

**HEARING TO RECEIVE TESTIMONY ON THE
INCIDENCE OF SUICIDES OF UNITED
STATES SERVICEMEMBERS AND INITIA-
TIVES WITHIN THE DEPARTMENT OF DE-
FENSE 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 Kenneth, 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. But, appreciate everyone's patience, and I'm happy to see you all here, and look forward to the testimony.

As the Personnel Subcommittee hearing comes to order, we meet today to receive testimony on the incidence of suicides of United States servicemembers and initiatives within the services and the Department of Defense to prevent military suicides.

I'm honored to welcome back Senator Graham as this committee'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, preserved the freedoms we all cherish. And 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 27th '08, 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 had. 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. And 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. And this hearing will help all of us understand what initiatives and programs each service, as well as the Department of Defense, has in place to prevent suicide among service members, 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, 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. And 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 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 the suicides 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 to—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. And 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 the Department of Defense 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, Substance Abuse and Mental Health Services Administration.

And 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 services members 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. And while we consider the establishment of this task force a priority, and we're eager to hear about that—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 year—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. And 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. And while there are reasons that the Army's numbers are the highest, 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—Chairman—is here, and I would ask him if there are any opening statements he might make.

STATEMENT OF SENATOR CARL LEVIN

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

I want to thank you, first, for holding this hearing at your subcommittee. It is a subcommittee which is critically important to us, the Personnel Subcommittee, focusing on the kind of issues which 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. And 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 Housing Recruiting Brigade who have committed suicide between January of 2005 and September of 2008.

Congress has recognized the strain on our ground forces, 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 and have experienced.

We have an increasing number of troops returning from combat with post-traumatic stress disorder, 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 when they receive mental health care. And 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 which they experienced as a result of deployments to combat areas. One of them, Brigadier General Patton, said, quote, "We need all of our soldiers and leaders to approach

mental health like we do physical health. No one would ever question or even 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:]

[SUBCOMMITTEE INSERT]

Senator BEN NELSON. Senator Cornyn?

**STATEMENT OF HON. JOHN CORNYN, A 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 important 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, 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 a necessary—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, hostile combat 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 with me by my constituents. And I want to commend the Army, particularly Secretary Geren, General Freakley, 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 taking 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 not available—that are available on most military installations, but may not be available where they are actually located. In addi-

tion, the 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 that—ensure 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. And 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 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:]

[SUBCOMMITTEE INSERT]

Senator BEN NELSON. Thank you, Senator Cornyn, for your thoughtful testimony. We invite you to join us here at the dais, if you like. 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, 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 the—as noted, each of the services have had increased rates of suicide between the year—calendar years 2007 and 2008.

General Chiarelli?

**STATEMENT OF GENERAL 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. I and the other senior leaders of the Army 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. And 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:]
Senator BEN NELSON. Admiral Walsh?

**STATEMENT OF ADMIRAL 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 of—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 individual 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 Chief of Naval Operations 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 physical—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 decision-making tools for sailors, leaders, and families so that it can identify stress responses and problematic tension. By addressing problems early, individuals can mitigate the effects of personal turmoil and get the necessary help and professional counseling, where 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:]

Senator BEN NELSON. Thank you, Admiral.

General Amos?

**STATEMENT OF GENERAL JAMES F. AMOS, USMC, ASSISTANT
COMMANDANT, 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 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 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 noncommissioned officers 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 noncommissioned officers and our corpsmen, and asking them to provide additional—or 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.

[The prepared statement of General Amos follows:]

Senator BEN NELSON. It will be accepted. Thank you, General Amos.

General Fraser?

STATEMENT OF GENERAL 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.

As an Air Force, we believe that when an airmen raises their hand and takes the oath, their lives are forever changed in the name of service. And 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, 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 too many. And 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, Chairman.

[The prepared statement of General Fraser follows:]

Senator BEN NELSON. Thank you.

Senator Graham has arrived for an opening statement.

**STATEMENT OF HON. LINDSEY O. GRAHAM, U.S. SENATOR
FROM SOUTH CAROLINA**

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 has really gotten the spirit of what we're all about here and try to be as non-partisan as possible, and I think we've been very good at that.

This issue obviously is something that the country is concerned with. And what I want to know is, When we exceed the population—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. You know, if you step out and say, "I'm having a problem," people worry that it's going to affect their ability to be promoted. And 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.

And so, 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:]

[SUBCOMMITTEE INSERT]

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, they—as you well know, the problem is not solved, but I think we've—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 current stand-down—our stand-downs for the active-component force on the 15th of March, 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 2009, once confirmed, will be briefed to me. I held that first session with the leaders 2 weeks ago. Two-and-a-half hour session, 15 minutes, 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 from—about the lessons of everyone, 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 OSCAR, or Operational Stress Control and Readiness 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? And has the Marine Corps concluded that this is, indeed, an efficient use of mental health providers?

General Amos: Chairman, the—we have just recently—we have three OSCAR teams in—

I think I'm on.

Sir, we have three 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 four forward-deployed. It's too soon to tell the real benefit of these. Anecdotally, we believe that—and—we believe this is going to be a significant force multiplier, reducing the stigma and in allowing us to be able to actually look young marines in the eye with a mental health professional while they are deployed, so 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 CENTCOM right now, with marines.

The real issue—challenge across all of DOD—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 and in the military. So, I think it's too soon to tell. My anticipation and expectations are, 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, right now it's just a—it's a total—it's a function of numbers right now; we just don't have enough to be able to provide all the ones that are going, 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 indications— anecdotal indications from units returning indicate that this is an great help to 'em. But, I think, you know, Senator, we rely on PROFIS doctors.

I want to lay it all out, here. I have found that, because those PROFIS doctors were turned back, those are doctors—and a mental healthcare provider would be the same—they 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 mental—that facility—medical facility, and we have a problem, because that continuity is important when they're deployed, but the continuity—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. And we've got to find a way to provide that, 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, though. However, this last year we have taken action to bring on more. In fact, within the last 12 months, we have—we've gone out and we've hired 97 new mental healthcare providers to place them with our units and—so that, across all of our installations, that we have it 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, though, too. This is a seam, when you have a lack of mental health providers in the other services, and then, as General Chiarelli just talked about, these PROFIS who have to go forward. What we want to make sure that we do, though, for those who support those types of taskings, is to ensure that we've got a good handoff. We don't want them to fall through the seam. And that is something that our healthcare providers are very intent on doing, because you can see how that would happen when they come back and they're no longer attached to those units, or they deployed less time than what that unit may deploy. We know that the Army is on longer deployments, and we tend to stick to about 179 to 180. We are getting longer deployments in there, but yet, at the same time, we also realize there's other things that we have to do.

The other thing that we're noticing and we want to do with these 97, 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. And so, these are other types of things that we're doing.

Another thing that we're finding that we're doing, not just with the embeds, sir, but we're finding great utility in the health assessments, not only the PHAs that folks do on an annual base, but the pre-, the post-, and then, more importantly, actually, it's the post-deployment, the reassessment that occurs, the 90 to 180 days after a troop has returned. What we're finding in that assessment, because it is very sensitive assessment, is that a large number of the folks begin to exhibit stress. And so, it's necessary, then, that we get them the care that they need to have. And we're battling 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 PDHRA is actually yielding great benefits after that deployment and being forward in the theater.

Thank you, sir.

Senator BEN NELSON. General Amos. Oh, 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 that deploying unit.

So, 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—in times when people have stepped away from the checks and balances, the lines of accountability, and the clear oversight that comes from a deploying unit. And those are our areas of vulnerability.

Senator BEN NELSON. Thank you. My time's expired.

Senator Graham?

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

Senator GRAHAM. Thank you, Mr. Chairman.

I think Senator Cornyn has to leave, if you would like to—

Senator BEN NELSON. Oh, sure.

Senator CORNYN. Well, thank you very much, Senator 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 and 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. And you—we can all see the concern, because, of course, we've had many hearings, a lot of efforts undertaken to try to deal with everything from traumatic brain injury 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, are 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 their own life. And 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 life. And so, I'm just wondering if you think—and I'd be pleased if we could just go down the line and get your reaction to this—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 best likely to identify an individual like this and intervene in a way that saves them from the—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, that 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 greater, 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, where—nine suicides, where I've got six out of nine soldiers who have deployment history—and that fits about the statistics we're looking at—one-third deployed, one-third not deployed, and one-third, when they were deployed, committed the act—and of those six soldiers who have deployment history, four of them have multiple deployments. And that doesn't normally fit. But, I think we have to attack from this a multidisciplinary approach and understand that we've got 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, a peer, and 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 that—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 for—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.

And what we have learned is the importance of demanding feedback, to demand a dialogue. And 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. And that, to me, is the way we go out, proactively, and go looking 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 Pete Chiarelli have said. You asked, How do we—is there anything we could do early on with the—just the recruiting and kind of the 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 200—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 'em 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. And we're pretty good at that. Those drill instructors are pretty good.

So, at the end of 12 weeks at Parris Island in San Diego, on that Friday morning, I would say that we've probably done a pretty job of filtering out those that we might otherwise—that you and I might think that there's 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, trying to—how do you build a young man or a woman and make them strong enough so that, when a relationship issue 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.

And finally, the last thing I would say in my list is that we don't—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. And so, as we learn from each suicide, we then take that into account across those 11 initiatives, but, moreover, we take it into account in the community in which they live. Every community is different, whether it's in North Dakota or in Texas or Florida or Alaska. And so, the other thing that we've done is—through the Community Action Information Board, is to get that information out there. And 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. And we, in the Pentagon, even at the air staff level, hold a Community Action Information Board so that we can better understand, What can we do with our processes, with our procedures or resources need to be provided to 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. And 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. So, 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. So, it's a part of our military treatment facilities.

So, these are some of the things that we're learning. And 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. And 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. So, it's multifaceted.

Senator CORNYN. Thank you very much. My time's 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 so accepted.

Senator GRAHAM. Okay.

[The prepared statement of Senator McCain follows:]

[SUBCOMMITTEE INSERT]

Senator GRAHAM. Well, what brings us here is the spike, I guess, 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. And any indications as to why, General—big-theme 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. And you can look at the numbers and try to make yourself feel that you—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, deployments, as you know, 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 til June of this year, and our last combat service—combat service support unit, those enablers you often hear about, until September of 2009. And 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—one thing—

Senator GRAHAM. Sure.

General Chiarelli:—that I think has caused that spike, that is, in fact, it.

Senator GRAHAM. On the Air Force side, from 2004 til 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? Is the—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. In fact—

Senator GRAHAM. Have you been deployed substantially from '04 to '08?

General Fraser: Yes, sir. In fact, we have been—actually, if you take into account 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—

Senator GRAHAM. So—

General Fraser:—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. And so, we've got to stay on top of this.

Senator GRAHAM. Well, just—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've—probably have gone up, I would imagine. But, your rates have come down, and your program—well, 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 been a pretty consistent rate from '04 to '08. 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 '06, '07, and '08, 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—and we are a very deploying force, you know; as you know, Senator, many of our units are right around the one- to-one deployment-to-dwell. 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—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, our typical age of our young marines, our marines, are very, very young. And 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 noncommissioned officer.

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. And you're—I'm from a generation of naval officers who remembers exactly where they were when Admiral Boorda committed suicide. as the Chief of Naval Operations, in May of 1996.

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

Senator GRAHAM. Has your deployment schedules gone up or down from '04 to '08?

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—

Admiral Walsh: No, sir, they've been—

Senator GRAHAM.—service as a whole?

Admiral Walsh: 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—

Senator BEN NELSON. Without exception—

Senator GRAHAM.—pretty informative.

[The information previously referred to follows:]

[SUBCOMMITTEE INSERT]

Senator BEN NELSON. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

Mr. Chairman, let me first thank you and 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, and publications and 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 then 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.

And 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 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.

General Chiarelli: Well, this is a real issue for us. And 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. And 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. And 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 got 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. And 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 NDAA, 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's 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 that, really, 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?

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

Senator COLLINS. Right.

Admiral Walsh: And the issue with the Reserves is having visibility on the Reserves. 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 the Department of Defense 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. And 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.

Senator COLLINS. Okay.

General?

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

Senator COLLINS. Right.

Admiral Walsh: But, I—we are a total force, and all our Reserves, for the most part, are deployed—almost all our units are deployed at least twice in the Reserves. So, we are actually integrated, and we track them very carefully. So, when we talk about programs for—whether it be mental health programs or tracking wounded or care for families, we really talk about everybody, to-

gether, the 239,000 Active and Reserve marines. So, we bring them together, and it's—and they are an integral part of that.

The Wounded Warrior Regiment, when it 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 wounded marines that have come to the—you know, 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 8800 through the Wounded Warrior Regiment. We have the Call Center that was established a year and a half ago and then made over 37,000 phone calls. They call the wounded marines, they call their mothers, they call their wives. And the idea is, How are you doing? And 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 the—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?

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. And 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. And one of the things, though, that, for instance, 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 Reserves, get them back on orders and get them the help they need.

Senator COLLINS. Good.

General Fraser: And so, there's no time lost if it's identified that someone needs help. We're part of the Yellow Ribbon Program, 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 Reserves 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 post-traumatic stress, post-traumatic stress disorder. And so, 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 going. 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—and 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 has done—have done, there now is screening for traumatic brain injury, both pre- and post-deployment. I wonder if that could be expanded to also be a screen for mental health problems. And if you did it predeployment, the—and that's the concept to identify traumatic brain injury—then you'd have a baseline that you could compare with post-deployment screening. And if you did it as part of the screening for traumatic brain injury, 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—and you might be able to, as part of that review, identify those with problems or at risk. And 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. And 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, hope that you 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've got 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. And 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 the medical services—mental health services, and yet, it was not sufficient—or, may not have been sufficient; 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 before—mental health assistance or counseling and things of that nature—the other thing that we have instituted and that we are now doing, it also becomes 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. Because 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 and all these 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. Well, 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'd have is—I think it was—General Chiarelli, you said "learning to cope," trying to identify, at the time that you bring individuals in—and I think—that you recruit—that you identify, in your own minds, the ability of that person to cope with the strains and the stress and everything that would come along in their military career. Are the other branches focused more on mental health up front 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 break-up of a romantic relationship or financial problems that might develop?

Admiral Walsh?

Admiral Walsh: Coping for the—targeted towards 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. And 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've look at this by rating; we find corpsmen have a statistically high number, an unacceptable number. And so, 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, one of the things we—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. And 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, you—we say that, but the—really, in many cases, I think the figure was somewhere—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. And that's where we're headed, sir.

Senator BEN NELSON. General?

General Fraser: Sir, we think that it begins at the accession, and we begin, right away, assessing those young airmen and—in understanding 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. And so, as you see 'em out running, as you see 'em 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 wingman, and helping each other, we think's going to pay great dividends, though.

These assessments that we're doing are telling us a lot, though. The annual assessments of the PHA from the 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. And 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, 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. And so, 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?

Senator GRAHAM. I know we want to get to the next panel. And, gentlemen, just one quick question. I don't want—make sure I've got your testimony right, here. 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. We are also short substance-abuse counselors.

Senator GRAHAM. Right.

Admiral?

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

Senator GRAHAM. You're what?

Admiral Walsh: We are asking for more. We're about—

Senator GRAHAM. Okay.

Admiral Walsh:—88 percent of the fill that we need.

Senator GRAHAM. Okay.

General Amos: Senator, you know we don't have medical—

Senator GRAHAM. Right. You've got—

General Amos:—in our corps, but we—

Senator GRAHAM.—the Navy folks—

General Amos:—rely on the Navy, and we are significantly short.

General Fraser: Sir, we are short in our Active Duty authorizations. We—

Senator GRAHAM. Well—

General Fraser:—do not have them all filled.

Senator GRAHAM. Well, my question is, Is there anything can this subcommittee 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 our—at this time. I can tell you that we have a rough time. We've got the resources out there to hire, right now, but when you go to places like Fort Drum, Fort Campbell, Fort Hood, Texas, 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 that 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 ACMC described.

Senator GRAHAM. Yeah, well, the—we stand ready, if you think of something down the road, General. And what I've gotten from this, it seems like the deployment activity of the Marine Corps and the Army obviously are putting more stress. I mean—and 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, you know, ground commitments. And 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. And 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. And if it's money, and that will help, I think we're ready to help with money.

Thank you.

Senator BEN NELSON. I see Senator Thune has arrived. We could go to the second panel.

Thank you, gentlemen. And thank you, particularly, for waiting and being patient with the delayed start. Thank you for your serv-

ice to our country. And, 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 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 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 in the 2009 National Defense Authorization Act.

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, Mrs. A. Kathryn Power, who is the director of the Center of Mental Health Services within the Substance Abuse and Mental Health Services Administration, which is under the Department of Health and Human Services. Ms. Power has a long career of outstanding public service, including participation in the Department of Defense Task Force on Mental Health, whose report we all consider a valuable resource. She will share views from the public-health's 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 LIEUTENANT GENERAL BENJAMIN C. FREAKLEY, USA, COMMANDING GENERAL, U.S. ARMY ACCESSIONS COMMAND, DEPUTY COMMANDING GENERAL, INITIAL MILITARY TRAINING

General Freakley: Chairman Nelson, Ranking Member Graham, 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 of 2005 and September of 2008, there were four suicides within the United States Army Recruiting Battalion at Houston, Texas. 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 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, postdeployment 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 G1, the Surgeon General, have adopted procedures to ensure compliance with recruiter screening and selection process, the provisions of care for soldiers who require mental healthcare, Armywide 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 commandwide 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 the 13th, 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 G1, 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 to support—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:]

Senator BEN NELSON. Thank you.
General?

**STATEMENT OF MAJOR GENERAL 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 of 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, the WTU, of his post because of a motorcycle accident 2 and a half years ago that left him with a traumatic brain injury, 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 Traumatic Brain Injury 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. And, 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:]

Senator BEN NELSON. Thank you.
General?

**STATEMENT OF BRIGADIER GENERAL LOREE K. SUTTON, USA,
DIRECTOR, DEFENSE CENTERS OF EXCELLENCE FOR PSY-
CHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY**

General Sutton: Chairman Nelson, Ranking Member Graham, other distinguished members of the committee, thank you so much for the opportunity—

Senator BEN NELSON. Is it on?

General Sutton: Perhaps it's not close enough. Is that better?

Senator BEN NELSON: That's better.

General Sutton: Yes, sir.

Thank you for the opportunity to bring you up to date on what the Department of Defense 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 traumatic brain injury, what we often call TBI, for the Department of Defense. In coordination with the Department of Veterans Affairs, academia, and many others, DOD established the Defense Centers of Excellence for Psychological Health and TBI in November of 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 of 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, Web 2.0, 3.0 interactive tools. It's currently getting 6,000 hits per month, and is continuing to grow. We will build on that tool.

In November of 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 2500 years ago, the Trojans—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 traumatic brain injury, 24 hours a day, with members of the military services, vet-

erans, 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 TAPS Program, 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, known as 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, or OAFME, and the National Center for TeleHealth and Technology, or 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 of 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 selec-

tion 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:]

Senator BEN NELSON. Thank you.
Commandant?

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

General Linnington: Chairman Nelson, Ranking Member Graham, 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 are also—also require support from a variety of sources; most importantly, 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 suicides 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 seri-

ously. 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 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 completely 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:]

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 committee, 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. Department of Health and Human Services.

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 a suicide—one suicide every 16 minutes. Clearly, suicide is a public health crisis in America, and it demands a public health response. And 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 and throughout our Nation. We provide national leadership for suicide prevention, leading a broad group of Federal partners, including the Department of Defense and Veterans Affairs, to implement the National Strategy for Suicide Prevention within the transformation of our Nation's health system.

SAMHSA has three major suicide initiatives. 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 1500 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 1700 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 three a day, identified themselves as being on Active Duty.

Our soldiers, sailors, airmen, and marine 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 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, Kentucky, 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, 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:]

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—is it Rubenstein? Is that right? 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 of—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 a 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 Active Duty member, and they get the same service from either the Crisis Center locally or we can, in fact, connect them to the Veterans, if they so want. So—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've got a problem here"?

Ms. Power: A matter of routine for—

Senator GRAHAM. I mean, when you talk to the person, is the—

Ms. Power: When we talk to them?

Senator GRAHAM. Yes. 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 have—they are on Active Duty; and generally either those—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, about some—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. General Sutton—how many did you say, this year—or, last year—Active Duty people that were calling in the Hotline? Ms. Powell, how many Active Duty people identified themselves when they called the hotline—

Ms. Power: Last year?

Senator GRAHAM. Yeah.

Ms. Power: It was 780 callers. And thus far this year, three per day.

Senator GRAHAM. Okay. Well, 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—these are—we've established a network, so that no matter—

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 changing—transforming the culture.

We are, however—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 with 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, how many—do we have any numbers to compare to, how many Active Duty people—

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

General Rubenstein: This is disturbing, for those Active Duty soldiers who live on or in the immediate vicinity of a military base—if those soldiers feel they—

Senator GRAHAM. That's the point.

General Rubenstein:—if those soldiers feel they have to call a—

Senator GRAHAM. I mean—

General Rubenstein:—third party

Senator GRAHAM.—that is an astonishing number, to me, if you had 780 contacts last year.

General Rubenstein: I—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. And it's the leadership that we have to work with so hard in order to ensure the leadership is—

Senator GRAHAM. Right. Right.

General Rubenstein:—taking the—

Senator GRAHAM. And I know this is hard, but that's the most—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. And I understand. I mean, I—this is not easy. I'm—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. And so, if y'all could talk, that would be helpful. Find out exactly what's going on here and try to—you know,

all I can say, that's just a big number. And 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, you know, it's just a—you know, 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. And they 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, number two is our delegated hiring authority which allows—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, the committee has done, and as Congress has done and—

Senator GRAHAM. General Sutton?

General Rubenstein:—hiring actions.

General Sutton: I would just add to those points also the points that General Chiarelli brought up earlier, in terms of the importance of establishing a robust TeleHealth and technology network, which we are in the process of doing, working with the VA, working with the National Guard, 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, their laptop—

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

General Sutton: Sir, we're—you've already—

Senator GRAHAM. Okay.

General Sutton:—gotten us launched, so we'll keep you posted—

Senator GRAHAM. Okay.

General Sutton:—on the progress.

Senator GRAHAM. 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've got is a resource problem, but, more than anything else, we've got 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. And 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 providers, mental health providers, if they're in—if they're within the system, do they become part of the problem, in terms of want—not—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 or 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 2500 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. If—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 had a—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 there's an accident, and 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, was being used as a motivational speaker for other patients in the area of TBI. The question comes down to, How closely is the healthcare team, the leadership team—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 is, in the military we provide ourselves about putting our arms around our soldiers and looking into our eyes and having battle buddies. Don't have the same thing in the civilian sector. And 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's got 2 and a half 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 a "cluster"—"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. And 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 very—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. And 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. And 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. And, 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. And, 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. And their findings were quite the opposite, that there was not a large stigma at the Academy. And 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. When I—you know, I—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 was very involved in the drug court movement in this country. And so, I'm pretty well versed on the issues of substance abuse, based on my background.

When 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 a good 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, 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 was; many of them were waiting, for a variety of reasons. And it—and I saw nothing anywhere—there was a bar you could go in, and drink, but there was nothing anywhere about substance abuse counseling. And 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, and I don't know how aware you all are that I've introduce a piece of legislation dealing with substance abuse in the military, to try to look at this more carefully. And I don't need to tell you that we've got 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, that—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. 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—and if you all would address that, I would appreciate it.

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

And, 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. And if we don't address them—and that's why we actually promote the notion of integrated treatment—from a prevention standpoint to an intervention standpoint to an integrated standpoint. And I now that several of the military programs have really focused on an integrated treatment approach in a way that I think is quite superlative. And 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—who go to our ASAP, our Army Substance Abuse Program, 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 they—the only reason you would walk in the building and those kinds of things.

So, both from the physical standpoint, but also, most importantly, soldier self-identifies, 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. And 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. And—because 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," when, in reality, they're—it's—

I think it might be easier to say, "I've got a drinking issue" than "I've got a mental health issue," understanding the kind of pride and the kind of atmosphere that is so important to our military, that, you know, everybody drinking is not something that is weird.

General Rubenstein: You're absolutely right. And, 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. Yup. Starting point. Yeah, 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? And I—first of all, I don't mean to pick on Fort Leonard Wood. I'm proud of the Fort, and my father has a history there, and it's not that, I just—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—

General Rubenstein: Right.

Senator McCASKILL.—in place to actually provide the counseling for the folks who needed it and wanted it.

General Rubenstein: We have a little over 250 counselor today. We have over 70 open hiring actions. The problem that we have put ourselves 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." And 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: And 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, successful—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. Well, I thank you all. And 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, so—that happened with the 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 we're—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 them, and—programs, as well as the research? Or, is the—are the centers more responsible for creating Department-of- Defensewide 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 programs. 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, ma'am, 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 Warrior Transition Unit 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. And he's given me permission to give his name, 1st Sergeant Creed McCaslin. And he was able to talk about how, after his multiple tours in Iraq, with, as his command sergeant major described it, possibly the most exposed—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 3:00 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 the Department of Defense, but it's something that I'm working closely on, now I'm going to be reaching out within our priority working group for re-integrating veterans, warriors, and their families, Ms. Power, as well as—I'm working with Matt Friedman, who's the director of the National Center for Post-Traumatic Stress Disorder, 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, you know, 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's—it also boils down to such simple things as human connection.

I recently got a letter—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, ma'am, 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, 8 years ago—I've carried in my letter, I have taken out, on more than one occasion—it has kept me from a very, very desperate decision."

And 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. You know, 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 and nutrition and friends and family and love and faith and hope and growth. And so, 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.

And 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 three out of every ten Americans aged 18 to 24 is 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. Well, you know. Is—before we conclude, is there anything that we didn't ask or—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.]

Senator BEN NELSON. Well, if not, thank you very much. Appreciate your wisdom and your service. And we hope, as a result of this and the days ahead, we will see improved results.

Thank you.

[Whereupon, at 6:04 p.m., the subcommittee adjourned.]