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FINAL VERSION

STATEMENT BY

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US ARMY

COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON PERSONNEL

UNITED STATES SENATE

FIRST SESSION, 111TH CONGRESS

SUICIDE PREVENTION

18 MARCH 2009

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

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

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

Surveillance in Theater

The Army's ground breaking Mental Health Advisory Teams (MHATs) have shown that longer deployment, multiple deployments, greater time away from base camps, and combat frequency and intensity all contribute to higher rates of Post Traumatic Stress Disorder (PTSD), depression, and marital problems. All of these factors can contribute to increasing suicide rates. MHAT V findings show that rates of mental health problems rose significantly with each deployment, reaching nearly 30% among Soldiers on their third deployment to Iraq. The 2007 effort also showed that Soldiers in brigade combat teams deployed to Afghanistan are now experiencing levels of combat exposure equivalent to levels in Iraq, and that the rate of mental health problems is comparable between these two countries as well.

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

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

Surveillance Army-Wide

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

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

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

Treatment

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

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

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

Conclusion

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

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

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