the notion of integrated treatment—from a prevention standpoint to an intervention standpoint to an integrated stand-

point. I know that several of the military programs have really focused on an integrated treatment approach in a way that I think is quite superlative. I will defer to my military colleagues to talk about that.

General RUBENSTEIN. Ma'am, I'll address this from the Army's perspective, and that is, we have far too few soldiers who voluntarily go to our Army Substance Abuse Program (ASAP), and enroll in order to receive help. The Army is, very shortly, going to be releasing a new policy that allows a soldier to self-refer to ASAP for training and education, and then, at the call of the counselor, into treatment, without the chain of command being notified of that.

Tied to that, of course, is ensuring that our ASAP programs are not in buildings that are off in parking lots that are not surrounded by anything else so it's not the only reason you would walk in the building and those kinds of things.

So, both from the physical standpoint, but also, most importantly, when a soldier self-identifies, the commander does not get told about it. It's been that age-old problem of balancing the need for the soldier's health with the need for good order and discipline of the military. We're very excited about this new proposal. The policy will be released very shortly, and we're looking forward to great results out of this.

Senator MCCASKILL. I'm so glad I got here. That's terrific news.

General RUBENSTEIN. Yes.

Senator MCCASKILL. I do believe that, in many ways, it might be easier for a soldier to say, "You know, maybe I need to think about this drinking," or "I have a drinking issue" than "I have a mental health issue," understanding the kind of pride and the kind of atmosphere that is so important to our military, that everybody drinking is not something that is weird.

General RUBENSTEIN. You're absolutely right. As I said, as we pilot this and bring it out, we're looking for good results, we're looking to be able to show commanders, "It's okay for your soldier to say, 'I have a problem,' and you not knowing about it. If the soldier is at risk to himself or to others, we'll let you know."

Senator MCCASKILL. Now, that soldier is probably more healthy than some of the ones that aren't going to step forward, and the commander will never know about that.

General RUBENSTEIN. Starting point, though.

Senator MCCASKILL. Yes. Starting point. Yes, it's good.

General RUBENSTEIN. Thank you very much.

Senator MCCASKILL. Good. That's terrific.

Do we think we have enough people that are qualified to be substance abuse counselors, that are actively working now in the military? First of all, I don't mean to pick on Fort Leonard Wood. I'm proud of the Fort. My father has a history there, and it's close to home, and I know a lot about it. But, we're anxiously looking at all of the military bases because I have a feeling that Fort Leonard Wood's not the only place where they don't have sufficient personnel in place to actually provide the counseling for the folks who needed it and wanted it.

General RUBENSTEIN. Right, we have a little over 250 counselors today. We have over 70 open hiring actions. The problem that we have put ourself into is that we are going for master's-prepared

counselors. What we have to do, and what we are doing, is rewriting our own policies so that we have a mix of the master's-prepared counselor and the paraprofessional. The paraprofessional, as in the civilian sector, works very well under the supervision of an independent licensed practitioner. We're fully convinced that if we go to a mix of master's-degreed and paraprofessional counselors, we will have a much broader range of population to recruit from and be able to fill, not only those 71 holes that we have, but more, as well.

Senator MCCASKILL. Has there been any talk about whether or not it would be a good idea to look at some of the members of the military who have been through substance abuse counseling and are recovering, and to pull them in to the counseling process? I know that it's hard to go to a successful drug treatment facility and not find former users that have become counselors and are very, very good at it, because nobody can look at them and say, "Well, you don't understand," because they can say, "Well, you know what, yup, I just definitely can understand." I think, in the military, that would be particularly helpful because you would have that recognition that someone who has been in exactly the same position has struggled with this issue and come out the other side whole.

General RUBENSTEIN. By broadening the potential population to other than the master's-degreed counselors, I think we're going to reach into that pool who are successful graduates, if you will, have gone through the program, but haven't gone out and pursued a full-blown academic preparation resulting in a master's degree with certification; the paraprofessional that we're talking about. Yes, ma'am.

Senator MCCASKILL. I thank you all. On the issue of the confidentiality, there's nothing better than realizing that part of the legislation you're pushing may not even be needed anymore. That happened with Walter Reed, too. So many of the things that then-Senator Obama and I originally put in that legislation that was filed that very next week, the military acted carefully and quickly to fix many of those problems before we ever had a chance to get the bill off the printing press, almost. So, thank you all very much.

Thank you, Mr. Chairman.

Senator BEN NELSON. One final question, here, recognizing the time.

General Sutton, obviously we've heard from each of the Services today about the various suicide prevention programs, the policies, the initiatives, and what could be better, and what everyone is attempting to do to improve them. Do the Defense Centers of Excellence for Psychological Health and TBI assess service-level suicide prevention programs, do an assessment of programs, as well as the research? Or, are the centers more responsible for creating DOD-wide programs?

General SUTTON. Actually, sir, both.

Senator BEN NELSON. You do both.

General SUTTON. As of January of this year, as we've grown into our potential, we accepted the responsibility, across the Department, for suicide prevention, and that includes working with the Services. We're putting outcome metrics against number of the pro-

grams. We're also working at the Samueli Institute and the RAND Corporation. We have a number of promising practices that are across installations, such as yoga, mindfulness, acupuncture, as well as, for example, Senator McCaskill, you had mentioned whether we could use servicemembers who have successfully gone through substance abuse programs—one such individual, a 1st sergeant—who's a 1st sergeant of the WTU at Fort Lewis, he traveled with me to Germany last month to address the senior leaders under General Hamm's leadership, and he was able to tell his story. He's given me permission to give his name, 1st Sergeant Creed McCaslin. He was able to talk about how, after his multiple tours in Iraq, with, as his command sergeant major described it, possibly the most trauma-exposed individual he knows of in this conflict, and as he came back from that, he was experiencing very severe post-traumatic stress, started to self-medicate, as you mentioned, ma'am, got himself into trouble, was relieved from his position for a DWI; he had gone to a buddy's house that night and didn't want his buddy to know what he was experiencing, woke up at 3 o'clock in the morning with dreams, flashbacks, severe post-traumatic stress, got himself into trouble, and now has been able to, through that experience, talk about his journey to claiming post-traumatic growth, and to talk to young soldiers, sailors, airmen, marines, and troops, leaders, to let them know that, yes, you can make a mistake, you can go get treatment, and you can come back, and you can still lead. So, I think it's a very powerful example that we will continue to build upon.

We also know, Mr. Chairman, that there are some effective suicide prevention practices that have been established in the literature. One such program is called the Caring Letters Project. Now, we have not yet implemented this within DOD, but it's something that I'm working closely on, now I'm going to be reaching out within our priority working group for reintegrating veterans, warriors, and their families, Ms. Power, as well as working with Matt Friedman, who's the Director of the National Center for PTSD, because this project is a very simple project, but what it involves is writing a letter, a supportive, caring motivational letter, to individuals at risk who have been discharged from psychiatric units in the past year, a letter that comes from the staff, that have a relationship with that individual, every quarter for the next year. That practice has shown itself to actually prevent suicides.

So, there are things that we know, in addition to all that the Services are doing right now, to get the providers and the care networks and the identification and the gatekeepers, all of those things, the community-based efforts, primary-care treatment, awareness, cultural transformation, but we know it also boils down to such simple things as human connection.

I'm an Army psychiatrist. I recently got a letter from a senior NCO with whom I had worked, actually, at Fort Leonard Wood several years ago, Senator McCaskill, when I was the deputy commander there. This sergeant major sent me a copy of a tattered e-mail that I had shared with him several years ago. Unbeknownst to me, he had been carrying it in his wallet for these last almost 9 years. He said, "Ma'am, with all of the talk right now and the crisis having to do with suicide, I want you to know that having

this note from you from 8 years ago. I've carried in my letter, I have taken out, on more than one occasion, and it has kept me from a very, very desperate decision."

So, I think there are some things there that we can learn, both formal programs, as well as informal ways of, as we transform the culture, to help individuals connect. Just as health is much more than the absence of disease, resilience is much more than the presence of destructive behavior, such as suicide. It has to do with proper rest, nutrition, friends, family, love, faith, hope, and growth. Those are all things that, as we, yes, work to prevent that individual who's at that desperate point, that we also move to the left to build resilience from day number one of accession.

I would say, when it comes to the screening question that was mentioned earlier, we already know that, as important as screening is, we cannot screen our way out of this challenge. When only 3 out of every 10 Americans aged 18 to 24 are even eligible to put on this uniform, we have a national resilience crisis, and that's something that I look forward to in our position with the Defense Centers of Excellence and the Services and working across the government, around the country, and, yes, around the world. I really look forward to continuing this journey of identifying best practices and putting them to use where they will count for our troops and their loved ones and our Nation at large.

Thank you, Mr. Chairman.

Senator BEN NELSON. Before we conclude, is there anything that we didn't ask and should have, or anything that we didn't touch on that you would identify that would be helpful for us as we continue this journey together?

[No response.]

If not, thank you very much. I appreciate your wisdom and your service. We hope, as a result of this and the days ahead, we will see improved results.

Thank you.

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR E. BENJAMIN NELSON

RESERVE COMPONENT

1. Senator BEN NELSON. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, National Guard and Reserve members who do not live in close proximity to a military installation, or who live in very remote locations, can experience their own set of issues when it comes to access to health care and family support programs that may be needed following a deployment. Are there any specific programs in place in each of the Services to address the unique needs of National Guard and Reserve members and their families, to ensure there are no gaps in access to help and support for the National Guard and Reserve when it comes to suicide prevention?

General CHIARELLI. From February 15 to March 15, 2009, the Army conducted a service-wide Suicide Prevention Stand Down and Chain Teaching, a first according to the Center for Military History. During the stand down, the Army trained every soldier on suicide risk identification and intervention, and addressed the stigma associated with behavioral health counseling, using an interactive video titled "Beyond the Front." Feedback from soldiers about the video was so positive that new, similar videos are being created for families and DA civilians; and the Army National Guard and Reserve plan to tailor these videos for their soldiers as well. Also during the stand-down, the Army distributed thousands of Ask, Care, Escort (ACE) wallet cards to soldiers; these cards provide a quick reference on how to identify and care for a potentially suicidal buddy. Follow-up to the stand down included chain teach-

ing on suicide prevention tactics. Chain teaching remains underway through July 1.

Army Reserve

The Army Reserve is taking a proactive approach to the Suicide Prevention Program by coordinating workshops to train personnel as Applied Suicide Intervention Trainers and Train-the-Trainers who will assume responsibilities for conducting Applied Suicide Intervention Skills Training (ASIST) from LivingWorks Education, Inc workshops in their region.

The Army Reserve is also placing emphasis on suicide prevention through its Yellow Ribbon Reintegration Program (YRRP), which includes loved ones as well as fellow soldiers. The Army Reserve has an initiative to include suicide awareness training to its units' Family Readiness Groups (FRGs). The more people in a soldier's life who are aware of signs and symptoms associated with a soldier contemplating suicide, the more likely we will be able to work to prevent these tragedies.

The Army Reserve stays in touch with soldiers and family members throughout the deployment cycle through events outlined in the YRRP. YRRP activities are conducted at 30-, 60-, and 90-day intervals prior to mobilization and deployment, while deployed, and at 30-, 60-, and 90-day intervals after re-deployment. YRRP topics of discussion, informational briefings, and training activities focus on services and support directly affecting the well being of soldiers and their family members. Army Reserve leaders also have periodic town halls and information-sharing sessions, supplemented by recurring training on suicide prevention, during the deployment cycle.

The Army Reserve is coordinating with the National Guard Bureau and others to pursue the development of a suicide prevention training package for families. The ultimate plan for the Army Reserve Family Suicide Prevention Training is to have a Reserve component-family unique interactive video, Reserve component-family unique intervention tools, and family facilitator/training guide.

The Army Reserve Command has implemented new required training for the commander, First Sergeant, Family Readiness Liaison/Rear Detachment Commanders, FRG leaders, and key volunteers of alerted and/or deployed units (the "Family Readiness Team"). This training, called Army Reserve-Family Readiness Education for Deployment training was formerly known as Deployment Cycle Support training. The objective is to provide information for family members and soldiers affected by mobilization, deployment, sustainment, and reunion. The intent is to develop a network of informed personnel associated with the Army Reserve Family Program to help alleviate concerns by family members and/or soldiers trying to find answers to deployment-related questions. Family Program Academy (FPA) training is divided into three parts: fundamental, developmental, and resource. Fundamental FPA training includes the basics required to establish and maintain a viable, functioning FRG at the unit level. Developmental FPA training builds on those basics and enhances the participant's capability to sustain and enhance unit family programs. Resource training is provided at the unit.

Operation Resources for Educating about Deployment and You (READY) is a series of training modules, videotapes, CDs, and resource books published for the Army as a resource for staff to train Army families who are affected by deployments. Operation READY materials include: pre-deployment and ongoing readiness, Family Assistance Centers, Homecoming and Reunion, the Army FRG Leader's Handbook, and the Army Leader's Desk Reference for Soldier/Family Readiness. The training is a train-the-trainer program for instructors and senior volunteer resource instructors to take back to units and show how information and materials are accessed and utilized. Chain of command training is designed to familiarize unit leadership with the scope of family programs within the Army Reserve. Briefings are provided on all aspects of family programs, such as mobilization training, volunteer management, and the Army Family Action Plan.

Finally, the Army Reserve encourages its soldiers to participate in the "Strong Bonds" program to help rebuild relationship skills with loved ones. These events typically occur on a weekend and are funded by the Army Reserve at a non-military site.

Army National Guard

The Army National Guard has a suicide prevention program at the National Guard Bureau level and in the States. The Army National Guard Suicide Prevention Program Management team trains State Suicide Prevention Program Managers in intervention skills so that they can intervene when they encounter someone in crisis. Depending on their issues, someone in crisis would be referred to a counselor, taken to the hospital, connected with a chaplain, etc. The Army National Guard policy requires annual ACE Suicide Prevention for Leaders training and annual ACE

Suicide Prevention for Soldiers training. Additionally, the unit-level Suicide Intervention Officers receive the ACE Suicide Intervention Training, and gatekeepers, like chaplains and behavioral health workers, attend ASIST. The Army National Guard relies heavily on families as our first line defenders against suicide. While the State Suicide Prevention Program Managers have the training to intervene in a crisis, they are often limited in the amount of help they can render. Specifically, unless a citizen-soldier or a family member contacts the State military leadership, there may not be an opportunity for the Suicide Prevention Program Manager to intervene when the citizen-soldier who is in a citizen status is having suicide ideations. As a result, the United States Army Center for Health Promotion and Preventive Medicine has produced a training program geared to increase suicide awareness for families. We have provided that training package to our States.

Family Support Programs

The Army OneSource (AOS) provides a multiagency approach for community support and services to meet the diverse needs of soldiers and families, regardless of where they reside. The AOS connects soldiers and their family members to support services using both personal and web-based (www.armyonesource) means. AOS provides information on 14 baseline services at 87 Army Community Service (ACS) centers, 249 enduring Guard Family Assistance Centers, Army and Child and Youth Programs, Operation Military Kids in 42 States and Operation Military Child Care in 50 States, Reserve Readiness Centers, and recruiting battalions.

To augment existing military support services, DOD established the Military Family Life Consultant (MFLC) program to provide non-medical, short term, situational, problem-solving counseling services to address issues that occur as a result of the military lifestyle and help servicemembers and their families to cope with the reactions to the stressful/adverse situations created by deployments and reintegration. The MFLC works directly with ACS, National Guard Headquarters, and Reserve Regional Commands to provide support to servicemembers and their families.

Military OneSource supplements existing Army family programs by providing a 24/7 toll free information and referral through telephone and web-based services. One of the many services available is up to six face-to-face counseling sessions for active duty, National Guard, Reserve soldiers; deployed civilians; and their families worldwide. Military OneSource provides information ranging from every day concerns to deployment and reunion issues. Additionally, if there is a need for face-to-face counseling, Military OneSource will provide referrals to professional civilian counselors for assistance in the continental United States, Alaska, Hawaii, Puerto Rico, and the U.S. Virgin Islands. Outside these areas, face-to-face counseling is provided via existing medical treatment facility services.

In addition to face-to-face counseling and short-term-telephonic consultation, Military OneSource is now providing e-consultation for those who prefer communicating online. This option uses instant-messaging, with the consultant and participant communicating online in real time; however, online consultations are not appropriate for children under 18, for people with complex issues, or for situations that require a group setting (couples and family counseling).

As part of the DOD Joint Family Support Program, Military OneSource has hired State-based consultants to work at State Joint Force headquarters. These consultants assist the State family program directors and other joint headquarters staff in integrating Military OneSource into operations around the deployment cycle and identifying resources that support the well-being of Service and family members at the State level.

Admiral WALSH. To specifically address the psychological health (PH) needs of Navy reservists, two programs were funded by the PH/TBI supplemental. Both are non-installation based programs that address the unique circumstances of Reserve component members and their families. We know improvement in the overall PH of the Navy Reserve will be achieved by quickly identifying members with stress disorders, helping them secure appropriate and timely care, identifying long-term strategies to improve PH and resiliency, and by providing PH education and training to leadership down to the deck plates.

Navy Reserve Psychological Health Outreach Program

The Navy Reserve Psychological Health Outreach Program was implemented in 2008, and has facilitated the assignment of two Psychological Health Outreach Coordinators and three outreach Team members to each of the five Reserve Component Commands (RCC). They are licensed clinical social workers who provide initial mental health clinical assessment of Reserve component servicemembers and provide appropriate care referral, if needed, and subsequent follow-up. The Outreach team members make visits to two to three Navy Operational Support Centers

(NOSC) per month in their respective Reserve Regions where they provide PH education including the Operational Stress Control Awareness and Suicide Prevention briefs to NOSC staff and Reserve unit members. The Psychological Health Outreach Team is also available upon request by the NOSC to make special visits for PH assessment of unit members affected by suicides and suicide attempts.

Reserve Returning Warrior Weekends

The Returning Warrior Workshop (RWW) is a "five-star event" conducted on weekends and attended by up to 200 sailors, marines, and family member or spouse. It is the signature event of the Navy Reserve Reintegration program. Attending participants have the opportunity to address personal, family, or professional situations experienced during deployment and receive readjustment and reintegration support from a network of counselors, PH outreach coordinators, chaplains, and Fleet and Family Support Center (FFSC) representatives. Throughout the weekend, participants benefit greatly from considerable counseling opportunities to educate and support the Navy family and to assist sailors re-acclimating to their families and civilian lives.

Both of these programs will be extended in the summer 2009 to provide support to the USMC Reserve.

General AMOS. The Selected Marine Corps Reserve (SMCR), Navy Selected Reserve (SELRES) assigned to SMCR units, Active Reserve (AR), and Active component (AC) personnel are advised by their leaders that the help offered by Military OneSource is only a phone call away at any time of the day or night and is available anytime to all servicemembers and their families. Marines, sailors, and family members are briefed that this organization can provide immediate telephonic intervention, can alert hands-on providers as needed, and can provide on-line or face-to-face counseling by licensed clinicians for up to 12 sessions per year. Additionally, they are advised of the services provided by the nearest Veterans Administration (VA) facility and the Veteran Center. Information on local hotlines, mental health facilities, community agencies, internet sites, and governmental resources is also provided.

Programs of the YRRP specifically address PH/wellness during Pre-deployment, Mid-deployment, and Post-deployment events-both for marines, sailors, and their families. Combat Operational Stress Control (COSC); physical, behavioral, and spiritual health issues; relationship sustainment and reconciliation; financial management; compulsive behavior prevention; substance abuse; and societal reintegration topics are all covered. Though suicide is not specifically addressed as a topic in this setting, these presentations address the top five most-common stressors associated with suicide.

In addition to the annual Suicide Awareness and Prevention training provided to all marines and sailors, unit leaders at all levels within the SMCR units receive additional training and have access to a leader's guide on dealing with suicidal ideations, statements, and behaviors. Real-life events and challenges that lead some to entertain suicidal thoughts are discussed. Licensed clinicians, available through the MFLC program that is provided through an Office of the Secretary of Defense (OSD) contract, are available to units for their pre- and post-deployment events. These consultants provide short-term, non-medical, solution-focused counseling to members and their families on issues arising from the military lifestyle.

General FRASER. Yes. In addition to training requirements, that are the same for the Active Duty members, Reserve component members are part of the YRRP. It pays for servicemembers and several family members to attend events at 30, 60, and 90 days post-deployment. As part of this program, the Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA) are tools to identify members that may have suicidal tendencies. If geographically separated from their unit of assignment, members can also register and attend another Service's YRRP events.

Additionally, VA mental health and medical services are available to all military members that deployed. The member needs only to show a copy of their orders to receive care. Transitional Assistance Advisors provide a person in each State/territory to serve as the statewide point of contact to assist members in accessing Veterans Affairs benefits and healthcare services.

Military OneSource also provides support to members and their families. Members and families are briefed on these programs/resources before deploying and after redeploying.

Air National Guard:

In addition to YRRP, each Air National Guard Wing has a Family Readiness person and a Medical Unit that provides help and support. The Air National Guard

Readiness Center has a Director of Psychological Health on staff and 40 out of 56 Directors of Psychological Health have been hired for each of the States and territories. Military Health Net assists redeploying ANG members and their families in personal interviews and re-interviews. There is a TRICARE provider network who can refer members for financial management assistance, mental health assistance and care, family and individual counseling, anger management, etc.

Air Force Reserve:

The Air Force recently stood up four regional Psychological Health Advocate (PHA) teams and hired a Director of Psychological Health (DPH). There are plans for an additional four teams. These teams will develop and implement population-based PH at each wing within their respective region, ensure access to quality mental healthcare at Air Force Medical Treatment Facilities for eligible Air Reserve component beneficiaries, and follow-up, as necessary to ensure positive outcomes.

Air Force reservists are currently required to complete (in person) an in-processing checklist with their unit/wing upon return from deployment. Reserve unit deployment managers and full time unit personnel maintain contact with Reserve members during deployment, post-deployment, while on leave, and during downtime. The PDHRA screening is being accomplished 90–180 days after returning from deployment and any positive response results in contact with the member for further assessment and possible referral for services.

Other programs and resources already in place to address the needs of Air Force reservists and their families: YRRP, Joint Family Support, routine screenings (Physical Health Assessment (PHA), PDHA and PDHRA, Expanded benefits such as Tricare Reserve Select, increased collaboration between DOD and the VA on medical issues, Landing Gear, annual suicide prevention training, MFLCs, Military OneSource, ESGR, Transition Assistance Advisors, Childcare for personnel on extended AD orders, family care plans, chaplain support, and financial counseling.

2. Senator BEN NELSON. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, is anything being done to reach out to members of the Individual Ready Reserve (IRR), who are not required to drill or check in with units?

General CHIARELLI. IRR soldiers who have recently returned from a deployment or attended a muster event are screened and/or received information regarding reintegration/coping techniques from the Department of Veterans Affairs (VA).

The US Army Human Resources Command (HRC) began a pilot program in 2007 to muster IRR soldiers; 29,000 IRR soldiers were sent orders to muster, with over 8,000 completing muster duty. Of these, 7,500 completed a Personnel Accountability Muster (PAM), a one-on-one event with an Army Career Counselor at one of over 200 Army Reserve centers. An additional 600 IRR soldiers completed a Readiness Muster, a full spectrum medical and mobilization validation event, conducted at four Pilot Army Reserve locations. Since 2007, the muster program outreach continues to expand and regularly sends muster orders to 35–40,000 IRR soldiers each year; with 11–13,000 mustering. IRR soldiers can now complete a PAM at over 400 locations; anywhere there is an Army Reserve Career Counselor. This year nearly 1,300 soldiers will muster at 13 Readiness Muster locations, 5 which occur at a Veteran Affairs Medical Center. They initiate the Army Periodic Health Assessment (PHA), Post-Deployment Health Reassessment, validate their readiness for continued service, receive vital information regarding veteran's benefits, and guidance regarding Federal and local employment opportunities. With sustained funding, the projection for 2010 is to expand the collaborative partnership with Veterans Affairs to maximize the opportunity for more IRR soldiers to complete a full spectrum Readiness Muster screening.

HRC facilitates the participation of IRR soldiers who have recently returned from deployment in the YRRP. IRR soldiers (and a family member) on a voluntary basis may attend an event hosted either by the Army Reserve, the Army National Guard, or another military Service. Soldiers normally attend an event that is nearest their home, but consideration is given, upon request, to send them to the events hosted by the unit with whom they deployed.

The Human Resources Command initiates contact with newly assigned IRR soldiers through an IRR Welcome Letter and Orientation Handbook. This information is mailed about 30 days after assignment to the IRR and explains general requirements, expectations, training opportunities, and annual muster duty.

There are three kinds of musters. Approximately 5 months after entering the IRR a soldier is ordered to a PAM at a local Army Reserve center for a one-on-one event with a career counselor. In following years, some soldiers will be ordered to a Readiness Muster at a local Army Reserve center or Veterans Affairs Medical Center. This event is a full spectrum medical screening to identify any challenges they may

be experiencing and educate them on a wide variety of veteran benefits available. Soldiers who cannot attend a centralized Readiness Muster are ordered to visit a unit visit muster in their local area focused on orientating IRR soldiers on the camaraderie and esprit-de-corps available in Army Reserve units. At all musters, soldiers are screened for completion of the Post-Deployment Health Reassessment, which based on answers provided in the screening, can alert a medical professional of suicide ideations. Additionally, all soldiers complete an online PHA as required.

Admiral WALSH. The Navy Reserve Psychological Health Outreach program is available to assist with providing outreach services to the IRR—this is a natural extension of services already being provided. In addition, IRR members are encouraged to attend a RWW and other reintegration events if they have been recently deployed. Names of recently deployed IRR personnel have been forwarded to the Navy's YRRP leader, and future lists are available on request. Accordingly, the principal intent is to forward IRR sailors' names to the RCC coordinating the RWW to facilitate invitations to the appropriate upcoming RWW. Additionally, IRR members participate in the Navy's PDHRA program to follow up on their physical and PH. The first PDHRA occurs within 90–180 days following re-deployment. Finally, IRR members are required to complete an annual virtual muster questionnaire, part of which addresses any health concerns or changes in health status. If members bring up concerns or changes, IRR counselors are present 5 days per week to follow up with members and provide advice and assistance when necessary.

General AMOS. Marines in the IRR are managed by Marine Forces Reserve's Mobilization Command (MOBCOM). In addition to a full-time Family Readiness Officer (FRO) and a specially-trained Religious Ministry Team, other members of the command's Marine Corps Family Readiness Team (MCFRT) contact IRR marines within 60 to 90 days after their discharge from the Active component. Marines who have been mobilized from the IRR are asked to complete a PDHRA. Any responses indicating a need for referrals receive a personal telephone call and follow-up action. RWWs are used as the Yellow Ribbon 60-day Reintegration Event. The comprehensive event provides a safe and open environment for Service and family members to openly discuss issues ranging from reintegration difficulties to past combat traumas. A psycho-educational model is used to help attendees realize they are having normal reactions to abnormal events. The setting provides a sense of commonality and helps individuals realize they are not alone. Though geographically isolated they come connected to a larger community. Chaplains and counselors are readily available to provide counseling as required. Follow-up for individuals is obtained through the use of mental health resources near the member's residence.

General FRASER. Members of the Participating IRR have the same annual requirements as members of the Selected Reserve. These members receive the same Suicide Prevention briefings and are afforded the same access to resources like the YRRP and Military OneSource. Non-participating members of the IRR do not have the same annual requirements, but they are afforded some access to those resources.

DWELL TIME

3. Senator BEN NELSON. Brigadier General Sutton, we know that deployments put great stress on servicemembers and their families. While deployment and exposure to combat are not the sole reasons a member may kill himself or herself, and in many cases the member has never deployed, they can contribute to other stressors such as financial or marital instability. In your view, would increased dwell time, for the Army in particular, help to ease these stressors?

General SUTTON. Suicide risk factors are related to the number of stressors and demands on the individual balanced by the ability to cope with multiple stressors at the same time. To the extent that some of those demands can be alleviated by more time at home to clear away problems, there may be a benefit. In addition, given the increased level of health and fitness that comes with increased time to pay attention to health, resilience in the face of stress can be enhanced as well. Lack of social support or loss of important relationships in an individual's life significantly increases suicide risk. Long deployments and multiple deployments within a short time of each other can lead to deterioration in relationships, especially marriages and close intimate relationships. When the individual comes home without a strong social network, risk of self-harm, to include reckless behavior, self-injurious behavior, and more extreme suicidal behavior can result. In addition, mental health conditions, especially depression and substance abuse, add to those risks and may be associated with deteriorated coping and prolonged exposure to stress. Sleep problems, fatigue, and overall feelings of inability to cope with probably without enough energy also contribute to overall risk levels. These problems are often associated

with both deployments and with suicidal behavior. Clearly, any measure that reduces the stress to individuals, while building individual strength and protective factors, such as strong social networks, will help to minimize the risk.

4. Senator BEN NELSON. Brigadier General Sutton, have you derived from the Defense Centers of Excellence's studies or collaborative efforts with other agencies or outside groups a recommended length of time a servicemember should have between deployments to recover from the stresses incurred during their time in theater?

General SUTTON. The Defense Centers of Excellence (DCoE) for PH and Traumatic Brain Injury (TBI) has not identified a recommended length of dwell time for servicemembers. Additional research is needed to better understand the effect of deployment stressors on individuals and variables unique to the individual Services. Length of deployment may be just as important, or more important, as dwell time to reduce all signs of distress. In addition, optimal dwell time may vary based on length of deployment, number of previous deployments, and nature of combat exposure during deployments. We have learned that the British Forces have standardized dwell time based on a ratio of time away in a combat environment. Their experience may help to inform our research efforts and, ultimately, our policies.

RESEARCH FUNDING FOR PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY

5. Senator BEN NELSON. Brigadier General Sutton, over the past 2 years a great deal of money, to the tune of at least $600 million, has been put towards PH and TBI. Could you please explain how you have allocated the funds authorized to the Defense Centers of Excellence for PH and TBI, what mechanisms you have in place to vet and execute contracts to conduct research, and describe the timelines you have in place for actionable results?

General SUTTON.

Fiscal Year 2007/Fiscal Year 2008:

While well over $600 million was provided for PH and TBITBI efforts, $300 million was assigned to fund RDT&E projects specifically focused on PH and TBI, $45 million of which was assigned to support specific DCoE for PH and TBI RDT&E priorities. The remaining $255 million was assigned to the United States Army Medical Research and Material Command (USAMRMC) for execution. Recommendations for investment of these funds were provided by key stakeholders, which included representatives from the Armed Services Biomedical Research Evaluation and Management Secretariat (Army, Navy, Air Force, the OSD/Office of Health Affairs); Uniformed Services University of the Health Sciences; Director of Defense Research and Engineering; the VA; the National Institute of Health (NIH); clinical consultants from each of the Services, and the DCoE.

In regard to mechanisms in place to vet and execute contracts to conduct research, program management responsibility for the full $300 million RDT&E appropriation was administered by the USAMRMC in collaboration with DCoE as applicable. The program execution model for the fiscal year 2007 PH/TBI research program was conducted according to the USAMRMC two-tier review model, which includes scientific peer review and programmatic review, recommended by the National Academy of Sciences Institute of Medicine. The USAMRMC Acquisition Activity was responsible for negotiation of awards. Program execution through award can take up to 12 months.

About $5 million of the $45 million assigned to the DCoE for PH and TBI was directed toward Complementary and Alternative Medicine research proposals. The remaining funds, assigned to the USAMRMC Congressionally Directed Medical Reach Program (CDMRP), were distributed across preclinical studies, clinical research, and clinical trials addressing research focused on five critical research gap areas for both PH and TBI. Among the 201 projects funded, three were multidisciplinary consortia, including a $60 million Clinical Consortium focused on Post-Traumatic Stress Disorder (PTSD) and TBI and two $25 million research consortia, one each for PTSD and TBI. The DCoE has visibility on these consortia through participation on External Advisory Boards for each.

The USAMRMC, in collaboration with the DCoE as applicable, will provide full lifecycle management for all projects supported via the $300 million assigned in fiscal year 2007 to support PH and TBI RDT&E efforts. These efforts make possible a dynamic continuum of scientific knowledge between basic research and clinical observation. Actionable outcomes for these research projects are expected over the next 1–5 year range. Abstracts for all of these awards can be viewed at http://cdmrp.army.mil/search.aspx.

Additionally the DCoE was instrumental in providing expertise on the panel which recommended the fiscal year 2008 Deployment Related Medical Research Program (DRMRP) awards. Of the DRMRP awards recommended, ten targeted PH for approximately $30 million and ten targeted TBI for approximately $9 million. Abstracts for these awards will be posted at the CDMRP site listed above upon completion of award negotiations.

Fiscal Year 2009:

Again, significant funding has been appropriated for PH/TBI research, but the DCoE only had responsibility to make recommendations for $90 million. Since the granting process is not yet complete, the information remains procurement sensitive. However, the approved execution plan is in compliance with the guidance provided in the language that accompanied the appropriation as well as incorporates some emerging priorities. The DCoE continues to enhance its relationship with USAMRMC and to leverage and participate in their proposal review process as well as their contracting and management capabilities.

ROLE OF THE DEFENSE CENTERS OF EXCELLENCE FOR PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY

6. Senator BEN NELSON. Brigadier General Sutton, we have heard from each of the Services today about various suicide prevention programs, policies, and initiatives. Do the Centers of Excellence for PH and TBI assess Service-level suicide prevention programs and research, or are the Centers only responsible for creating Department of Defense (DOD) programs?

General SUTTON. The DCoE for PH and TBI has undertaken program evaluation responsibilities for all programs, including suicide prevention. It is one of the DCoE's core responsibilities to assist the Services in conducting their own program evaluations using subject matter experts as consultants to enable effective evaluation protocols. This function is not yet available within the DCoE, but it is in development. DCoE does not establish DOD policy or create new programs just for informing policy offices of the best research and practice in the area. The Services are all members of the DOD Suicide Prevention and Risk Reduction Committee and coordinate their programs through that joint forum to share best practices. DCoE assumed the Chair of that committee in October 2008. The Air Force has proven to have the most effective model for suicide prevention through its community-based suicide prevention program and 11 program components. This program has been cited as a model for the Nation and often cited in the professional literature for its effectiveness. In addition, DCoE will provide support to the DOD Task Force on Suicide Prevention, responsive to the NDAA for Fiscal Year 2009, section 733. This task force will assess suicide education and prevention programs of each military Service.

7. Senator BEN NELSON. Brigadier General Sutton, what is the Defense Centers of Excellence doing to coalesce the projects being performed by other agencies and entities, such as the VA and other Federal agencies, State and private universities, and non-governmental organizations to identify gaps in research or treatment, as well as to avoid duplication of efforts?

General SUTTON. The DCoE for PH and TBI established a Research Directorate to oversee the coordination across DOD and other Federal and non-Federal agencies. In addition, DCoE engages in activities to identify gaps in research and to avoid duplication of effort, including:

- Coordinating development of recommended PH and TBI research strategies, requirements and priorities jointly across multiple agencies;
- Creating common data elements, definitions, metrics, outcomes, and instrumentation standards;
- Conducting comprehensive scan for current research activities related to PH and TBI, and integrating research efforts of component centers, DOD including Blast Injury Research Program coordination, VA, Federal agencies, and civilian organizations;
- Performing gap analysis using the Joint Process Integration Panel to define requirements and priorities as inputs to the overarching Health Affairs biomedical research, development testing, and evaluation (RDT&E) portfolio, joint development of requests for proposals, and both programmatic and peer reviews;
- Developing PH and TBI research and clinical practice clearinghouse capabilities;

- Consolidating and disseminating best practices and monitoring clinical investigations (non-RDTE); and
- Translating research into practical tools, technologies, protocols, and clinical practices.

The following is a selected (not comprehensive) list of agencies and institutions with whom DCoE actively collaborates:

DOD Agencies:

- Bureau of Medicine and the Office of Naval Research
- U.S. Army Medical Research and Materiel Command
- Armed Forces Health Surveillance Center
- Armed Forces Institute of Regenerative Medicine
- Uniformed Services University of the Health Sciences
- Center for Neuroscience and Regenerative Medicine
- Joint Improvised Explosive Device Defeat Organization
- Defense Advanced Research Projects Agency

Other Federal Agencies:

- Department of Veterans Affairs
- National Institutes of Health
- National Institute on Disability and Rehabilitation Research
- Centers for Disease Control and Prevention
- Department of Health and Human Services

Non-Federal Institutions:

- University of California San Diego Medical Center
- University of Southern California—Institute for Creative Technologies Sesame Workshop
- Medical University of South Carolina
- University of Cincinnati
- University of Washington
- Dartmouth College
- University of Maryland Baltimore
- Spaulding Rehabilitation Hospital
- Massachusetts General Hospital
- Duke University
- Brigham and Women's Hospital
- RAND Corporation
- National Military Family Association
- Purdue University
- Massachusetts Institute of Technology
- Laurel Highlands Neuro-Rehabilitation Center, Johnstown, PA
- Lakeview Virginia NeuroCare, Charlottesville, VA

OVERSIGHT OF SERVICES

8. Senator BEN NELSON. General Sutton, what is DOD doing to understand what programs the Services are undertaking and what works?

General SUTTON. The DCoE for PH and TBI works with the Services and external partners to understand and track suicide prevention programs. In addition to DCoE research studies, the Suicide Prevention and Risk Reduction Committee provides a venue for the Services to discuss their current efforts. Also, DCoE will provide support to the DOD Task Force on Suicide Prevention. This task force augments DOD efforts to capture Service-level prevention and intervention efforts. It will establish and update suicide education and prevention programs conducted by each military department based on identified trends and causal factors.

9. Senator BEN NELSON. General Sutton, is DOD overseeing a best practices model, taking into account the differences of the Services and incorporating those things and treatments that could work DOD-wide?

General SUTTON. One of the core functions of the DCoE for PH and TBI is to assess programs across the Services as measured against a set of core principles to find best practices and pockets of excellence. The goal is to feed evidence-based information to the Service leadership to take appropriate action as they implement and shape programs for their Services as well as to the Assistant Secretary of Defense for Health Affairs to establish policy that will proliferate best practices across

the enterprise. Of course, we are cognizant of the fact that Service-unique cultures must be taken into consideration as well as Service-unique requirements.

An example of a product from our process is the publication of the guideline for Clinical Management of Mild TBI in Theater. We gathered our best clinicians from the Services who had treated patients in theater and developed a standardized guideline for use by our providers in Iraq and Afghanistan. To improve the quality of care, we established clinical standards, which incorporated lessons learned and best practices, and introduced evidence-based care as the enterprise standard for acute stress disorder and PTSD, depression, and substance use disorders.

10. Senator BEN NELSON. General Sutton, if we are not doing this, how can we do this and who should oversee the overall mental health and wellness of our armed services?

General SUTTON. For prevention methods to work, building protective factors and reducing risk factors at the early stages of distress are effective. This cannot be done solely from a medical point of view because if only medical or mental health intervention is used, the intervention is too late. Ideally, prevention takes a community approach. First-line supervisors, family members, and friends are in the best position to identify behaviors that might indicate an individual is experiencing distress far in advance of that distress resulting in suicidal behaviors. Educating supervisors, commanders, and peers in identification of distress and sources of support can help. Working from a positive perspective, creating a strong, supportive community that fosters well-being is our best approach to PH, strong social networks, and overall well-being of the force. The DOD will establish more resources for use by line commanders to foster well-being rather than relying solely on last-minute identification of suicidal members. Clearly, a full continuum of care is needed and the mental health community will be an important link in the chain. Increased focus on positive strength building in the organization and community will prove critical to our prevention efforts in the future.

HEALTH CARE PROFESSIONALS

11. Senator BEN NELSON. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, throughout the hearing, we heard a consistent concern about the shortage of healthcare professionals. Please address the shortage of healthcare professionals, including those who are specialized in the treatment of mental health matters, by noting the shortage in billets authorized and the shortage in billets assigned or filled. The goal is to develop a clear picture as to whether this is a billet problem or a fill problem. Please note the percentage of fill with regard to the number of authorized positions. Additionally, please provide the retention rate associated with each health care career specialty.

General CHIARELLI. Army requirements for mental health providers include psychologists, social workers, psychiatrists, and psychiatric registered nurses. Current inventory as of March 2009 totaled 2,579 assigned personnel against 2,501 billets, for a fill rate of 103 percent against documented military authorizations and civilian requirements. However, our manning documents do not yet reflect the needs of a force stressed from 7 years of combat operations. We believe we have a need for at least 3,072 military, civilian, and contract behavioral health providers. This represents a shortage of 493 behavioral health providers. When compared to current on hand behavioral health assets, the Army has an 84 percent fill rate.

Despite increasing behavioral health assets by almost 40 percent since 2007, the Army recognizes additional needs and is trying to hire or contract approximately 87 psychiatrists, 146 psychologists, 222 social workers and 38 psychiatric nurses.

The Army Medical Department military force is monitored by use of continuation rates. These rates depict the number of individuals who continue from 1 year of service to the next and have proven to be a reliable indicator of force behavior. For the last 3 years, the overall continuation rates for mental health specialties ranged from 86.6 percent to 94.1 percent.

The Army Medical Command (MEDCOM) has identified some medical professional specialties to monitor closely based on concern about fill rates (percent inventory against military authorizations or civilian requirements), distributable inventory, deployment frequency, and historic ability to recruit, hire, and retain individuals in these positions. The top four of these specialties of concern are Neurosurgeon (70 percent fill rate), Nurse Anesthetist (77 percent fill rate), Dentist (77 percent fill rate) and Family Medicine Physician (96 percent fill rate).

In response to the National Defense Authorization Act prohibition on medical or dental military to civilian conversions, the Army afforded MEDCOM the flexibility

to reshape restored structure as necessary to support Grow the Army and to meet emerging medical requirements. Documented increases in military structure included 25 psychiatrists; 15 psychiatric nurses; 20 social workers; 12 clinical psychologists and 103 enlisted mental health specialists. Even with these increases, as the operational tempo of the force leads to growing psychological stress, the actual need for behavioral health providers exceeds the manpower requirements currently documented on MEDCOM manning documents. MEDCOM will continue to assess the demand for services in this dynamic environment to keep manning documents as current as possible. The Army is committed to addressing any shortfalls in mental health support for our soldiers.

Admiral WALSH and General AMOS. Healthcare professional retention, although improving, still remains below the rate needed to meet inventory requirements by specialty skill mix. While incentives and bonuses have contributed to reduced loss trends, in the attached charts we highlight select specialties that continue to require attention.

The attached charts display the percentage of fill to the number of billets authorized for each Navy medical community. Additionally, the attachment depicts retention by specialty in the form of a 5-year average loss rate. Loss rates are used to identify recruiting and training demand for individual designators and specialties.

MEDICAL CORPS (as of Feb 2009)

SPECIALTY	INVENTORY	# ASSIGNED TRAINING	NET INVENTORY	BILLETS	PERCENT MANNED	LOSS RATE (5 YR AVG)
Aviation Medicine	292	40	252	236	106.8%	16.08%
Aerospace Medicine	58	10	48	71	67.6%	10.59%
Anesthesia	193	60	133	134	99.3%	14.43%
Surgery	**236**	**60**	**176**	**201**	**87.6%**	**9.77%**
Neuro Surg	24	6	18	15	120.0%	16.67%
Ob/Gyn	160	43	117	105	111.4%	12.74%
General Medicine	519	259	260	229	113.5%	13.86%
Ophthamology	60	9	51	42	121.4%	11.30%
Orthopedic Surg	170	53	117	126	92.9%	16.02%
Otolaryngology	78	24	54	45	120.0%	10.41%
Urology	41	14	27	30	90.0%	17.86%
Prev Med	**50**	**15**	**35**	**54**	**64.8%**	**16.06%**
OCC Med	40	6	34	36	94.4%	10.50%
Phys Med & Rehab	3	0	3	3	100.0%	22.86%
Pathology	88	20	68	61	111.5%	8.05%
Dermatology	54	23	31	32	96.9%	23.33%
Emergency Med	177	54	123	133	92.5%	13.20%
Family Practice	**430**	**81**	**349**	**406**	**86.0%**	**12.10%**
Internal Med	391	122	269	249	108.0%	12.53%
Neurology	29	6	23	21	109.5%	9.29%
Undersea Med	114	13	101	102	99.0%	11.26%
Undersea Med, Sub	3	0	3	0	N/A	11.26%
Pediatrics	171	40	131	116	112.9%	15.75%
Nuclear Medicine	0	0	0	2	0.0%	20.00%
Psychiatry	**132**	**46**	**86**	**98**	**87.8%**	**14.26%**
Diagnostic Rad	160	69	91	91	100.0%	17.89%
Radiation Oncology	12	1	11	9	122.2%	12.77%
Hlth Care Mgmt	2	1	1	0	N/A	N/A
Gmc 1/Gme 2/F/S/Umo Trng				1014		
TOTAL	**3687**	**1075**	**2612**	**3661**	**100.7%**	**14.11%**

DENTAL CORPS (as of Feb 2009)

SPECIALTY	INVENTORY	# ASSIGNED TRAINING	NET INVENTORY	BILLETS	PERCENT MANNED	LOSS RATE (5 YR AVG)
General Dentist	**369**	**16**	**353**	**441**	**80.0%**	**21.27%**
Endodontist	**51**	**10**	**41**	**47**	**87.2%**	**12.35%**
General Dentist ACP	96	2	94	69	136.2%	5.99%
Comprehensive Dentist	113	11	102	105	97.1%	5.34%
Maxillofacial Prosth	12	1	11	11	100.0%	3.85%
Orthodontist	22	7	15	16	93.8%	14.29%
Operative Dentist	20	3	17	22	77.3%	6.00%
Oral Diagnostician	10	1	9	10	90.0%	7.02%
Exodontist	35	0	35	21	166.7%	4.87%
Oral Surgeon	**101**	**28**	**73**	**85**	**85.9%**	**9.86%**
Periodontist	57	10	47	44	106.8%	9.71%
Prosthodontist	**53**	**9**	**44**	**56**	**78.6%**	**8.24%**
Pub Hlth Dentistry	7	0	7	6	116.7%	6.12%
Oral Pathology	10	1	9	9	100.0%	4.08%
Orofacial Pain	11	0	11	13	84.6%	4.48%
Dental Research	3	1	2	6	33.3%	5.56%
Pediatric Dentist	19	3	16	13	123.1%	14.29%
Training Billets				134		
TOTAL	**989**	**103**	**886**	**1108**	**89.3%**	**12.93%**

MEDICAL SERVICE CORPS (as of Feb 2009)

SPECIALTY	INVENTORY	# ASSIGNED TRAINING	NET INVENTORY	BILLETS	PERCENT MANNED	LOSS RATE (5 YR AVG)
Health Care Adm	549	19	530	459	115.5%	
Patient Admin	45	0	45	62	72.6%	
Mat'l Logist Mgt	65	2	63	77	81.8%	
Info Systems	27	1	26	33	78.8%	
Med Construct Lia	17	0	17	19	89.5%	
Plans/Ops/Med Int	135	5	130	169	76.9%	
Financial Mgt	75	2	73	83	88.0%	
MPTA	23	3	20	33	60.6%	
Educ & Trng Mgt	9	0	9	22	40.9%	
Operation Research	6	0	6	7	85.7%	
HCA Subtotal	951	32	919	964	95.3%	8.31%
Biochemistry	35	1	34	33	103.0%	9.58%
Microbiology	49	3	46	45	102.2%	9.61%
Radiation Health	71	7	64	67	95.5%	9.14%
Physiology	16	1	15	12	125.0%	4.84%
Aerospace Physio	94	9	85	82	103.7%	5.97%
Clinical Psych	**117**	**21**	**96**	**118**	**81.4%**	**12.38%**
Aerosp Exper Psych	30	5	25	27	92.6%	7.38%
Research Psych	18	0	18	17	105.9%	9.80%
Entomology	38	3	35	34	102.9%	8.14%
Environmental Hlth	79	2	77	83	92.8%	11.08%
Industrial Hygiene	112	2	110	108	101.9%	8.06%
Audiology	18	0	18	19	94.7%	9.82%
Medical Technology	79	2	77	70	110.0%	5.25%
Social Work	**24**	**0**	**24**	**26**	**92.3%**	**14.10%**
Physical Therapy	76	1	75	68	110.3%	8.57%
Occupation Therapy	20	1	19	20	95.0%	6.25%
Clinical Dietetics	29	0	29	22	131.8%	9.39%
Optometry	120	3	117	110	106.4%	11.67%
Pharmacy, General	118	3	115	118	97.5%	13.53%
Podiatry	**15**	**1**	**14**	**20**	**70.0%**	**11.01%**
Physician Assistant	**168**	**4**	**164**	**217**	**75.6%**	**10.67%**
Training Billets				151		
TPPH Billets				40		
HCA Subtotal	951	32	919	964	95.3%	
HCS Subtotal	1,326	69	1,257	1,316	95.5%	
TOTAL	**2,277**	**101**	**2,176**	**2,471**	**92.1%**	**9.60%**

NURSE CORPS (as of Feb 2009)

SPECIALTY	INVENTORY	# ASSIGNED TRAINING	NET INVENTORY	BILLETS	PERCENT MANNED	LOSS RATE (5 YR AVG)
Med/Sug	654	23	631	452	139.6%	12.96%
MPTA	13	3	10	12	83.3%	2.33%
E & T Management	26	2	24	36	66.7%	7.22%
Professional Nursing	626	5	621	840	73.9%	6.76%
Nursing PhD	7	1	6	11	54.5%	14.71%
Nursing Ed	21	1	20	33	60.6%	13.10%
Maternal Infant	242	2	240	139	172.7%	12.84%
Pediatric Nursing	52	1	51	37	137.8%	12.79%
Community Health	21	4	17	39	43.6%	7.28%
Psychiatric Nursing	60	4	56	45	124.4%	8.79%
Psych/Mental Health NP	7	1	6	6	100.0%	N/A
ER/Trauma Nursing Community	196	5	191	173	110.4%	11.52%
Perioperative Nursing Community	**240**	**12**	**228**	**279**	**81.7%**	**9.82%**
Critical Care Nursing	**250**	**18**	**232**	**330**	**70.3%**	**11.82%**
NICU Nursing	17	0	17	30	56.7%	14.29%
CRNA PhD	10	3	7	4	175.0%	4.55%
Nurse Anesthesia	184	37	147	140	105.0%	7.82%
Pediatric NP	29	1	28	29	96.6%	8.51%
Family NP	**83**	**17**	**66**	**78**	**84.6%**	**11.83%**
Women's Health NP	13	1	12	13	92.3%	10.75%
Nurse Midwife	28	2	26	26	100.0%	7.80%
Training Billets				153		
TOTAL:	**2,779**	**143**	**2,636**	**2,905**	**95.7%**	**9.94%**

General FRASER. Our consultant for mental health indicates the current billets would be adequate to meet Air Force needs if we could fill them all. The following data reflects the number of authorizations and members assigned to corps and specific career fields/AFSCs. The data reflects Duty AFSCs for the billets and the assigned personnel. The numbers include training billets and members in training status (Graduate Medical Education residents). The data source is the Fiscal Year 2008 Health Manpower Statistics report, published by the Defense Manpower Data Center (DMDC) from information compiled by the automated Health Manpower and Personnel Data System (HMPDS).

TABLE 1. OVERALL AFMS MANNING BY CORPS

AFMS Corps (including training billets)	Authorized	Assigned	Percent Manned
Medical Corps	3,371	3,459	102.6
Dental Corps	971	922	94.9
Nurse Corps	3,501	3,276	93.6
Biomedical Sciences Corps	2,345	2,182	93.0
Medical Service Corps	1,049	1,029	98.1
Enlisted Corps	20,924	21,551	103.0

Table taken from 2008 HMPDS Report.

TABLE 2. CRITICAL AFMS SHORTAGES

Specialty	AD Authorized	AD Assigned	Percent Manned	Retention Rate[1] at mid-career (10 YOS) (Percent)
General Surgery	78	57	73.1	22
Pharmacist	258	219	84.8	12

TABLE 2. CRITICAL AFMS SHORTAGES—Continued

Specialty	AD Authorized	AD Assigned	Percent Manned	Retention Rate[1] at mid-career (10 YOS) (Percent)
Public Health Officer	199	176	88.4	39
Family Practice Physician	448	399	89.0	21
Operating Room Nurse	236	212	89.8	25

Table taken from 2008 HMPDS Report.
[1] Retention Rate added by AF/A1I based on current data. Mid-career (10 year point) used as commonality among career fields with differing educational obligations and requirements.

TABLE 3. MENTAL HEALTH SPECIALTIES

Specialty	Civilian Auth/ Assigned	Civilian Percent Manned	Active Duty Auth/ Assigned	Active Duty Percent Manned	Retention Rate [1] at mid-career (10 YOS) (Percent)
Psychologist	18/18	100	256/205	80.1 6	
Social Worker	168/165	98.2	199/209	105.0	53
Psychiatrist	1/1	100	87/94	108.0	25
Mental Health Nurse [2]	1/1	100	47/55	117.0	39
Mental Health Technician	11/12	109	763/695	91.1	22

Table taken from 2008 HMPDS Report.
[1] Retention Rate added by AF/A1I based on current data. Mid-career (10 year point) used as commonality among career fields with differing educational obligations and requirements.
[2] Mental health Nurse: Due to small population size, Retention Rate may have high error rate.

Regarding Clinical Psychologists, we have a fill problem due to retention issues. Special Pays will be of significant help in retaining psychologists. Regarding accessions, we bring most psychologists on to active duty through one of three Air Force internship programs. Historically they have been successful in filling their training authorizations (though some difficulties this year, and 2 years ago). We have increased the number of Health Professions Scholarship Program scholarships for psychologists in an effort to help fill our internship slots.

Retention Rates

The average career length (ACL) for mental health providers is as follows:
(Time is in Commissioned Years of Service (CYOS))

ACL - Social Worker - 12.78 CYOS
ACL - Mental Health Nurses - 11.22 CYOS [1]
ACL - Psychiatrists - 8.78 CYOS
ACL - Psychologists - 5.47 CYOS

The decision point is where all military and educational obligations have been fulfilled and the individual is first able to separate. Based on historical data, retention for Mental Health Providers is as follows:

Clinical Psychologists - 20 percent after their military obligation is complete (4 years).

Mental Health Nurses - 58 percent after their military obligation is complete (4 years).

Psychiatrists - 25 percent after their military obligation is complete (9 years).

Social Worker - 88 percent after their military obligation is complete (4 years).

QUESTIONS SUBMITTED BY SENATOR LINDSEY GRAHAM

SUICIDE PREVENTION IN THE ARMY

12. Senator GRAHAM. General Chiarelli, we all share your view that the current numbers of suicides in the Army are unacceptable. What are your expectations for the initiatives that you have described?

General CHIARELLI. Several events have occurred since my March 2009 testimony, which have shaped my expectations. First, I have gathered information and made

[1] Mental Health Nurse (46P) auths are extremely small (<100); data based on 3-year average (Fiscal Year 2006–Fiscal Year 2008)

important observations during an 8-day, six-installation visit. Second, the Army Suicide Prevention Task Force has completed a multidisciplinary review of Army doctrine, policies, organizations, training, materiel, leadership, personnel, and funding. As a result of these events, approximately 250 action plans were developed to form one part of the overall prevention effort: the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention, issued in April 2009. Additionally, I convene a senior level council that regularly meets to vet and refine those action plans for my approval. I expect this process of vetting and review to continue for several months as the council develops recommendations for long-term, large-scale changes Army-wide, to include increasing the number of behavioral health personnel and Chaplains Corps personnel. Meanwhile, Army leaders and medical treatment facilities will optimize existing policies and resources in the short term to prevent suicides and set the stage for the longer-term changes. I have already alerted commanders to begin that optimization and preparation immediately.

The YRRP, already adopted by the Army Reserve and National Guard as a model and implemented in many States, will be implemented in all States.

On-line mental health services (via web-based or video-teleconference) will be expanded and made available on an Army-wide basis, both in theater and in the continental United States. The interactive video "Beyond the Front" will continue to be available to soldiers and their families online.

A mechanism for ensuring continuity of treatment will be developed to ensure appropriate transfer of care from professional officer filler information system (PROFIS) care providers to state-side behavioral health care providers upon soldiers' return from theater.

Bottom line for expectations: it will ultimately be soldiers taking care of soldiers. Soldiers will be the first to recognize another soldier in need; feel empowered to get his or her buddy the help he or she needs; and will know where to go to get it.

13. Senator GRAHAM. General Chiarelli, what are the metrics you will use to gauge the success of these programs?

General CHIARELLI. The overall metric for the success of Army programs is a reduction in the rate of suicides by Army soldiers.

For the Army Suicide Prevention Task Force and Council, I would measure their success by the institutionalization of the Task Force's functions and the perpetuation of the Council process to ensure that the Army is continually re-examining itself to find new ways to reduce the number of suicides.

The success of the YRRP will be its implementation rate by State National Guards, and with appropriate modifications, by the Army Reserve.

The success of on-line mental health services (via web-based or video-teleconference) will be increased access to, and use of, those services and the success of the "Beyond the Front" video would be its review by all soldiers, Army-wide.

The success of changes to the PROFIS system would be the seamless handoff of behavioral health care from PROFIS providers to state-side behavioral health care providers.

Finally, the success of soldiers taking care of soldiers is when a soldier can recognize the symptoms or behavior of a soldier in need just as he or she would recognize the symptoms of a heat or cold injury.

14. Senator GRAHAM. General Chiarelli, do you anticipate reducing dwell times as part of this strategy?

General CHIARELLI. The Army's suicide prevention strategy does not rely on increasing dwell time as part of our approach to reducing suicides. Increasing dwell time is critical to bringing our Army back into balance and is a top priority for us. So while it is not part of our suicide prevention strategy per se, reducing dwell time should have a beneficial impact on a host of behavioral health issues and make our suicide prevention efforts more effective.

15. Senator GRAHAM. General Chiarelli, what are you goals for the program in the next 6 months? In 1 year?

General CHIARELLI. Overall, my goal in the next 6 months is due diligence and regimented enforcement of all institutional processes that exist to take care of soldiers with an ultimate goal being significant reduction in the number of suicides. The heightened state of awareness of the suicide problem has caused our commanders to widen their aperture and get back to the basics in caring for soldiers.

At 6 months, the Task Force should be dissolved, with the transfer of its functions to an appropriate proponent on the Army Staff, and the continued evaluation of the Army's efforts to combat suicide and risky behavior utilizing the Council process.

The YRRP should be increased in the Guard and Reserve. Within 1 year, I would like to see this program implemented throughout the Guard and Reserve.

My goal for the use of on-line mental health services is removal of any legal or policy impediments to expand use of such services, and increased implementation of those services. At 1 year, I would like to see additional expansion of those services and increased use of those services. Additionally, the "Beyond the Front" video should be viewed and internalized by every soldier and that we continue to exploit its learning methods.

My goal for the success of the changes to PROFIS is improvement in the continuity of care being provided to soldiers returning from theater.

COMMAND LEADERSHIP AND SUICIDE REDUCTION

16. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, let's talk about command climate and the importance of that as a contributor or as a protective factor in suicide, as well as holding leaders accountable for climate within their commands. Is command climate routinely studied when a suicide occurs, as it was in the Houston Recruiting Battalion?

General CHIARELLI. Any significant serious event within a unit, i.e., suicide, AWOL/desertion, domestic abuse, should send a signal to the leadership that potential unit morale and welfare issues are creating risky behaviors and impacting the readiness of the unit. The command climate survey is one of many tools the command can utilize to obtain a better perspective of what is happening within their units.

The Command Climate Survey is anonymous and briefly addresses 20 climate areas including: officer leadership, NCO leadership, immediate supervisor, leader accessibility, leader concern for families, leader concern for single soldiers, unit cohesion, counseling, training, racist materials, sexually offensive materials, stress, training schedule, sponsorship, respect, unit readiness, morale, sexual harassment, discrimination, and reporting harassment/discrimination incidents.

The Command Climate Survey is one of many tools in the command; others include unit climate, observations, personal interviews, reports, and other unit data. Combined, these can be effective in determining where potential problem areas are, and where to focus priorities. Army values will compel the command group to take action in the areas where soldiers are most vulnerable.

Admiral WALSH. The Navy Operational Stress Control program emphasizes the role of leadership in fostering resilience and mitigating stress reactions, in part through positive command climate and unit cohesion.

Navy assesses command climate at the unit level in multiple ways to include use of Command Assessment Teams and command climate surveys as part of a long standing Navy Equal Opportunity Program.

Additionally, the Navy monitors organizational climate through a variety of Tone of the Force Metrics and multiple questionnaire and survey instruments.

Navy assesses behavioral health needs, and associated command climate factors, for ground deployed sailors using the Behavioral Health Needs Assessment. This tool has enabled corrective action, when climate concerns have arisen associated with behavioral health needs, before waiting for suicides to occur.

Each suicide in the Navy is investigated to identify contributing factors. Any misconduct, on the part of individuals or the command, identified in the course of JAGMAN Line of Duty Investigation or NCIS investigation is referred to the adjudicating authority for disposition.

The NCIS death investigation process is aimed at ruling out criminal causality. Therefore, careful examination, documentation and processing of the death scene, forensic analysis of recovered evidence, and extensive interviews are conducted in order to garner a full picture of the deceased, their mindset, and their environment. In addition to command climate, other factors that are taken into consideration as part of the NCIS investigation may include the level of security clearance and whether the deceased had access to classified information, financial hardship, marital/relationship problems, substance abuse, job satisfaction and if there is a history of previous suicide attempts.

The DOD Suicide Event Report includes questions that relate to command climate (for example Q. 90 "Prior to the event was there evidence of unit or workplace hazing?"). However, a formal command climate assessment is not automatically triggered by a suicide death.

General AMOS. Global command climate is not always a significant factor in assessing stressors related to a specific suicide. Specific issues of local command climate may play a role and are assessed through questions on the DOD Suicide Event

Report (DODSER), the use of command interviews associated with the DODSER, command investigations, and NCIS investigations. The Marine Corps has not found instances of suicide clustering that would indicate a unique command climate condition. Were we to see indicators of that, we would investigate to examine possible causal or contributing factors.

General FRASER. The Air Force agrees that a positive command climate is essential to unit cohesiveness and readiness, and it serves as a protective factor to prevent suicides. Because of this, Wing Commanders initiate an investigation after every suicide and all contributing factors are examined. The lessons learned are shared with the MAJCOM, commanders and unit leaders.

Additionally, the Air Force regularly assesses command climate in all units through Unit Climate Assessments. Additionally, Community Action Information Boards (CAIBs) at each base identify and address vulnerabilities that may exist in the community. CAIBs are cross functional and provide senior leaders visibility on suicide risk factors such as marital/relationship problems, substance abuse, legal/disciplinary actions, financial, et cetera. This awareness combined with rapid notification of suicides allows senior leaders to identify cases where leadership issues may contribute to increased risk for suicide.

17. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, what systems are in place to identify a command in which there may be leadership problems which contribute to an increased risk of suicide?

General CHIARELLI. For a healthy command environment to exist there must be proactive actions on the part of the commander and all of his or her leadership. Conducting a climate assessment in accordance with Army Regulation 600–20 (Army Command Policy) provides the leadership with the basis to know where the unit stands, and what, if any actions will be required to improve the climate. Leaders at all levels within any command are responsible for assisting the commander in the conduct of assessments.

Unit "climate" factors such as leadership, cohesion, morale, and the human relations environment have a direct impact on the effectiveness of each unit. The requirement to assess the environment is within 90 days of taking command and once annually thereafter.

The Command Climate Survey is anonymous and briefly addresses 20 climate areas including: officer leadership, NCO leadership, immediate supervisor, leader accessibility, leader concern for families, leader concern for single soldiers, unit cohesion, counseling, training, racist materials, sexually offensive materials, stress, training schedule, sponsorship, respect, unit readiness, morale, sexual harassment, discrimination, and reporting harassment/discrimination incidents.

The Command Climate Survey is one of many tools in the command; others include unit climate, observations, personal interviews, reports, and other unit data. Combined, these can be effective in determining where potential problem areas are, and where to focus priorities. Army values will compel the command group to take action in the areas where soldiers are most vulnerable.

Admiral WALSH. The Navy proactively assesses command climate at command and unit level in multiple ways, to include use of Command Assessment Teams (CAT-Teams), command climate surveys, and cultural workshops as part of a long standing Navy Equal Opportunity and Naval Safety Center programs and policies.

Further, the Navy monitors organizational climate through a variety of "Tone of the Force" Metrics and multiple questionnaire and survey instruments. Commanding Officers are provided direct feedback from CAT-Team leadership and workshop/survey facilitators, enabling instantaneous visibility of where leadership intervention is required.

In addition to the many positive programs and systems in place that are utilized to proactively prevent suicide incidents, the Navy also thoroughly investigates each incident. These investigations help identify contributing casual factors, and the navy applies the lesions learned to prevent similar incidents in the future. If any misconduct is discovered during the course of the JAGMAN Lind of Duty Investigation or NCIS investigation, on the part of individuals or the command/unit, the adjudicating authority is called upon for disposition.

General AMOS. The Marine Corps has both internal and external systems in place to assess commands in which problems may exist. Commanders continuously assess the leadership environment within their unit and subordinate units. They assess mission performance, disciplinary issues, and morale, among a multitude of indicators. Our senior enlisted marines provide another source of information. We also have Request Mast procedures whereby any marine can bring issues up the chain of command for resolution. These procedures are reviewed by our command inspection process to ensure they are not only in place but working. The Marine Corps

conducts command climate assessments; QOL surveys; command chaplain assessments; mental health liaison with commanders; and IGMC inspections. For non-hostile deaths in add, commanding generals conduct back-briefs with the unit leadership and associated staff officers to understand what happened in context and see if there are lessons learned that can prevent future losses. Additionally for non-hostile deaths not in a medical facility, NCIS conducts an independent investigation.

General FRASER. The Air Force utilizes the Air Force Climate Survey, the Unit Climate Assessment (UCA), and the CSAF's weekly suicide report to identify commands that may be experiencing leadership problems that contribute to an increased risk of suicide.

The Air Force conducts two climate surveys on a recurring basis. The Air Force Climate Survey is conducted every 2 years to assess Air Force organizational climate and provide feedback to leaders to improve their units. It focuses on leadership support and job satisfaction. The UCA measures unit effectiveness and the unit's human relations environment. The CSAF's weekly suicide report provides a brief description of any suicide that has occurred. This description includes the unit the member was assigned to, providing senior leadership timely visibility on issues and where they are occurring.

LIMITED PRIVILEGE SUICIDE PREVENTION PROGRAM

18. Senator GRAHAM. General Fraser, please elaborate on the Limited Privilege Suicide Prevention Program described in your written testimony. Please articulate the way in which you believe your programs have been effective and how that reconciles with increased levels after implementation?

General FRASER. The objective of the Limited Privilege Suicide Prevention (LPSP) program, initiated in 1999, is to identify and treat those Air Force members who, because of the stress of impending disciplinary action under the Uniform Code of Military Justice (UCJM), pose a genuine risk of suicide. In order to encourage and facilitate treatment, the LPSP program provides limited confidentiality under specific circumstances. Air Force members enrolled in the LPSP program are granted limited protection with regard to information revealed in, or generated by their clinical relationship with mental health providers. Such information may not be used in the existing or any future UCMJ action or when weighing the characterization of their service during the separation process.

The Air Force Suicide Prevention Program (AFSPP) is a leadership driven, cross-functional program that relies on ongoing reassessment and reinvigoration. The AFSPP is comprised of 11 initiatives and takes a community wide approach. The Air Force Community Action and Information Board (CAIB) and Integrated Delivery System (IDS) work at each installation, and at the Air Force level, bridging communication between helping services and leadership providing community level support and action. Prior to adopting the AFSPP in 1998, the pre-AFSPP suicide rate from 1987 to 1996 was 13.5 suicides per 100,000. Since adoption of the AFSPP, the post-AFSPP suicide rate average from 1997 to 2008 is 9.8 suicides per 100,000, resulting in a 28 percent rate reduction.

MENTAL HEALTH PROVIDERS

19. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, you have all testified that more mental health providers are needed in your Service. Please identify the authorities that you have to provide incentives to mental health providers for both Active and Reserve military Service and civilian service.

General CHIARELLI. Each category of personnel (Active, Reserve and civilian) has multiple incentives to support both recruitment and retention. For the Active component, the full array of Physician Special Pays (Variable Special Pay, Medical Additional Special Pay, Incentive Special Pay/Multiyear Incentive Special Pay, Multi-Year Special Pay) and the Critical Wartime Skills Accession Bonus are available to Psychiatrists/Child Psychiatrists. Additionally, psychiatrists are eligible for Board Certification Pays and the active Duty Health Professions Loan Repayment Program (ADHPLRP). Psychiatric nurses are eligible for both Incentive Special Pay if they have completed an approved graduate program, and for Non-Physician Board Certification (NPBC) pay while on active duty. Fully qualified psychiatric nurses are also eligible for the Nurse Accession Bonus and/or ADHPLRP as a recruitment incentive. Licensed Clinical Psychologists and Licensed Social Workers are eligible for ADHPLRP and NPBC. Clinical psychologists are additionally eligible for the Critical Skills Accession Bonus. Under the new Consolidation of Health Professions Special

Pays (section 335, title 37, U.S.C.), Social Work officers and Clinical Psychologists will be offered both Incentive Pays and a Retention Bonus in addition to Board Certification Pay. Implementation is pending with the OSD.

Incentives for the Reserve Forces are only available to specialties listed on the Army Reserve Critical Wartime Specialty List in accordance with DOD Instruction 1205.20. Psychiatrists are authorized to receive the Accession and Retention Special Pays (provided they have completed an approved graduate program and are board certified) and to participate in the Selected Reserve Health Professions Loan Repayment Program. Those in training are eligible for the Medical/Dental School Stipend Program. Fully qualified Clinical Psychologists in the Selected Reserves are authorized the same incentives as the fully qualified Psychiatrist.

There are two separate authorities granting direct hire authority for civilians, allowing MEDCOM to streamline traditional hiring processes and make on-the-spot selections to reduce hiring times. These authorities are legislated in the Defense Appropriations Act for Fiscal Year 2009 and the National Defense Authorization Act for Fiscal Year 2009. The Appropriations Act for Fiscal Year 2008, for the first time, granted direct hire authority for an additional 12 occupations, for a total of 24 occupations, including social workers, social services assistants, psychologists, and psychology technicians. The challenge is that this authority expires at the end of the fiscal year, creating a lapse period until the next year's authority is delegated to management officials. The direct hire authority granted initially under the NDAA for Fiscal Year 2008, and extended until 2012 under the NDAA for Fiscal Year 2009, was to provide uninterrupted appointment coverage through 30 September 2012. However, this authority has not been delegated from the OSD to the Services. OSD is withholding delegation pending review of the implications of the *Gingery* v. *Department of Defense* case regarding veterans' preference for excepted service positions. Meanwhile MEDCOM continues to use the direct hire appointment authority under the Appropriations Act for Fiscal Year 2009.

Admiral WALSH.

Federal Civilians:

Recruitment, relocation, and retention incentives, each up to 25 percent of annual adjusted base salary, may be given in a multi-year package up to a total of 4 years as allowed at 5 U.S.C. 5753. Federal Student Loan Repayment Program up to $10,000 per year up to a total of $60,000 as allowed at 5 U.S.C. 5379.

Military Personnel:

Currently DOD has authorized the payment for all Services the following special pays:

Medical Corps: Title 37, Chapter 5,

Section 301d, Multi-year Special Pay (MSP). Psychiatry, $43,000/$28,000/$17,000 annually for 4/3/2 years of obligation.

Section 302, Psychiatry, Incentive Special Pay (ISP), $20,000 with or without MSP. Variable Special Pays (VSP), Additional Special Pays (ASP) and Board Certified Pays (BCP) which vary by individual by years of creditable service.

Medical Service Corps:

Currently Navy authorizes a clinical Psychologist Critical Skills Retention Bonus of $15,000 per year for a 4 year agreement. Section 302c authorizes Clinical Psychologist and Social Workers Board Certified Pay (BCP) which vary by individual by years of creditable service. Awaiting Assistant Secretary of Defense (Health Affairs) (ASD(HA)) authorization for a Clinical Psychologist Retention Bonus, Incentive Pay and Accession Bonus and an accession bonus for Social Workers as authorized in National Defense Authorization Act 2008 Section 335.

Nurse Corps:

Title 37, Ch5, Sec 302e, ASD(HA) authorizes payment of Incentive Special Pay for Mental Health Nurse Practitioners and Mental Health Nurses of $20,000/$15,000/$10,000/$5,000 annually for 4/3/2/1 years of obligation.

General AMOS. The USMC does not have the responsibilities or authorities for maintaining adequate numbers of Mental Health providers. Rather, in our unique relationship with Navy Medicine the Marine Corps establishes validated requirements for providers of all types that Navy Medicine uses its authorities and tools to meet the requirements. The Marine Corps concern is that although Navy Medicine has filled all of our validated requirements to date, there appears to be the potential in the not to distant future for Navy Medicine for the first time ever not

being able these requirements. We are in coordinated and constructive dialogue at this time to meet this challenge.

General FRASER. Active Component Accession Bonuses: Under title 37, U.S.C. 302, in January 2009 we offered a psychiatrist accession bonus of $272,000 for a 4-year contract. We also offered a nurse contract of $30,000 for 4-years or $20,000 if they take the Health Professions Loan Repayment Program (HPLRP) assistance of up to $40,000. HPLRP and Health Professions Scholarship Program (HPSP) authority is granted by title 10, U.S.C., and implementation guidance of DODI 6000.13. HPSP provides tuition and a monthly stipend for Medical Corps, Dental Corps, Nurse Corps, or Biomedical Sciences Corps officers. In general quotas are based on specialty with quotas specifically set aside for Clinical Psychologists.

Active Component Retention Bonuses: Under title 37, U.S.C. 301, and 302, psychiatrists are offered up to $92,000 per year based on the pay tables published annually by Health Affairs. This includes $15,000 in Additional Special Pay; up to $12,000 in Variable Special Pay based on years of service; up to $6,000 for Board Certification based on years of service; Incentive Special Pay of up to $20,000, up to $43,000 in Multi-year Special Pay for a 4-year contract; and $39,000 for a 4-year commitment, for those with a completed residency, but still have 18-months educational commitment remaining. Psychiatrists receive additional special, variable, and board certification pay of up to $57,500 over regular officer salary.

Mental Health Nurses and Psychiatric Nurse Practitioners: Under title 37, U.S.C. 302, up to $20,000 for a 4-year contract and up to $5,000 per year for certified nurses is offered.

The National Defense Authorization Act of 2008, Consolidation of Special Pays, allows special pays including board certification pay for careers previously excluded from Special Pays incentives programs. Implementation is funded for fiscal year 2009, but is in coordination at USD/DOD level. Under the consolidation authority, we hope to offer an Accession Bonus of $20,000 per year for a 4-year contract and allow up to $31,000 per year to retain Clinical Psychologists.

Since fiscal year 2007, Clinical Psychologists have been offered a Critical Skills Retention Bonus (CSRB) of $30,000 for a 3-year contract at 3 to 6 years of service, under authority of title 37 U.S.C. 355. Most psychologists separated at the 4-year point.

Reserve Component Accessions: The Reserve Component Wartime Health Care Specialties with Critical Shortages list is published every 2 years. Bonuses are offered per title 37, U.S.C., section 302. Accession Loan Repayment: The HPLRP is for members not taking or not eligible for the Wartime Health Care Specialties incentive pay program.

Civilian Component: Available accession and retention tools for civilian employees include recruitment bonuses of up to 25 percent of base salary, retention allowances of up to 25 percent of base salary, credit for non-Federal and Uniformed Service experience for annual leave accrual for new employees, and Student Loan Repayment of $10,000 per year with $60,000 maximum payment. Superior Qualification Appointments (for GS employees only) provides an advance in-hire rate up to Step–10 of assigned grade.

20. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, what authorities are being used today?

General CHIARELLI. Each category of personnel (Active, Reserve and civilian) has multiple incentives to support both recruitment and retention. For the Active component, the full array of Physician Special Pays (Variable Special Pay, Medical Additional Special Pay, Incentive Special Pay/Multiyear Incentive Special Pay, Multi-Year Special Pay) and the Critical Wartime Skills Accession Bonus are available to Psychiatrists/Child Psychiatrists. Additionally, psychiatrists are eligible for Board Certification Pays and the active Duty Health Professions Loan Repayment Program (ADHPLRP). Psychiatric nurses are eligible for both Incentive Special Pay if they have completed an approved graduate program, and for Non-Physician Board Certification (NPBC) pay while on active duty. Fully qualified psychiatric nurses are also eligible for the Nurse Accession Bonus and/or ADHPLRP as a recruitment incentive. Licensed Clinical Psychologists and Licensed Social Workers are eligible for ADHPLRP and NPBC. Clinical psychologists are additionally eligible for the Critical Skills Accession Bonus. Under the new Consolidation of Health Professions Special Pays (section 335, title 37, U.S.C.), social work officers and clinical psychologists will be offered both Incentive Pays and a Retention Bonus in addition to Board Certification Pay. Implementation is pending with the OSD.

Incentives for the Reserve Forces are only available to specialties listed on the Army Reserve Critical Wartime Specialty List in accordance with DOD Instruction 1205.20. Psychiatrists are authorized to receive the Accession and Retention Special

Pays (provided they have completed an approved graduate program and are board certified) and to participate in the Selected Reserve Health Professions Loan Repayment Program. Those in training are eligible for the Medical/Dental School Stipend Program. Fully qualified Clinical Psychologists in the Selected Reserves are authorized the same incentives as the fully qualified Psychiatrist.

There are two separate authorities granting direct hire authority for civilians, allowing MEDCOM to streamline traditional hiring processes and make on-the-spot selections to reduce hiring times. These authorities are legislated in the Defense Appropriations Act for Fiscal Year 2009 and the National Defense Authorization Act for Fiscal Year 2009. The Appropriations Act for Fiscal Year 2008, for the first time, granted direct hire authority for an additional 12 occupations, for a total of 24 occupations, including social workers, social services assistants, psychologists, and psychology technicians. The challenge is that this authority expires at the end of the fiscal year, creating a lapse period until the next year's authority is delegated to management officials. The direct hire authority granted initially under the NDAA for Fiscal Year 2008, and extended until 2012 under the NDAA for Fiscal Year 2009, was to provide uninterrupted appointment coverage through 30 September 2012. However, this authority has not been delegated from the OSD to the Services. OSD is withholding delegation pending review of the implications of the *Gingery* v. *Department of Defense* case regarding veterans' preference for excepted service positions. Meanwhile MEDCOM continues to use the direct hire appointment authority under the Appropriations Act for Fiscal Year 2009.

MEDCOM spent $27.3 million in fiscal year 2007 for recruitment, relocation, and retention (3Rs) incentives to attract and retain civilians across MEDCOM. Spending on 3Rs in fiscal year 2008 increased by 44 percent to $39.2 million, with $48 million earmarked for fiscal year 2009. At the end of first quarter fiscal year 2009, spending for the year on 3R incentives totaled $11.3 million.

During fiscal year 2008, MEDCOM undertook a major initiative to review and update special salary rates for civilians. As a result, over 15 special salary rate tables were updated, predominately for nurses and pharmacists, at a cost of $11 million. Currently MEDCOM has over 5,500 civilians receiving special salary rates, which represents 25 percent of our Army civilian healthcare force.

Additionally, MEDCOM allocates $1.5M annually for student loan repayment for registered nurses.

Throughout MEDCOM, managers have used the Direct Hire Authority (DHA) for medical occupations to expedite the hiring process. Since May 2002, 900 physicians and over 5200 registered nurses were hired using DHA. Since December 2007, when additional occupations were added to the DHA, MEDCOM managers used DHA to hire over 100 psychologists and almost 200 social workers.

Admiral WALSH. Current authority by Assistant Secretary of Defense (Health Affairs) (ASD(HA)) is Title 37, Chapter 5, Sections 301d (Medical Multiyear Special Pay (MSP), 302 (Medical Variable Special Pay (VSP), Additional Special Pay (ASP), Incentive Special Pay (ISP), and Board Certification Pay (BCP)); Section 302c MSC Psychologist BCP and Navy Critical Special Retention Board (CSRB); Section 302c also authorizes Social Workers BCP. Section 302e Special Pay Nurse Anesthetists authorizes the Secretary of Defense to extend authority to any nurse designated as critical with "post-baccalaureate" education and training. ASD(HA) is processing new pay authority Section 335 for Medical Service Corps Clinical Psychology Retention Bonus, Incentive Pay and Accession Bonus and an accession bonus for Social Workers.

General AMOS. My understanding is that for Navy Medicine all active duty Medical Professional Corps (Medical Corps, Nurse Corps, Medical Service Corps and Dental Corps) met recruiting goals for fiscal year 2008 and are on track to meet fiscal year 2009 targets. Civilian health care professional recruiting is done locally as individual medical commands recruit to meet their specific requirements. For some medical specialties in less population dense geographic locations civilian health care professional recruiting is more challenging, but no more of a challenge than seen by the private sector in those regions. Additionally, the reversal of the military-to-civilian medical billet conversion has helped ease requirements to find civilian medical professionals for hard to fill assignments.

General FRASER. AF Active Duty and Reserve/Guard components are using all authorities established by title 37, U.S.C., chapter 5, in addition to title 10, U.S.C., chapter 105, and title 10, U.S.C., section 16302, for the Health Professions Scholarship Program and Health Professions Loan Repayment Program. The Active component also uses DODI 6000.13 for implementation guidance for many of the accession and retention programs.

Civilian Component:

Multiple tools are available for civilian employees for both accession and retention purposes:

- Recruitment bonuses for new accessions (up to 25 percent of base salary)
- Retention allowances to sustain high caliber employees (up to 25 percent of base salary)
- Credit for non-Federal and Uniformed Service experience for annual leave accrual for new employees
- Student Loan Repayment for new accessions ($10,000 per year with $60,ooo max payment)

Superior Qualification Appointments (for GS employees only) provides an advance in-hire rate up to Step–10 of assigned grade

21. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, how much money was allocated by component in fiscal year 2008, and fiscal year 2009 to attract and retain mental health professionals both in uniform and as civilian?

General CHIARELLI. The Health Professions Special Pays are not apportioned specifically to mental health providers but encompass all health care providers. In fiscal year 2008, the budget to support active duty health professional special pays (both retention and incentive) was $206.1 million. The fiscal year 2008 budget to support Reserve duty health professional special pays (both retention and incentive) was $22.3 million. In fiscal year 2009, the current budget is $225 million for the Active component and $32.4 million for the Reserve component. In fiscal year 2009, $770,000 has been paid out to support Registered Nurse incentive special pay for Psychiatric Nurses. Additionally, $1.408 million has been expended to support the Critical Skills Retention Bonus for Clinical Psychologists.

Using a risk assessment tool to determine necessary funding levels for civilian hiring needs, MEDCOM programmed $48 million for 3Rs funding for fiscal year 2009. At the end of first quarter fiscal year 2009, spending for recruitment, relocation, and retention was $11.3 million of the $48 million programmed for fiscal year 2009.

Admiral WALSH. The following funding applies to military mental health professionals only. No funds were secured to for the purpose of acquiring civilian (GS) mental health providers.

Fiscal Year 2008:

Medical Corps -

Multiyear Special Pay (MSP): $1.425 million
Incentive Special Pay (ISP): $1.0 million

Medical Service Corps -

Critical Skills Retention Bonus (CSRB): $1.2 million

Nurse Corps -

$0

Fiscal Year 2009:

Medical Corps -

MSP: $1.821 million
ISP: $1.76 million

Medical Service Corps -

CSRB: $120,000, Retention Bonus: $1.55 million
ISP: $.5 million
Accession bonus: $.48 million

The CSRB is being phased out and replaced by accession, retention and incentive pays in accordance with title 37, section 335, approved in the 2008 National Defense Authorization Act.

Nurse Corps -

$.835 million

General AMOS. The USMC does not have the responsibilities or authorities for maintaining adequate numbers of Mental Health providers. Rather, in our unique relationship with Navy Medicine the Marine Corps establishes validated requirements for providers of all types that Navy Medicine uses its authorities and tools to meet the requirements. As such, I must defer to my Navy Medicine colleagues to answer this question.

General FRASER. Active component: Because of limitations imposed by law, accession and retention pays of mental health providers were restricted to physicians and nurses. All other mental health providers were precluded from participating in special pays programs. Because of this limitation, beginning in fiscal year 2007, the Air Force used the Critical Skills Retention Bonus (CSRB) under authority of title 37, U.S.C., section 355, to focus retention pay to targeted year groups of Clinical Psychologists in order to retain them past their first historical separation point. We have budgeted money against the new Consolidation of Special Pays authority for mental health providers.

	Fiscal Year 2008	Fiscal Year 2009
Active (Mental Health Only).		
Accession	$0	$2.1 million
Retention	$9.1 million	$12.4 million
HPLRP	$7.8 million	$9.5 million
HPSP	$129,000	pending
Reserve (Total Medical Budget).		
Retention	$5.2 million	$9.8 million
HPLRP	$2.8 million	$1.7 million
Civilian (Total Medical Breakout).		
Relocation	$12,900	$9,000

HPLRP: Health Professions Loan Repayment Program
HPSP: Health Professions Scholarship Program

Civilian component: In fiscal year 2008, there was $12,899 utilized for relocation incentives for civilian mental health providers, and $9,000 for relocation incentive in fiscal year 2009. There were no recruitment or retention incentives used.

22. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, how much is required in fiscal year 2010?

General CHIARELLI. The total requirement identified for health professions special pays in fiscal year 2010 is $297.9 million for the Active component and $19 million for the Reserve component. This increased requirement recognizes the expansion of special pays under section 335 of title 37, which now includes Clinical Psychologists and Social Work Officers.

The requirement to fund 3R incentives (recruitment, relocation, and retention) for civilian hires in fiscal year 2010 is $73.1 million.

Admiral WALSH. ASD(HA) and all three Services have agreed to not increase rates in fiscal year 2010 due to conversion to consolidated special pays as authorized in NDAA for Fiscal Year 2008, section 335; however, fiscal year 2010 DOD budget formulations are being finalized and once the President's budget is completed further details may be submitted.

General AMOS. The USMC does not have the responsibilities or authorities for maintaining adequate numbers of Mental Health providers. Rather, in our unique relationship with Navy Medicine the Marine Corps establishes validated requirements for providers of all types that Navy Medicine uses its authorities and tools to meet the requirements. As such, I must defer to my Navy Medicine colleagues to answer this question.

General FRASER. The Air Force will fully support the President's 2010 budget. We stand behind the Secretary of Defense's commitment to recognize the critical and permanent nature of wounded, ill and injured; TBI; and PH programs and to improve the efforts to care for wounded servicemembers and to treat their mental health needs.

23. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, do you believe the programs and authorities in place have maximized their potential or are new programs and authorities needed?

General CHIARELLI. Once the authorities contained within Section 335 of title 37, U.S.C., are fully implemented by the DOD, sufficient flexibility will exist to offer accession, incentive and retention pays to all categories of health care providers. While these authorities exist, there will be a need to insure that adequate appropriations are made available as we seek the most effective funding level to attract sufficient individuals to support the existing force structure.

Current programs in place have contributed to MEDCOM's ability to attract and retain high quality medical professionals, including mental health providers. The National Security Personnel System (NSPS) has provided much needed pay flexibilities, especially for physicians, dentists and registered nurses. For example, the cur-

rent provisions allow MEDCOM to offer competitive compensation for new graduate nurses. The ability to set pay within pay bands and use enhanced recruitment incentives when needed for new hires, allows management to more readily attract new employees. Earnings by physicians, such as psychiatrists, under NSPS are no longer restricted by the annual pay cap of $196,700 and may be as high as $400,000. The new DOD Physicians and Dentists "Hybrid" Pay Plan will provide the same level of compensation for general schedule (GS) physicians and dentists that cannot be converted to NSPS. This hybrid pay plan will grant these the same amounts of annual pay, will use the same medical specialty tables and will also raise the pay cap to $400,000. Implementation of this new pay plan must be expedited within DOD. MEDCOM believes that current title 38 authorities delegated to OSD are sufficient to address changes in qualifications and compensation for registered nurses. During mid-March 2009, the three Services conducted a 3-day Registered Nurse Workshop to seek changes by recognizing higher levels of education within the nursing community and seek market sensitive pay. MEDCOM also endorsed the DOD review to determine whether a civilian mental health scholarship program is necessary to meet future hiring needs. In terms of new program needs, MEDCOM needs the authority and flexibility to quickly offer market sensitive pay for our GS health care professionals. As an example, approximately 1,900 registered nurses are currently paid using special salary rates based on the current pay rate at the VA. In reality, MEDCOM's ability to increase salary rates for nurses, pharmacists, and other occupations is dependent on the VA updated pay schedules and is further limited to pay no more than VA rates. The DOD needs the authority and flexibility to set market sensitive pay on its own to be able to offer a competitive labor market salary rate for health care professionals.

Admiral WALSH. The Navy believes current and expected programs under the new consolidated special pays authority title 37, chapter 5, section 335 will be sufficient to meet Navy's accession and retention incentive requirements. However the Navy will be exploring a change to the maximum age to be accessed into the Navy from 42 to 48 for Nurse Corps and Medical Service Corps officers. This change will allow Mental Health providers who are seeking a career change or received their degree later in life the ability to be accessed on to active duty.

General AMOS. The Department is performing well overall currently on the recruiting front, with encouraging trends the past 2 years. According to Navy Medicine most significantly, the recruitment of Medical and Dental students via the Health Professions Scholarship Program has dramatically reversed its 3 year trend of failing to meet recruiting goals. Retention is also on the upswing throughout the Navy Medicine. The Department has launched several initiatives in the last 12–18 months that have provided leaders with additional tools to aid in recruiting and retention. These efforts are paying off and the Department will examine these initiatives closely to determine which are especially successful and which are less so in order to best focus future resources.

General FRASER. Active and Reserve components: The programs now in place are in their first year of execution. Further study is required to determine if they are having an effect in accessing and retaining medical specialties.

The new authorization under Consolidation of Special Pays (title 37 U.S.C. 335) has been funded by the Services. We anticipate that it will take at least 2 fiscal years to determine if this new authority will meet our future accession and retention demands for mental health professions.

Civilian component: Air Force Medical Group Commanders use of existing civilian pay incentives to attract and retain qualified employees while maintaining fiscal responsibility.

24. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, what additional authorities would be helpful to attract and retain more mental health providers to military and civilian service?

General CHIARELLI. Full implementation of section 335 of title 37, U.S.C., should provide sufficient statutory authorities to address all Active component requirements. Title 27, section 302 and title 10, chapter 1608, U.S.C., should provide sufficient statutory authorities to address all of the Reserve component requirements.

A major change is needed to grant DOD civilian healthcare providers the same benefits, entitlements, and pay flexibilities that are granted to the VA. Civilian employees of the VA and Army Medical Command (MEDCOM) work side by side at a number of our medical treatment facilities, where compensation differences are discussed and noted among employees. Currently, title 38 appointment, pay and other authorities are delegated to DOD through an Office of Personnel Management Delegated Agreement. A revised Delegated Agreement is reissued by OPM to DOD each time the VA is granted new civilian personnel provisions through legislation.

Recommend that DOD be granted the identical VA legislative provisions directly by Congress, instead of relying on an OPM Delegated Agreement. Additionally, it would benefit MEDCOM to partner directly with the VA to align compensation, grade structure, and other personnel program provisions. Also, as many of the current Office of Personnel Management qualification and classification standards are outdated, MEDCOM would also benefit by using standards to similar to those used by the VA.

Admiral WALSH. The Navy believes that a change in the maximum accession age for Medical Service Corps and Nurse Corps is needed to increase mental health provider accessions. The Navy will be proposing a change to the maximum age to be accessed into the Navy from 42 to 48 for Nurse Cops and Medical Service Corps officers. This is the same age limit authority that the Medical Corps and Dental Corps presently have. This change will allow Mental Health providers who are seeking a career change or received their degree later in life the ability to be accessed on to active duty.

General AMOS. The Navy Medical Department has launched several initiatives in the last 12–18 months that have provided leaders with additional tools to aid in recruiting and retention. These efforts are paying off and the Department plans to examine these initiatives closely to determine which are especially successful and which are less so in order to best focus future resources.

General FRASER. Active and Reserve component: Current military special pay authorities are in place or coming on line soon with our educational accession programs. Additional time is needed to determine if they are having an effect in accessing and retaining medical specialties.

The Health Professional Scholarship Program does appear to contribute to attracting people with critically needed specialties. We are executing more scholarships than at anytime in the past and thanks to the $13.0 million congressional add for fiscal year 2008, we will fully execute 100 percent of our funded quotas this year.

Civilian component: Existing DOD Direct Hire Authority for medical occupations is a valuable recruiting tool and appears to be making a positive impact on medical occupation accessions.

SUICIDE PREVENTION

25. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, what is your Service providing now in leadership training for noncommissioned officers (NCOs) regarding suicide prevention and how is it different than what has been provided historically?

General CHIARELLI. At every echelon of leadership, the Army has heightened command emphasis on suicide prevention and Comprehensive Soldier Fitness and Resiliency. From February 15 to March 15, 2009, the Army conducted a service-wide Suicide Prevention Stand Down and Chain Teaching, a first according to the Center for Military History. During the stand down, the Army trained every soldier on suicide risk identification and intervention, and addressed the stigma associated with behavioral health counseling, using an interactive video titled "Beyond the Front." Feedback from soldiers about the video was so positive that new, similar videos are being created for families and DA civilians; and the Army National Guard and Reserve plans to tailor these videos for their soldiers as well. Also during the standdown, the Army distributed thousands of ACE wallet cards to soldiers; these cards provide a quick reference on how to identify and care for a potentially suicidal buddy. Follow-up to the stand down included chain teaching on suicide prevention tactics. Chain teaching remains underway through July 1.

In the past, suicide prevention training was PowerPoint slide-based, individual soldier focused, and failed to highlight sensitivity to the leading causative factors of failing personal relationships, financial problems, and/or professional setbacks. Today's program has evolved into a holistic approach that develops leaders at the lowest echelons who are focused on knowledge and signs, and are capable of providing direct intervention. Suicide prevention is also reinforced in Stress Management/PTSD, mild TBI, Health Promotion Awareness, and Fratricide prevention training programs. We have codified suicide prevention and resiliency training in the Noncommissioned Officer Education System (NCOES) to include 10 total hours of suicide prevention training during Warrior Leader, Basic NCO-Common Core, and Sergeants Major courses.

The newest and emergent program that the Army is undertaking attempts to prevent suicide by way of improving soldier resiliency through a program of Comprehensive Soldier Fitness. The vision of this program is an Army of balanced, healthy, self-confident soldiers, families, and civilians whose resilience and total fit-

ness enables them to thrive in an era of high operational tempo and persistent conflict. This program will increase the resilience of soldiers and families by developing the five dimensions of strength and fitness: physical, emotional, social, spiritual, and family. Several Training and Doctrine Command (TRADOC) Advanced Individual Training (AIT) platoon sergeants will participate in a program with the University of Pennsylvania this spring to develop a program of instruction in order to train, educate, and experience our TRADOC NCOs so that they can integrate soldier resiliency program into future basic training and AIT.

The bottom line, however, is that soldiers have always taken care of soldiers. The Army team is an unbroken chain from the Chief of Staff to the newest recruit, and the team has been mobilized to help one another. I firmly believe that ultimately, it is our soldiers who will turn this problem around.

Admiral WALSH. The Navy began Front-Line Supervisor Training in 2008. The course, jointly developed by the DOD Suicide Prevention and Risk Reduction Committee, is a 3 to 4 hour interactive train the trainer seminar that includes case examples, discussion, and role play to improve supervisory skills and confidence in assisting personnel in distress. Once trained, these trainers will provide training to all NCO (petty officers) front-line supervisors within the command.

General Military Training (annual suicide prevention training), required of all hands, is informational in nature and reviews warning signs, risk and protective factors, responsibilities for assisting a shipmate, and how to access assistance. The Front-Line Supervisor Training is more comprehensive, conducted live in small groups, and uses discussion and practice to improve suicide prevention knowledge and skills.

Currently suicide prevention training is not a required part of petty officer leadership training. Suicide prevention training will be included in petty officer leadership training starting in late fiscal year 2009.

General AMOS. The Marine Corps is currently developing a half-day, evocative, peer-led, leadership training suicide prevention course which will be mandatory for all NCOs this summer. The training is being developed under contract and includes a 30 minute dramatic video, video interviews with suicide survivor spouses and marines; marines who have made suicide attempts; and marines who intervened to support those in distress. The course is designed specifically for NCOs and has been developed with a focus group of NCO marines. Evocative, NCO directed training such as this has not been offered in the past. Upon implementation, it will be studied for efficacy and improvement through a relationship with the Uniformed Services University of Health Sciences.

Due to the unique nature of this training, it will not be available until the summer. In the interim, a 2-hour suicide prevention training was required of all marines during the month of March. All commanding officers (Colonel and higher) created 4–6 minute video taped messages for their marines and these were incorporated into the 2 hour training. This training was also a break from "training as usual" in that it highlighted the strong command senior leadership focus on suicide prevention and presented a "case study" of a stellar marine overcome by circumstances which led to a suicide. Resources were presented for those who needed help or for junior leaders who had marines they believed needed help.

General FRASER. Enlisted Professional Military Education (EPME) courses address suicide prevention as one of the most serious leadership issues affecting the Air Force. Leadership lessons are embedded in all levels of EPME. Specific Stress Management lessons are developed at the Senior Enlisted Leader, NCO, and airman levels. At the Senior Noncommissioned Officer Academy (SNCOA), suicide is addressed as a leadership issue with a focus on knowing, recognizing, coping and dealing with pre- and post-deployment stressors. The SNCOA includes lessons on risk factors, warning signs, providing assistance, post-suicide actions, and impact on the mission. The NCO Academy (NCOA) curriculum covers information on risk factors, warning signs, providing assistance, post-suicide actions, and impact on mission as part of the Contemporary Supervisor Issues lesson. The Airman Leadership School (ALS) curriculum discusses how stress directly relates to suicide and how negative stress can lead to suicidal behaviors and even death. Students must be able to explain the differences, and discuss the need for supervisors to realize their own limitations and seek more appropriate sources of assistance to remedy a situation.

Additionally the Air Force has implemented additional programs at the base level such as Front-Line Supervisor Training, introduced in 2008. This half-day course is based on the motto that "Good Leadership is Good Prevention" and provides in-depth training on assisting personnel in distress, as well as suicide prevention.

26. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, based on information provided to this subcommittee, the number of sui-

cides by members of the Reserves is significantly less than for the Active component. Is that correct? Please explain.

General CHIARELLI. That is correct to the extent we are talking about the absolute number of activated Guard and Reserve soldiers. To the extent we are talking about Guard and Reserve soldiers who are not serving on active duty, it is unclear if that is correct because we do not have complete data on these Guard and Reserve soldiers, but we are trying to develop data to clarify this.

To explain, we know that fewer completed suicides are observed among Guard and Reserve soldiers on active duty than among regular Army soldiers. Although the causes of suicide and risk factors for suicide are complex, we do know that those Guard and Reserve soldiers who die from suicide have a very different risk profile than what we typically see among Regular Army soldiers who die from suicide.

As for Guard and Reserve soldiers not serving on active duty, our analysis is limited by the data available to us. We are unable to calculate and compare rates for Guard and Reserve soldiers because it has been difficult to obtain accurate denominator data (total force strength) for Guard and Reserve soldiers for the period 2004–2008. This makes it difficult to calculate the rate of suicides within the Guard and Reserve (as compared to the absolute number of suicides). Additionally, it has been difficult to obtain accurate numerator data because it is less likely that the suicide will be captured in our data systems when a non-activated Guard or Reserve soldier dies from suicide. The Army is working on strategies for capturing data for suicides among Guard and Reserve soldiers who are not on active duty to enable us to calculate the rates accurately for comparison with the active Army.

Admiral WALSH. The numbers regarding Reserve component suicides may appear to be misleading since, in accordance with DOD data standardization agreement, suicides of reservists are only investigated/reported if the death occurs while the member is serving on active duty, during drill, training, or travel to or from drill or training. This represents only a limited segment of Reserve sailor deaths. reservists who commit suicide while not in a duty status as described above (i.e., in civilian status) are not captured in suicide statistics.

Going forward, Navy is revising reporting requirements to capture all suicides and suicide behavior by Reserve component members, both on active duty and in civilian status. Incidents will be reported by DODSER beginning in 2009 so that Navy can capture a more accurate suicide rate for the Navy Reserve.

General AMOS. Yes, the number of suicides by reservists is lower than those of the Active component. It is important to note that the Marine Corps does not separate Reserve component from Active component marines when reporting and calculating overall active duty suicide numbers and rates. We are looking at ways to better capture and understand Reserve suicides as there may be different stressors that require different approaches. We are also considering the most effective method for tracking Selected Marine Corps Reserve suicide data.

General FRASER. While the number of individual suicides committed by members of the Air Force Reserve is lower than that of our regular component counterparts, the rate per 100,000 is comparable. Risk factors for suicide are the same for Reserve, Regular Component, and civilian populations (relationships, marriage, finance, work, legal/disciplinary, and substance abuse).

27. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, reaching reservists potentially at risk for suicide poses special challenges. Do you agree on that? Please explain.

General CHIARELLI. U.S. Army Reserve soldiers potentially at risk for suicide do pose special challenges. Army Reserve unit leadership typically will not be in contact with their soldiers outside of a weekend battle assembly (BA) or an annual training event. Army Reserve soldiers are geographically dispersed, with most of them not near a military installation or VA Medical Center, in the event care is needed. These challenges have made it even more important for Army Reserve leadership to get to know their soldiers while at BA and schedule activities that build unit cohesion; in essence, the key to addressing these challenges is through preventative measures. The Army Reserve relies heavily on battle buddies to keep in touch with each other outside of BA weekends and the Army Reserve senior leadership has placed extensive emphasis to ensure that unit commanders reduce the stigma associated with seeking behavioral/mental health. It is critical that leadership creates a comfortable command climate for soldiers to come forward seeking help. The Army Reserve is placing emphasis on suicide prevention through its YRRP. The Army Reserve keeps in contact with soldiers throughout any deployment through events outlined in the YRRP. YRRP activities are conducted at 30-, 60-, and 90-day intervals prior to mobilization and deployment, while deployed, and at 30-, 60-, and 90-day intervals after re-deployment. YRRP topics of discussion, informational brief-

ings and training activities focus on services and support directly affecting the soldier's well-being (and that of their family members, as well). The Army Reserve is working an initiative to include suicide awareness training to its units' FRGs. The more people in a soldier's life aware of signs and symptoms associated with a soldier contemplating suicide, the more likely we will be able to head off this tragedy. The Army Reserve encouraged its soldiers to participate in the "Strong Bonds" program to help rebuild relationship skills with loved ones. These events typically occur on a weekend and are funded by the Army Reserve at a non-military site. Army Reserve soldiers who may not have immediate resources are encouraged to talk with their unit leadership, battle buddies, family members, friends, Military OneSource and the VA Hotline.

Admiral WALSH. Until the fall of 2008, there had been many challenges in identifying and reaching all reservists who might be at risk for committing suicide due to the part-time visibility of Reserve unit personnel by their Reserve unit leadership. The establishment of the Navy Reserve Psychological Health Outreach program in August 2008 now provides a means of providing proactive outreach and assessment of those reservists who are identified by unit commanding officers, family members, self-referral, or other unit members as being potentially at risk for harm to themselves. In addition, Outreach Team members are available to provide special site visits to NOSCs or to units that have dealt with a suicide in order to provide intervention and counseling for unit members and family members affected by the death. As the Outreach program has matured and become more visible through the Navy Reserve, identification and early intervention has increased exponentially; the Outreach coordinators are now working with over 400 reservists who have sought assistance with various PH issues, including seven who have actually attempted suicide or expressed thoughts of suicide.

General AMOS. It is true that Reserve communities can pose some unique challenges due to limited contact and geographic distance from resources; however, we are committed to reaching all Reserve component marines with suicide prevention and psychological wellness resources. Marines in the IRR are managed by Marine Forces Reserve's MOBCOM. In addition to a full-time Family Readiness Officer (FRO) and a specially-trained Religious Ministry Team, other members of the command's MCFRT contact IRR marines within 60 to 90 days after theft discharge from the Active component. Marines who have been mobilized from the IRR are asked to complete a PDHRA. Any responses indicating a need for referrals receive a personal telephone call and follow-up action. RWWs are used as the Yellow Ribbon 60-day Reintegration Event. The comprehensive event provides a safe and open environment for Service and family members to openly discuss issues ranging from reintegration difficulties to past combat traumas. A psycho-educational model is used to help attendees realize they are having normal reactions to abnormal events. The setting provides a sense of commonality and helps individuals realize they are not alone. Though geographically isolated they come connected to a larger community. Chaplains and counselors are readily available to provide counseling as required. Follow-up for individuals is obtained through the use of mental health resources near the member's residence.

The Marine Corps Suicide Prevention Program is in Manpower and Reserve Affairs and works with Marine Forces Reserves to ensure that all guidance and resources are relevant and available for the Reserve community. We have programs that reach out to all marines, including those currently inactive and geographically separated. These include the Marine for Life Hometown Links and the Wounded Warrior Regiment. The Wounded Warrior Regiment offers a call center that is available 24/7 to assist marines in their recovery regardless of their geographic location. In addition, the Marine Corps works with the Defense Centers of Excellence on PH and TBI which offers a 24/7 call center that is available for all Reserve marines and family members regardless of theft active or inactive status.

General FRASER. Air National Guard: Yes, the ANG poses a unique challenge due to the nature of its mission and members' military status. Guard Airmen are covered by the same suicide prevention training requirements as our Active Duty force.

Air Force Reserves: There are special challenges associated with reaching reservists potentially at risk for suicide. While our Citizen Airmen have volunteered in record numbers, a great deal of their time is spent in civilian status. In civilian status, privacy laws limit our ability to monitor their behavior and actions. It is very difficult to accurately investigate or review suicides of those reservists who commit suicide while they are in civilian status. These investigations are managed by local authorities who sometimes share results with family members, but are not obligated to collaborate with the military.

The Air Force Reserve will continue to enforce programs like mandatory Suicide Prevention briefings. These briefings emphasize identification of suicide risks and

the appropriate courses of action. Additionally, we will also continue to promote the "Wingman" concept of caring for our airmen both in and out of uniform and capitalize on all available YRRP efforts.

28. Senator GRAHAM. General Chiarelli, Admiral Walsh, General Amos, and General Fraser, how are you tailoring your prevention strategies to identify and stay in contact with Reserve members, especially following an extended period of Active Duty?

General CHIARELLI. It is critical that leadership in the U.S. Army Reserve develop a command climate where soldiers feel comfortable coming forward to discuss issues. When Army Reserve unit leadership is engaged and genuinely concerned about soldier well-being, many issues are identified and corrected before they become larger concerns. The Army Reserve keeps in contact with soldiers throughout any deployment through events outlined in the YRRP. YRRP activities are conducted at 30-, 60-, and 90-day intervals prior to mobilization and deployment; while deployed; and at 30-, 60-, and 90-day intervals after re-deployment. YRRP topics of discussion, informational briefings and training activities focus on services and support directly affecting the soldier's well-being (and that of their family members, as well). Army Reserve leaders also have periodic town halls and information-sharing sessions supplemented by recurring training on suicide prevention and must conduct Post-Deployment Health Risk Assessments. The Army Reserve family programs staff is conducting several events that bring soldiers and families together to discuss these issues.

The U.S. Army Reserve Command has implemented new required training for the commander, First Sergeant, Family Readiness Liaison/Rear Detachment Commanders, FRG Leaders, and key volunteers of alerted and/or deployed units (the "Family Readiness Team"). This training was formerly known as Deployment Cycle Support Training and is now Army Reserve-Family Readiness Education for Deployment training. The objective of this training, conducted by the 88th Regional Readiness Command Family Readiness Division, is to provide information to key Army Reserve staff and volunteers who are likely to be asked questions, or offer assistance to family members and soldiers affected by mobilization, deployment, sustainment and reunion. The intent is to develop a network of informed personnel associated with the Army Reserve Family Program to help alleviate concerns by family members and/or soldiers trying to find answers to deployment-related questions. FPA training is divided into three parts: fundamental, developmental, and resource. Fundamental FPA training includes the basics to help establish and maintain a viable, functioning FRG at the unit level. Developmental FPA training builds on those basics and enhances the participant's capability to sustain and enhance unit family programs. Resource training is provided at the unit upon request for those that are more advanced in their family program.

Operation READY is a series of training modules, videotapes, CDs, and resource books published for the Army as a resource for staff to train Army families who are affected by deployments. Operation READY materials include: pre-deployment and ongoing readiness, Family Assistance Centers, Homecoming and Reunion, the Army FRG Leader's Handbook, and the Army Leader's Desk Reference for Soldier/Family Readiness. The training is a train-the-trainer program for Instructors and senior volunteer resource instructors to take back to units and show how information and materials are accessed and utilized.

Chain of command training is designed to familiarize unit leadership with the scope of family programs within the Army Reserve. Briefings are provided on all aspects of family programs such as mobilization training, volunteer management, and the Army Family Action Plan.

Admiral WALSH. The Psychological Health Outreach Team members have been provided with the names of returning unit members and Individual Augmentee personnel, and Team members actively call these individuals as soon as they are released from active duty. Team members have also been actively engaged with Reserve component servicemembers assigned to Medical Hold, engaging with them to ease their transition back into civilian life and to ensure continuity of care by available local providers. Outreach team members visit the NOSC in their respective Regions on a routine basis, where they meet with unit members, NOSC staff personnel, and family members if they are available. During these visits, the Outreach team provides the Operational Stress Control brief as well as the Suicide Prevention brief. Team members are also available to meet with unit members and, if necessary, link them up to an Outreach Coordinator for care referral and follow-up.

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wellness resources. Marines in the IRR are managed by Marine Forces Reserve's MOBCOM. In addition to a full-time Family Readiness Officer (FRO) and a specially-trained Religious Ministry Team, other members of the command's MCFRT contact IRR marines within 60 to 90 days after their discharge from the Active component. Marines who have been mobilized from the IRR are asked to complete a PDHRA. Any responses indicating a need for referrals receive a personal telephone call and follow-up action. RWWs are used as the Yellow Ribbon 60-day Reintegration Event. The comprehensive event provides a safe and open environment for Service and family members to openly discuss issues ranging from reintegration difficulties to past combat traumas. A psycho educational model is used to help attendees realize they are having normal reactions to abnormal events. The setting provides a sense of commonality and helps individuals realize they are not alone. Though geographically isolated they come comiected to a larger community. Chaplains and counselors are readily available to provide counseling as required. Follow-up for individuals is obtained through the use of mental health resources near the member's residence.

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General FRASER. The YRRP for members and families has proven to be a highly successful program. Deployment support and reintegration programs are being provided in all phases of deployment, including but not limited to pre-deployment, deployment, demobilization, and post-deployment and reconstitution phases. Reconstitution activities are being held at approximately 30-, 60-, and 90-day intervals following demobilization or deployment. Activities focus on reconnecting members and their families with the service providers to ensure that members and their families understand benefits and entitlements as well as the resources available to help them overcome the challenges of reintegration. Best practices from the most successful programs are being collected to populate other base YRRPs.

Through the YRRP, the Air Force Reserve was able to develop and hire Regional Psychological Health Advocate teams (overseen by a Director of Psychological Health). These teams help identify and respond to PH needs of members of the Air Force Reserve. They help ensure that identified issues, such as a potential TBI or line of duty determinations, are processed in a timely manner. These actions ensure speedy referrals are accomplished and additional access to mental health and/or other appropriate services are provided to maximize positive outcomes. The PHA teams also consult with Air Force Reserve leadership on PH issues and respond to specific matters that may become more challenging if not addressed.

POST-DEPLOYMENT HEALTH ASSESSMENTS

29. Senator GRAHAM. Major General Rubenstein, we often hear that although the post-deployment health assessments are performed by a high percentage of soldiers returning from combat, many who are referred for follow-up care never obtain it. What is the evidence on obtaining follow-up care in the Army?

General RUBENSTEIN. According to data obtained from the Defense Medical Surveillance System (6 April 2009), between 1 January 2003 to 6 April 2009, 472,840 active duty soldiers completed the PDHA. Thirty percent of the soldiers received referrals. Of the 30 percent who received referrals, 97 percent of the referrals had a medical visit with a health care provider within 6 months after the referral (this includes either inpatient or outpatient visits).

From 2005 through 2008, 190,742 active duty soldiers completed the PDHRA. Of the total number completing the PDHRA, 52,189 (27 percent) of the soldiers received referrals and 77 percent of the referrals had a medical visit with a health care provider within 6 months after the referral.

The Army Reserve and Army National Guard do not maintain reliable data concerning referrals from the PDHA or PDHRA. They have each identified this as an issue and are currently in the process of developing automated solutions.

30. Senator GRAHAM. Major General Rubenstein, how do you track whether or not a soldier attains that care?

General RUBENSTEIN. Referral completions within the Military Health System are tracked by the installation military treatment facility (MTFs). The MTFs use the DOD's electronic health record for capturing referrals identified on the PDHA and PDHRA. Unfortunately, this tracking system is only effective for Active component soldiers. No formal tracking of PDHA/PDHRA referrals is in place for the Reserve component. The Army Reserve and Army National Guard have each identified this as an issue and are currently in the process of developing automated solutions.

31. Senator GRAHAM. Major General Rubenstein, does failure to obtain follow-up mental health care place a soldier at greater risk of suicide?

General RUBENSTEIN. Soldiers who are depressed or abusing substances or who have psychiatric pathology are at a higher risk for suicide. Soldiers who fail to receive treatment for these disorders may have an increased risk for suicide. However, most soldiers who commit suicide in the Army do not have a mental health diagnosis. Instead, many suicides appear to be related to recent life stressors, such as a relationship break-up or job difficulty.

32. Senator GRAHAM. Major General Rubenstein, how are we going to fix this problem?

General RUBENSTEIN. The Army has been vigorously pursuing suicide prevention and intervention efforts. Nevertheless, the number of suicides has continued to rise, which is an issue of great concern. Some of our recent efforts are outlined below.

In March 2009, the VCSA established a new Suicide Prevention Task Force to integrate all of the efforts across the Army. A Suicide Prevention General Officer Steering Committee (GOSC) stood-up in March 2008. The GOSC's efforts are ongoing, with a focus on targeting the root causes of suicide, while engaging all levels of the chain-of-command.

From February 15, 2009 to March 15, 2009, the Army conducted a total Army "stand-down" to ensure that all soldiers learned not only the risk factors of suicidal soldiers, but how to intervene if they are concerned about their buddies. The "Beyond the Front" interactive video is the core training for this effort. It was followed by a chain-teach which focuses on a video "Shoulder to Shoulder; No Soldier Stands Alone" and vignettes drawn from real cases. The Army continues to use the ACE tip cards and strategy.

The Army established the Suicide Analysis Cell at the Center for Health Promotion and Disease Prevention (CHPPM) in July 2008. This is a suicide prevention analysis and reporting cell that has epidemiological consultation-like capabilities. They will gather suicidal behavior data through numerous sources, including the Army Suicide Event Report (ASER), the U.S. Army Criminal Investigation Division Reports, AR 15–6 investigations, and medical and personnel records.

The GOSC and related efforts reaffirmed the Army Suicide Prevention overarching strategies and expanded them. They include: 1) raising soldier and leader awareness of the signs and symptoms of suicide and improving intervention skills; 2) providing actionable intelligence to Leaders regarding suicides and attempted suicides; 3) improving soldiers' access to comprehensive care; 4) reducing the stigma associated with seeking mental healthcare; and 5) improving soldiers' and their families' life skills.

In the fall of 2008, the Army Science Board studied the issue of suicides in the Army. While their report has not been officially released, it reiterated the above strategies and the need for a comprehensive, multi-disciplinary approach. It did not find easy or simple solutions to the problem.

The Army has also developed a Memorandum of Agreement with the National Institutes of Mental Health (NIMH), which was signed in the fall of 2008. This is an ongoing 5 year research effort to better understand the root causes of suicide and develop better prevention efforts. This NIMH effort is being coordinated with the CHPPM Suicide Analysis Cell mentioned above, as well as with suicide prevention efforts from the Walter Reed Army Institute of Research.

The Army intends to roll out the Comprehensive Soldier Fitness Program this year. This program is designed to build resilience in all soldiers in the emotional, social, familial, and spiritual domains. The program as a whole will provide education that builds coping skills for soldiers to deal with challenges and adversity.

NATIONAL SUICIDE HOTLINE

33. Senator GRAHAM. Brigadier General Sutton and Ms. Power, I am concerned that DOD does not appear to get feedback from the National Suicide Hotline about calls to that hotline by military members. Would it be beneficial to explore some means of sharing general information about the nature of calls by military members, specific issues that are identified, the number of such calls, or other trends and characteristics?

General SUTTON. DOD has been using the National Suicide Hotline for well over a decade. This is the same hotline that the VA uses. Suicide risk factors are generally consistent across the different populations. Aggregate data are of approximately equal value in identifying characteristics or demographics as population-specific data. However, the primary purpose of the hotline is intervention rather than surveillance. Having trained respondents on the line who have experience talking with individuals with urgent problems is a great service to the public. The value of the specific arrangement the suicide hotline has with the VA lies in the ability to target intervention benefits to the veteran population, not necessarily identifying characteristics of the callers. The VA can access the individual's medical records (given caller consent) and can assist the caller in understanding and accessing resources that are available only to veterans and that may be more effective in treating veteran specific conditions and concerns.

The VA, which collects and maintains all data on Veteran Suicide Prevention Hotline callers, consistently shares general, non-identifiable data on active duty callers with both Substance Abuse and Mental Health Services Administration (SAMHSA) and DOD during various monthly meetings and conference calls, as well as upon request. When VA crisis counselors need to arrange an emergency rescue (for a servicemember at imminent risk of harm) on a military base, they always contact key base leaders. Callers not at imminent risk receive referrals for both military and non-military mental health resources, but a caller's confidentiality is not violated by disclosing this information to the chain of command in non-emergency situations.

In addition to active duty servicemembers calling the Veterans Hotline, some also choose to connect to local crisis centers. Callers access the Veterans Hotline through SAMHSA's National Suicide Prevention Lifeline (800–273–TALK), a system that routes calls based on the area code, from anywhere in the United States to a network of more than 135 independent, certified crisis centers across the country. Veterans and their families are invited to "press 1" to be routed to the VA call center in Canandaigua, NY, which maintains its own database.

Veteran and Active Duty callers who choose not to "press 1" are routed to the crisis center that is geographically closest to them. Following an assessment by the local crisis center, veterans and Active Duty military have the option of having their call "warm transferred" to the VA call center in Canandaigua. Similarly, calls can be "warm transferred" from the DCoE for PH and TBI to the Veterans Suicide Prevention Hotline. A "warm transfer" is a process in which a crisis worker stays on the line with the caller until contact is made with the center to which the call is transferred, thereby reducing the likelihood that a caller at risk will "fall through the cracks."

By the end of 2009, all of these independent crisis centers will be collecting and reporting to SAMHSA consistent, non-identifiable demographic data, including whether the caller has ever served in the U.S. military, but SAMHSA will not be able to determine how many of those callers are Active Duty.

We also are working with the VA and SAMHSA to determine the effectiveness of having specific VA respondents who can access veteran information and resources as compared with general community resources. If the interventions appear to have value, DOD will work to determine a method to add military specific respondents in either VA call centers or in dedicated military call centers to provide targeted interventions. In addition, making a warm hand-off to a military specific referral source may be an alternative option for both community-based and VA-specific call centers.

Ms. POWER. The VA which collects and maintains all data on Veteran Suicide Prevention Hotline callers, consistently shares general, non-identifiable data on active duty callers with both SAMHSA and DOD during various monthly meetings and conference calls, as well as upon request. Also, when VA crisis counselors need to arrange an emergency rescue (for a servicemember at imminent risk of harm) on a military base, the base is always contacted. Callers not at imminent risk are given referrals for both military and non-military mental health resources, but callers' confidentiality is not violated by disclosing this information to the chain of command in non-emergency situations.

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34. Senator GRAHAM. Brigadier General Sutton and Ms. Power, are there any discussions ongoing along these lines between DOD and the SAMSHA? If so, what is the intent?

General SUTTON. The DOD, VA, and Substance Abuse and Mental Health Services Administration (SAMHSA) meet regularly in a variety of venues to address suicide prevention, including the Federal Workgroup on Suicide Prevention, the Federal Workgroup on the Reintegration of Veterans and their families, and the DOD's Suicide Prevention and Risk Reduction Committee.

The DOD, VA, and SAMHSA frequently discuss the appropriate role of hotlines for Active Duty military. SAMHSA provides consultation as requested and as appropriate. DOD and SAMHSA leverage the wealth of information available when talking with agencies that are already managing programs that may be best practices in the field. Opportunities range from implementing lessons learned from the experiences of the VA hotline and SAMHSA's National Suicide Prevention Lifeline, to developing interagency partnerships that use current infrastructures to conduct joint programming, to intervening with servicemembers at risk who may reach out to civilian resources.

Ms. POWER. The DOD, VA, and SAMHSA meet regularly in a variety of venues during which suicide prevention is addressed including the Federal Workgroup on Suicide Prevention, the Federal Workgroup on the Reintegration of Veterans and their families, and the DOD's Suicide' Prevention and Risk Reduction Committee. The DOD, VA, and SAMHSA frequently discuss the appropriate role of hotlines for active duty military. SAMHSA provides consultation, as requested and as appropriate.

35. Senator GRAHAM. Brigadier General Sutton and Ms. Power, what are the opportunities and the parameters of such discussions from both DOD and SAMSHA perspectives?

General SUTTON. The DOD, VA, and the Substance Abuse and Mental Health Services Administration (SAMSHA) frequently discuss the appropriate role of hotlines for active duty military. SAMHSA provides consultation as requested and as appropriate. DOD and SAMHSA leverage the wealth of information available when talking with agencies that are already managing programs that may be "best practices" in the field. Opportunities range from implementing "lessons learned" from the experiences of the VA hotline and SAMHSA's National Suicide Prevention Lifeline, to developing interagency partnerships that use current infrastructures to conduct joint programming, to intervening with servicemembers at risk who may reach out to civilian resources.

Ms. POWER. As SAMHSA and the VA discovered in 2007 at the beginning stages ofplanning for the VA hotline, there is a wealth of information to be learned from talking with agencies that are already managing programs that may be "best practices" in the field. Opportunities range from implementing "lessons learned" from the experiences of the VA hotline, to developing interagency partnerships that use current infrastructures to conduct joint programming; to intervening with servicemembers at risk who may reach out to civilian resources.

SUICIDE AS A PUBLIC HEALTH EPIDEMIC

36. Senator GRAHAM. Major General Rubenstein, Brigadier General Sutton, and Ms. Power, what is your definition of a public health epidemic?

General RUBENSTEIN. A public health epidemic is the occurrence of an illness, health-related event, or health outcome that occurs in excess of the normal or above baseline levels in a specific population or place.

General SUTTON. An epidemic generally refers to a rapidly spreading, widely prevalent outbreak or disease that affects many people more rapidly or more widely than would be normally expected. While suicide is a public health problem, it still remains a rare event and would not be considered an epidemic.

Ms. POWER. The Centers for Disease Control and Prevention define epidemic as "the occurrence of more cases in a place (or population) and time than expected."

37. Senator GRAHAM. Major General Rubenstein, Brigadier General Sutton, and Ms. Power, does the Army's and Marine Corps' current experience with suicide meet that definition? If so, what additional prevention and surveillance measures should be applied?

General RUBENSTEIN. I'll address the Army's experience with suicide. Using the definition described in the previous question, the Army is experiencing an epidemic of suicides. However, the term "epidemic" is broadly and variously defined and the present application of this term to suicides is more a reflection of the sense of urgency we all share in addressing this problem in the Army. These tragic losses represent the most visible form of the cumulative adverse health outcomes experienced by soldiers, families, and communities in association with enduring contingency operations. Using the definition above, one should note that Army health data would support that we are seeing epidemic levels of substance abuse, depressive disorders, PTSD, and behavioral health hospitalizations in the Army. For many of our soldiers, these occurrences lie in the causal pathway to suicide. The Army has recently established a Behavioral and Social Health Outcomes Program at CHPPM for the purpose of conducting systematic surveillance on suicides and other associated social outcomes in the Army, such as substance use, domestic violence, and behavioral health diagnoses. This program will assess for emerging trends in social epidemiology and consider their implications for behavioral health policy, programs, and research. It will strive to provide expert consultation to the Army as it develops and implements evidence-based, effective approaches to maximizing the psychological and social health of our soldiers, families, organizations, and communities. CHPPM is currently building a comprehensive social outcomes database which will relate numerous data sources from within the Army. The information from this database will serve as a foundation for supporting future work in suicide reduction, such as the Army-NIMH 5-year epidemiologic study of mental health, psychological resilience, suicide risk, suicide-related behaviors, and suicide deaths in the U.S. Army.

As we learn more about those suicide risk factors that lie in association with combat experiences and the impact of lengthy overseas contingency operations on our soldiers, organizations, and communities, we will more readily be able to address the specific needs of these high-risk soldiers and their families. However, we do not have to identify individuals in order to save them. Most of our suicides will continue to come from the larger, lower-risk populations within our Army. For this reason, we will continue to move forward in supporting efforts to apply preventive strategies to the whole Army population; examples of such strategies include the recent standdown, the ACE card, and the "Beyond the Front" and "Shoulder to Shoulder; No Soldier Stands Alone" interactive videos. This approach is also the intent of the Battlemind Training System and the Comprehensive Soldier Fitness program.

General SUTTON. Suicide rates have increased, but suicide remains a rare event. Fluctuations in rare events can sometime seem dramatic, simply because any increase in a rarely occuring event looks bigger than an increase in a frequently occurring event. Random variation is normal. Only by watching over time, can you determine if there is an increasing trend. A single spike would not indicate a "rapidly spreading or prevalent" epidemic. That does not mean that we should not take action. Every increase should be a signal for additional efforts. We take every increase seriously.

In addition, we cannot compare current suicide rates for Active Duty with civilian populations because, while DOD compiles the statistics by the close of each quarter, national statistics for that same period are not available from Center for Disease Control (CDC) until approximately 3 years later. A sustained focus on and prioritization of suicide prevention is crucial regardless of whether the magnitude of the increase can be categorized as an epidemic. Losing even one member of the Armed Forces to suicide is not acceptable. Leadership continues to address this

issue in a comprehensive, public health manner, putting to use the best practices from both civilian and military experts, while evaluating the effectiveness of programs.

The DODSER was developed to examine the causes and circumstances of suicide related behaviors among servicemembers. It examines over 250 data points to look at all contributing risk and protective factors. Several efforts are underway to improve the quality of data—for example working on the standardization of nomenclature and clarification between attempts and self-injurious behaviors. The DODSER standardizes the data collected on all suicide events and is an integral part of DOD's Suicide Prevention Program.

Ms. POWER. Based on the above definition, the yearly rates reported by the U.S. Army seem to qualify as above the expected occurrence. However, it should be noted that we cannot compare current suicide rates for active duty with civilian populations because while DOD is able to compile its statistics by the close of each month, national statistics for that same time period will not be available from CDC until about 3 years later. We have no way of knowing whether the suicide rate for the civil ian population is increasing at a comparable rate to that within the military because, for example, of the current financial crisis.

While defining or establishing the.existence of an epidemic or disease cluster has an important role, a sustained focus on and prioritization of suicide prevention is crucial regardless of whether the magnitude of the increase can be categorized as an epidemic. Losing even one member of the Armed Forces to suicide is not acceptable. Leadership should continue to address this issue in a comprehensive, public health manner, putting to use the best wisdom from both civilian and military experts, while evaluating the effectiveness of programs that are being implemei1ted.

Prevention and surveillance measures that focus on suicide attempts are also of great importance. Suicide attempts are the strongest single risk factor for later death by suicide, highlighting the importance of suicide attempt surveillance as well as prevention and intervention strategies focused on members of the Armed Services who have attempted suicide.

NATIONAL INSTITUTES OF HEALTH

38. Senator GRAHAM. Major General Rubenstein, Brigadier General Sutton, and Ms. Power, the Army has recently entered into an agreement with the NIH to study factors in Army suicides. Although I commend the Army for reaching out beyond its borders for solutions to suicide prevention that can be effectively applied to the military, $50 million sounds like a lot of money to me. Do you support that initiative?

General RUBENSTEIN and General SUTTON. The Assistant Secretary of Defense for Health Affairs supports the study and has contributed funding as demonstrated in the answer to question #40. The DCoE for PH and TBI supports the Army's intention and commitment to examine suicide risk and take necessary action to prevent suicide among soldiers. At the moment, this is an Army effort with which the Marines have indicated interest. The results are expected to benefit the other Services' suicide intervention efforts as well. This 5-year longitudinal study will be the largest single study on the subject of suicide that National Institute of Mental Health (NIMH) has ever undertaken. The study is designed to provide a comprehensive evaluation of both risk and protective factors associated with suicides, and support the development of evidence-based prevention, assessment, and treatment services. The study's findings also will inform our general understanding of suicide in the U.S. population, and may lead to more effective interventions for civilian society.

In addition, soldiers can and do access civilian health and mental health resources, highlighting the importance of the study's findings by civilian resources. This study is a collaborative effort between the Army and NIMH, and includes considerable oversight by both the Army and NIMH through dedicated program management resources by both government agencies, frequent reviews and reporting, joint oversight committees, and a funding mechanism that allows the research to be re-directed quickly should promising avenues be discovered.

Ms. POWER. This will be the largest single study on the subject of suicide that NIMH has ever undertaken. The project aims to strengthen the Army's efforts to reduce suicide among its soldiers by identifying risk and protective factors for suicidal thinking and behavior, and then utilizing this information to identify specific intervention options and practical suicide risk reduction efforts. The study's findings will also inform our understanding of suicide in the U.S. population overall, and may lead to more effective interventions for both soldiers and civilians. In addition, soldiers can and do access civilian health and mental health resources, highlighting

the importance of the study's findings being utilized by civilian resources. SAMHSA stands ready to assist in that process.

39. Senator GRAHAM. Major General Rubenstein, Brigadier General Sutton, and Ms. Power, what are we getting for the investment?

General RUBENSTEIN and General SUTTON. While currently this is an Army effort with which the marines have indicated interest, the results are expected to benefit the other Services' suicide intervention efforts as well. This 5-year longitudinal study will be the largest single study on the subject of suicide that National Institute of Mental Health (NIMH) has ever undertaken. The study is designed to provide a comprehensive evaluation of both risk and protective factors associated with suicides, and support the development of evidence-based prevention, assessment, and treatment services. The study's findings will inform our general understanding of suicide in the U.S. population, and may lead to more effective interventions for civilian sectors of society.

In addition, soldiers can and do access civilian health and mental health resources, highlighting the importance of the study's findings being utilized by civilian resources. Rather than being a research grant in the conventional sense, this study is a collaborative effort between the Army and NIMH and includes considerable oversight by both the Army and NIMH through dedicated program management resources by both government agencies, frequent reviews and reporting, joint oversight committees, and a funding mechanism that allows the research to be re-directed quickly should promising avenues be discovered.

Ms. POWER. The Institute of Medicine's report, Reducing Suicide: A National Imperative, states, "Despite the extensive knowledge that research has provided regarding risk and protective factors, we are still far from being able to integrate these factors so as to understand how they work in concert to evoke suicidal behavior or to prevent it." This initiative has potential for assisting us in understanding what is evoking suicidal behavior in the Army, and, of greater importance, using such information to prevent suicide in the Army and in the Nation.

40. Senator GRAHAM. Major General Rubenstein, Brigadier General Sutton, and Ms. Power, how will DOD maintain oversight for money that is transferred to the NIH?

General RUBENSTEIN and General SUTTON. The $10 million was reprogrammed from the Defense Health Program to the Department of the Army to fund the Suicide Mitigation Study. The Department of the Army will allocate the funding to the NIH to conduct the study and will monitor the services rendered by the NIH to insure the funds are effectively used for the intended purpose.

Ms. POWER. We defer to DOD to respond to this procedural matter.

MEDICAL ACCESSION STANDARDS

41. Senator GRAHAM. Lieutenant General Freakley, Major General Rubenstein, and Brigadier General Linnington, previously Brigadier General Linnington testified that the DOD accessions screening process has remained relatively unchanged over the last 2 years. Is it appropriate to undertake a review of those standards in light of the increasing rate of suicide?

Lieutenant General FREAKLEY, General RUBENSTEIN, and Brigadier General LINNINGTON. The DOD Accession Medical Standards Work Group (AMSWG) reviews the accession standards every 4 years with the latest review due for publication later in 2009. In April 2009, the AMSWG has scheduled a conference with the psychiatric consultants from the three Services to review the accession standards and discuss current science as well as the feasibility of mental fitness prescreens applied to the accessions process. The DOD has explored psychological and mental health screening of applicants without success for many years. Unfortunately, no reliable screening tool has been developed. The Accession Medical Standards Analysis and Research Activity (AMSARA) at the Walter Reed Army Institute of Research is looking into the merits of conducting a case control study of suicide victims/attempters to identify whether accession risk factors exist, including medical (psychiatric) disqualifications and waivers as well as psychiatric morbidity while on active duty. If accession risk factors are found to exist, then a review of the accession standards and a possible change would be in order.

42. Senator GRAHAM. Lieutenant General Freakley, Major General Rubenstein, and Brigadier General Linnington, what changes or improvements could be made to reduce the risk of accessing an individual who is at risk for suicide?

Lieutenant General FREAKLEY, General RUBENSTEIN, and Brigadier General LINNINGTON. All potential recruits received a detailed physical with specific questions about whether or not they have received any psychiatric counseling. The current individual screening tools are self-reported instruments and rely largely on the knowledge and truthfulness of the applicant to disclose any disqualifying medical or psychiatric conditions. The current DOD self assessment screening tool (DD Form 2807–1) is under review for appropriate content. Additionally, the Accession Medical Standards Analysis and Research Activity (AMSARA) at Walter Reed Army Institute of Research has proposed using the Army's non-cognitive, executive function instruction, called the Assessment of Individual Motivation (AIM), to study it as a predictor of military success (6, 12, 24, and 36 months attrition) and to see if it can predict psychiatric morbidity, to include suicidal behavior (i.e. attempts, gestures). The AIM is a 27-item questionnaire available at all Military Entrance Processing Stations and administered currently to applicants without a high school degree to try and predict occupational success.

DATA ON SUICIDE ATTEMPTS

43. Senator GRAHAM. Brigadier General Sutton and Ms. Power, is there scientific evidence that indicates a relationship between suicide attempts and completed suicides?

General SUTTON. Suicide attempts represent a risk factor category for later death by suicide especially when alcohol is involved, highlighting the importance of suicide attempt surveillance as well as prevention and intervention strategies for members of the Armed Services. Importantly, when a serious suicide attempt is met with treatment and increased social support, later risk of suicide death is reduced. It is therefore important to provide attention and targeted treatment for individuals with suicide attempts. Longitudinal research also indicates that attempted suicide is an important clinical predictor of suicide completion. The frequency of suicide attempts per year are positively correlated with the likelihood of eventual death by suicide, with an estimated 10 percent to 15 percent of all attempters eventually take their lives. There do appear to be gender differences among suicide attempters, as males who have attempted suicide have been found to be more likely to eventually end their lives than do female attempters. Attempts also appear to be age dependent, with about 100 to 200 attempts for one suicide completion for young adults ages 15 to 24 years old and four attempts for every one suicide completion among adults ages 65 years and older (Goldsmith et al., 2002). The Air Force data on suicide attempts and completed suicides suggests that the individuals who attempt may be very different from those who die by suicide on the first attempt. Nevertheless, any self-injurious behavior is a sign of distress and warrants our compassion and intervention.

Ms. POWER. The single strongest risk factor for later death by suicide is a prior suicide attempt. One of the seminal studies in this area indicated that over 40 percent of individuals who attempted suicide either re-attempted or died by suicide within 5 years. (Beautrais AL)

Although there are no official national statistics on attempted suicides, it is generally estimated that there are 25 attempts for each death by suicide. Reports also indicate that there are three non-fatal suicide attempts among females for every one among males.

For the first time this year, SAMHSA's National Survey on Drug Use and Health (NSDUH) queried adults about suicide attempts and an analysis, including national, and State-level estimates, will be available during calendar year 2009.

44. Senator GRAHAM. Brigadier General Sutton and Ms. Power, should DOD and the Services more carefully collect and analyze data on suicide attempts?

General SUTTON. Prevention and surveillance measures that focus on suicide attempts are of great importance. DOD and Services are committed to collecting and analyzing the best possible data on suicide and suicide attempts.

Assessing suicide attempts and other self-injurious behaviors presents a complex challenge. These challenges are shared by the DOD, working to improve its capability to document attempts. The DOD Suicide Prevention and Risk Reduction Committee is currently addressing standardization in the nomenclature and is working towards cross Service standardization on suicide attempts and other self-injurious behaviors. In this effort, the DODSER database, overseen by the National Center for Telehealth and Technology, a component center of the DCoE for PH and TBI can capture and track trends and associated risk factors to better address the needs of our servicemembers.

The DOD and the Services agree that we must do everything possible to collect and analyze data that may be helpful for preventing suicides, reducing distress, and improving overall mental health and well-being. There has been inconsistency in the types of data collected and measures used. The main inconsistencies are associated with what data the Services collect, how they collect data on non-fatal suicide behaviors, and whether Services use the DODSER as a uniform tool. Progress has been made with the Services who have not tracked this data or used the DODSER for non-fatal suicide behaviors. They are exploring opportunities to track these behaviors, initiate policy changes, and conduct preparatory training needed to begin collecting DODSER data.

Ms. POWER. As noted above, there are no national surveillance statistics on attempted suicides, however the DOD is in a unique position to be able to collect this data among active duty servicemembers.

SAMHSA believes that surveillance on suicide attempts should be collected as soon as possible after an attempt to allow intervention efforts to commence as quickly as possible to prevent further self-harm. This would enable improved continuity of care for individuals at heightened risk for suicide following discharge from emergency departments and inpatient psychiatric hospitalizations for suicide attempts. Through its National Suicide Prevention Lifeline and Suicide Prevention Resource Center, SAMHSA is implementing initiatives to support that goal.

45. Senator GRAHAM. Brigadier General Sutton and Ms. Power, what additional metrics regarding attempted suicides are needed in order to tailor specific suicide prevention strategies to populations at risk in DOD?

General SUTTON. To tailor specific suicide prevention strategies to populations at risk in DOD, metrics regarding both completed suicides and attempted suicides are necessary in two areas. First, it is necessary to be able to predict who is at risk for suicide. To do this, it is necessary to collect comprehensive and reliable data on a variety of risk factors. Additional research is needed in this area to identify individuals at risk. Second, when high risk cases are identified, efficacious suicide prevention procedures must be available. Unfortunately, many suicide prevention approaches implemented at the point of actual suicidal behavior have only limited empirical support at this time. Additional randomized controlled trials are needed to improve our understanding of efficacious suicide prevention strategies. Again, our best opportunity for reducing suicide is relying on a community and organizationally based approach that seeks to reduce general distress and improve overall protective factors and coping behaviors in the face of the multiple stressors encountered by our military community. Only by implementing broad-based early prevention strategies can we hope to intervene early enough in the chain of events to prevent increasingly urgent problems.

Ms. POWER. We defer to DOD to respond to this question.

46. Senator GRAHAM. Brigadier General Sutton and Ms. Power, what is the source of data on suicide attempts within DOD?

General SUTTON. The Services collect available data on suicide attempts. Assessing trends within DOD is currently limited due to the difficulties detecting and documenting suicide attempts. The DOD and Services are committed to collecting and analyzing the best possible data on suicide and suicide attempts. Although this is a very challenging task, DOD is making great strides forward in this area. Some Services collect DODSERs on nonfatal suicide behaviors (e.g., Army). Other Services are exploring the opportunity to initiate such efforts. The DODSER is overseen by the National Center for Telehealth and Technology, a component center of the DCoE for PH and TBI. It can capture and track trends to address better the needs of our servicemembers.

The DOD and the Services agree that we must do everything possible to collect and analyze data that may be helpful for preventing suicides. There has been inconsistency in the type of data collected and measures used. The main inconsistencies are in whether the Services collect data, how they collect data on non-fatal suicide behaviors, and whether Services use the DODSER as a uniform tool. Progress has been made with the Services who have not tracked this data or used the DODSER for non-fatal suicide behaviors. They are exploring opportunities to track these behaviors, initiate policy changes, and conduct preparatory training needed to begin collecting DODSER data.

Ms. POWER. We defer to DOD to respond to this question.

47. Senator GRAHAM. Brigadier General Sutton and Ms. Power, is it collected centrally and by whom?

General SUTTON. By the end of fiscal year 2009, DODSER will store all Service information regarding suicide attempts.

A cooperative plan to standardize suicide surveillance across DOD was established in July 2008 by the Suicide Prevention and Risk Reduction Committee. DODSER is a web software system that allows the military to capture detailed information about suicide events. The DODSER enables DOD-level data collection and reporting of suicide events and risk/protective factors. The National Center for Telehealth and Technology, a component center of the DCoE for PH and TBI, created the software to automate standardized data collection efforts. The software requirements were collaboratively developed with the Suicide Prevention Program Managers from the Army, Navy, Air Force, and Marine Corps. Historically, all the Services used idiosyncratic suicide surveillance systems. In January 2008, the DODSER was launched as a DOD solution to serve all the Services.

Current functionality provides a secure website that collects a core of standardized DOD suicide surveillance items that differ by Service. Data collected includes detailed demographics, suicide event details (e.g., suicide method, substance use at the time of the event, sequence of events leading up to the suicide), decedent treatment history (e.g., mental health history, prior suicide attempts, diagnostic history), decedent military history (e.g., deployment, time in unit), and information about other risk factors (e.g., legal problems, relational problems, history of abuse).

Ms. POWER. We defer to DOD to respond to this question.

48. Senator GRAHAM. Brigadier General Sutton and Ms. Power, do military leaders routinely receive data on suicide attempts? If not, should they?

General SUTTON. The communication of information about suicides is inconsistent across Services and levels of leadership. This information is important for leaders to identify levels of distress and other indicators that prevention programs may need additional attention. The DOD Suicide Prevention and Risk Reduction Committee will address the issue of information flow in the coming meetings.

Locally, commanders are informed of suicides that occur under their command. That information alone is important for prevention; however, with expanded information on this indicator as well as other indicators of distress and well being, our commanders will be better positioned to ensure their responsibility for taking care of people is fulfilled.

Ms. POWER. We defer to DOD to respond to this question.

SUBSTANCE ABUSE COUNSELING

49. Senator GRAHAM. Major General Rubenstein, please provide clarification on the Army's proposal to do away with the requirement to inform commanders when a soldier seeks counseling for alcohol or drug abuse.

General RUBENSTEIN. Data from the PDHRA, a medical screening which occurs 3–6 months after a soldier returns from deployment, indicate that a significant number of soldiers screen positive for alcohol problems but very few are referred to the Army's alcohol treatment program (Journal of the American Medical Association, November 2007). When providers are asked about this, they indicate that the requirement for mandatory command notification, even when a soldier is self-referred, is a deterrent to seeking treatment for many soldiers-particularly for those who are career oriented. Army Substance Abuse Program enrollment data also show very few career oriented soldiers receive alcohol treatment.

Data from anonymous surveys indicate that alcohol is a problem for many post-deploying soldiers (New England Journal of Medicine, July 2004), and that these soldiers are also at a much higher risk for suicide, drinking and driving, riding with an impaired driver, and domestic violence. In addition, 50 percent of soldiers with Post-Traumatic Stress Disorder (PTSD) have alcohol problems. The latter occurs insidiously: many soldiers report using alcohol in an attempt to self-medicate early PTSD symptoms such as problems with sleep or irritability; however, it requires increasingly larger 'doses' of alcohol to achieve the same effect. Thus, many soldiers with no previous history inadvertently slip into having alcohol problems.

The change in policy would allow alcohol treatment to have the same confidentiality protections as other medical care, when a soldier accesses care for an alcohol problem voluntarily and proactively before there is an alcohol-related incident that has come to Command attention. The goal is to get more soldiers 'through the door earlier' and to get them help before alcohol-related problems progress to career, relationship, health, or even life-impairing dimensions.

50. Senator GRAHAM. Major General Rubenstein, please provide additional information on the types of providers needed to increase availability of substance abuse counseling, the number of additional providers that are needed, and the cost of providing additional substance abuse counseling in 2010.

General RUBENSTEIN. The Army plans to staff the Army Substance Abuse Program (ASAP) clinics with a ratio of 1 ASAP provider per 2,000 assigned troops. In addition, where installations have trainee populations, an augmentation formula is being developed to supplement the above staffing model. Select installations that have been identified to pilot an ASAP confidential self-referral program will receive additional providers to support the execution of that program. The ASAP requirement, based on the staffing model of 1:2000, equates to 347 providers. Presently, ASAP has 241 clinical providers on hand, requiring the hire of an additional 106 providers to fully comply with the staffing model calculation. ASAP has identified an additional requirement of 18 providers for the confidential self referral pilot projects, for a total identified current shortfall of 124 clinical ASAP providers.

Additionally, ASAP plans to intensify oversight and access by having 4 full-time Regional Medical Command (RMC) ASAP Coordinators who will oversee each Region in maintaining Joint Commission standards, not only ensuring timely evaluations and treatment, but actually serving as a provider when deployments/redeployments create inordinate surges in the number of referrals. We will need to add 21 ASAP-dedicated medical records/administrative positions to free providers from phone/receptionist functions, records management, and numerous other clerical duties. ASAP will also hire an independently licensed manager to implement a research pilot project in the use of Cranial-electro Stimulation (CES), a device which preliminary research indicates is beneficial in reducing cravings, anxiety, and stress. The total shortfall, when including support staff, clinicians and administrators equates to 150 current vacancies. I estimate the total cost of the 150 additional personnel plus travel and supplies of the CES Manager and the regional coordinators will be approximately $14 million annually.

As a result of the robust nationwide competition for social workers and psychologists, the Surgeon General recently approved a policy which will significantly increase the pool of providers eligible to be ASAP counselors. This policy allows employment of paraprofessional mid-level licensees, such as Licensed Professional Counselors (LPCs), Licensed Mental Health providers, and Licensed Masters in Social Work. These counselors will be supervised by the independently licensed Clinical Director (psychologist or social worker), in accordance with DOD policy. For those who choose to work toward independent licensure during this supervised employment period, they will have an opportunity to get promoted and become a part of the ASAP workforce as independent providers. This concept of "growing our own" has been used successfully by other agencies during periods of difficult recruiting and high turnover. Another aspect of this policy allows a grace period of 1 year for Masters level graduates of psychology and social work programs to obtain Substance Abuse Certification.

QUESTIONS SUBMITTED BY SENATOR ROGER F. WICKER

SIDE EFFECTS FROM PRESCRIPTION DRUGS

51. Senator WICKER. Major General Rubenstein and Brigadier General Sutton, a case has come to my attention where a servicemember was prescribed a drug with a listed potential side effect of an increased risk of suicide. What are the Services doing to ensure that those service men and women who are prescribed drugs with these side effects are being properly monitored?

General RUBENSTEIN. All medications have both benefits and risks. Antidepressant medications have great benefits but also may have side effects in some individuals. Some of these side effects are mild and transient, such as nausea and dizziness. In rare cases there are more serious side effects and in some instances there may be increased suicidal ideation. Before a servicemember is prescribed a medication, he or she receives a clinical evaluation. They are informed of the benefits and risks of any treatment, to include medication. Soldiers receiving treatment for depression or PTSD are closely monitored by their providers, especially in the beginning of treatment.

General SUTTON. Standards of care include providing patient education about potential side effects of medications and counseling, especially for those with moderate to severe major depressive disorders. Prescription and monitoring considerations are built into the VA/DOD Clinical Practice Guidelines (CPGs) for treating outpatients with major depression and PTSD. The VA/DOD CPGs include guidance on when

psychotropic medications are clinically indicated, as well as guidance on the selection of different types of medications, including mechanism of action, side effect profile, drug interactions, dosing, therapeutic blood levels (if applicable), ratings of quality of evidence, strength of recommendations, and follow up requirements. The follow up requirements are adjusted based on the severity of the condition.

The CPGs also provide specific guidance on evaluating potentially suicidal patients. This guidance includes gathering information on risk factors for completed suicide as one of the main parts of the evaluation. The guidance also includes risk factors that are common across multiple disorders (e.g., a history of suicide attempts, or the presence of substance use disorders), as well as risk factors that are specific to each disorder (e.g., among veterans with PTSD, intensive combat-related guilt has been linked to suicidality). Patients with acute suicidality are usually hospitalized.

Health Affairs' policy regarding deployment-limiting psychiatric conditions includes the admonition not to deploy servicemembers who have started on psychotropic medications, or whose medication regimen is significantly changed, within 3 months of deployment.

52. Senator WICKER. Major General Rubenstein and Brigadier General Sutton, how is this different from steps being taken by the Services to monitor other service men and women?

General RUBENSTEIN. There is no difference. Prescribing healthcare providers monitor their patients whenever a new drug is prescribed.

General SUTTON. For servicemembers not on prescription medication, monitoring is conducted by the individual treatment facility and/or provider based on their individual guidelines.

When Active Duty servicemembers call the National Suicide Prevention Lifeline, they are transferred to the VA Hotline. Callers not at imminent risk receive referrals for both military and non-military mental health resources, but callers' confidentiality is not violated by disclosing information to the chain of command in non-emergency situations.

For servicemembers who have deployed, the post-deployment health assessment and post-deployment health reassessment identifies PH concerns following combat operations and refers the servicemember to the appropriate resource.

The Caring Letter Project is a suicide prevention outreach program that involves sending brief letters of concern and reminders of treatment availability to inpatients at high risk for suicide following psychiatric hospitalization. This is a notable project because it has empirical support for preventing suicide completion. The National Center for Telehealth and Technology, a component center of the DCoE for PH and TBI, is currently piloting this intervention to tailor its use for a military setting.

In addition, the DOD/Veterans Health Administration CPGs for initial treatment of major depressive disorders recommend follow-up 1 to 2 weeks after initializing antidepressant treatment, irrespective of medications or psychotherapies used, to assess for compliance with recommended therapies or for side effects if medication is used.

53. Senator WICKER. Major General Rubenstein and Brigadier General Sutton, is there any type of psychological screening given to individual service men and women before prescribing these drugs?

General RUBENSTEIN. Before a servicemember is prescribed a medication, he or she receives a careful clinical evaluation. Psychological screening may be used, if clinically indicated. All soldiers are evaluated for their risk of suicide, homicide, and other risky behaviors. All medications have both benefits and risks. Medications should only be used when the benefit outweighs the risk.

General SUTTON. The VA/DOD CPGs advise psychiatrists and primary care providers to perform a thorough evaluation before prescribing psychotropic medication to include obtaining a history (including psychiatric, marital, family, military, past physical or sexual abuse, and medication or substance use), conducting a physical examination and laboratory tests, performing a mental status examination, completing a drug inventory to include over-the-counter drugs and herbals, and assessing and documenting signs and symptoms of depression.

As defined by the Diagnostic and Statistical Manual-IV TR, suicidality is one of the core symptoms and signs of depression (i.e., recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide). For example, the VA/DOD Guidelines for Depression describe assessing suicidal ideation and intent as "Direct and nonjudgmental questioning regarding suicidal ideation/intent is indicated in all cases where depression is suspected. A significant number of patients who contemplate suicide are seen by

a physician in the month prior to their attempt. Direct assessment of suicidal ideation and intent does not increase the risk of suicide. Consider gathering collateral information from a third party, if possible."

[Whereupon, at 6:04 p.m., the subcommittee adjourned.]