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Before the

Subcommittee on Personnel

COMMITTEE ON
ARMED SERVICES

UNITED STATES SENATE

HEARING TO RECEIVE TESTIMONY ON
SUICIDE PREVENTION AND RELATED BEHAVIORAL
HEALTH INTERVENTIONS IN
THE DEPARTMENT OF DEFENSE

Wednesday, April 6, 2022

Washington, D.C.

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1 HEARING TO RECEIVE TESTIMONY ON SUICIDE PREVENTION AND
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3 DEPARTMENT OF DEFENSE

4
5 Wednesday, April 6, 2022

6
7 U.S. Senate

8 Subcommittee Personnel

9 Committee on Armed Services

10 Washington, D.C.

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12 The committee met, pursuant to notice, at 10:00 a.m. in
13 Room SR-222, Russell Senate Office Building, Hon. Kirsten
14 Gillibrand, chairman of the subcommittee, presiding.

15 Committee Members Present: Gillibrand [presiding],
16 Tillis, Sullivan, Hawley, and Tuberville.

1 OPENING STATEMENT OF HON. KIRSTEN GILLIBRAND, U.S.
2 SENATOR FROM NEW YORK

3 Senator Gillibrand: Good morning, everybody. The
4 Personnel Subcommittee meets today to receive testimony on
5 the Department of Defense's efforts to address and prevent
6 servicemember suicide.

7 Let me start by welcoming Senator Tillis, our ranking
8 member of the subcommittee. I also want to recognize
9 Senator Tuberville for joining us on the onset. On many
10 issues that have come before the subcommittee, Senator
11 Tillis and I worked well together, and I know the issue of
12 today's hearing is also one that has been top of his mind
13 and a priority of his. I look forward to working with
14 Senator Tillis to investigate and address suicide prevention
15 across the Department and find bipartisan solutions to help
16 support our servicemembers and their families.

17 Suicide in the military is an epidemic and one we
18 cannot ignore. Last September, in my home state of New
19 York, three servicemembers based at Fort Drum died by
20 suicide in 3 days. What that demonstrated is that no
21 community is immune to the crisis.

22 After meeting with General Beagle of the 10th Mountain
23 Division last month I was pleased to learn that the programs
24 that their leadership is putting in place to prevent
25 suicide, from providing additional resources to training

1 individuals at all levels to identify those at risk, and
2 taking a holistic approach to provide supports to
3 servicemembers so they feel better equipped to handle a
4 range of challenges that they may face. I have also
5 believed mental health among our servicemembers is a
6 readiness issue, and in order to foster resilience and build
7 troop fitness our servicemembers need the tools to feel less
8 overwhelmed and stressed, in addition to having access to
9 mental health services as needed.

10 My goal in holding this hearing today is to better
11 understand what is being done by DoD to prevent suicides in
12 our military and to learn more about what can be done to
13 further eliminate barriers that stand between our
14 servicemembers and access to mental health. We have to end
15 the stigma that is too often associated with requests for
16 help.

17 In the last annual report on suicide using data from
18 2020, the Department of Defense noted that suicide rates for
19 the active component increased from 2015 to 2020. During
20 this time, the Department made substantial investments to
21 prevent suicide among the ranks, including training programs
22 for servicemembers, investment in communications and
23 outreach platforms, and increased access to behavioral
24 health screening and resources. Yet suicide rates continue
25 to increase.

1 While I am cautiously optimistic about the 2021 data,
2 which was just released last week and indicated a 10 percent
3 drop in servicemember suicide, 518 servicemember deaths are
4 still far too high, and the Department still has much work
5 to do to prevent these tragic losses.

6 I am looking forward to hearing from today's witnesses
7 on this topic. We will have two panels. The first consists
8 of DoD witnesses who will testify about the Department's
9 suicide prevention programs and its related behavioral
10 health interventions, and representatives from the Inspector
11 General's Office and Government Accountability Office to
12 help us understand the efficacy of these programs and any
13 recommendations they have for improvement.

14 Our second panel will include a military family member
15 who is personally impacted by suicide and experts outside of
16 the Department who have experience in research and outreach
17 in suicide prevention.

18 Our first panel of witnesses include Dr. Karen A.
19 Orvis, Director, Defense Suicide Prevention Office,
20 Department of Defense; Dr. Richard Mooney, Acting Deputy
21 Assistant Secretary of Defense for Health Services, Policy,
22 and Oversight, DoD; Mr. Michael J. Roark, Deputy Inspector
23 General, Evaluations Component, Department of Defense; Ms.
24 Brenda Farrell, Director, Defense Capabilities and
25 Management, Government Accountability Office.

1 I will also introduce the second panel after we receive
2 the testimony of the first panel.

3 Again, I welcome our witnesses today. Thank you for
4 appearing and thank you for your testimony.

5 Senator Tillis.

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1 STATEMENT OF HON. THOM TILLIS, U.S. SENATOR FROM NORTH
2 CAROLINA

3 Senator Tillis: Thank you, Senator Gillibrand, for
4 this hearing on military suicide prevention and mental
5 health care.

6 It will come as no surprise that we have a mental
7 health care crisis in this nation. The demand for mental
8 health services far exceeds the supply of mental health care
9 providers. The Health Resources and Services Administration
10 estimates by 2025 we will have a shortage of over 250,000
11 mental health professionals -- psychiatrists, mental health
12 and substance use disorder specialists, and clinical and
13 school psychologists. We do not train enough of them.
14 Their pay is low compared to other health care professionals
15 with similar education and experience, and we place more
16 administrative demands on them, and the pace of their work
17 often burns them out.

18 While this subcommittee cannot fix these problems, for
19 the nation we can look to improve access to mental health in
20 the military health system.

21 I look forward to hearing from the witnesses on the
22 first panel about the mental health staffing challenges in
23 DoD and to better understand what this subcommittee may do
24 to help the Department recruit and retain more military and
25 civilian mental health providers. I also want to know the

1 challenges that patients face when they are referred to care
2 for the TRICARE network. And finally, tell us how DoD will
3 expand the use of tele-behavioral health, especially in
4 remote locations where in-person services are not available.

5 Now turning to the issue of military suicides, every
6 suicide is a tragedy that could have been prevented with
7 early intervention. From DoD's data we know that most
8 suicides occur in young enlisted males who may have
9 experienced financial problems, failed personal
10 relationships, or legal problems. Leadership up and down
11 the chain of command, from the general officer down to the
12 most junior NCO, must do a better job of developing
13 servicemembers' connectedness to their military unit, to
14 their families, and their supporting community.

15 Military leaders need to know how to identify
16 servicemembers at higher risk of self-harm. They must
17 eliminate any remaining stigma associated with seeking
18 mental health care, and they must prioritize servicemembers
19 getting health over mission requirements.

20 I am encouraged by Secretary Austin's recent memo to
21 stand up a Suicide Prevention Response Review Committee, a
22 requirement under Section 738 of the NDAA for fiscal year
23 2022. I thank him for including Camp Lejeune and the North
24 Carolina National Guard as two of the locations that the
25 committee will review. I want to hear more about that

1 committee and the work that is going to be done.

2 Finally, I want to thank the witnesses on Panel 2. I
3 want to thank all the witnesses for being here but
4 especially the witnesses on Panel 2, who are from Durham,
5 North Carolina. Dr. Doraiswamy, who is in the back corner
6 to my right, from Duke University School of Medicine, and
7 Mr. Ford, from a terrific nonprofit organization called Stop
8 Soldier Suicide. I hope the witnesses on Panel 2 can
9 describe some of the innovative best practices in suicide
10 prevention and help us understand how technology can be
11 applied to prevent suicides.

12 Again, Senator Gillibrand, thank you for holding this
13 important hearing. I look forward to hearing everyone's
14 testimony.

15 Senator Gillibrand: Thank you. We would now like to
16 hear from our witnesses. Dr. Orvis, we are prepared to hear
17 your opening statement first.

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1 STATEMENT OF KARIN ORVIS, PhD, DIRECTOR, DEFENSE
2 SUICIDE PREVENTION OFFICE, DEPARTMENT OF DEFENSE

3 Dr. Orvis: Thank you. Madam Chair Gillibrand, Ranking
4 Member Tillis, and distinguished members of the
5 subcommittee, thank you for the opportunity to appear before
6 you today.

7 Let me start directly first. I am deeply disheartened
8 by the rates of suicide in our military. Every suicide is
9 heartbreaking, resulting in horrifying pain of losing a
10 loved one. This drives us every day to find answers, to
11 ensure those who need help ask for and receive that help,
12 and to be certain that not another son or daughter, brother
13 or sister, or mother or father must also live with the
14 searing pain and emptiness that never goes away after losing
15 a loved one to suicide.

16 This is a shared challenge. Nationwide suicide rates
17 are alarming, and we continue to observe heightened risk for
18 our young and enlisted servicemembers. My office, the
19 Defense Suicide Prevention Office, works to enhance
20 holistic, data-driven suicide prevention through non-
21 clinical policy oversight and engagement across populations
22 in our armed forces. DoD Health Affairs joins me today to
23 discuss their work with individual servicemembers in health
24 care settings, including clinical suicide prevention efforts
25 and mental health delivery.

1 Together we are committed to addressing suicide
2 comprehensive through a public health approach. We also
3 leverage best practices from the broader scientific
4 community, including the Centers for Disease Control and
5 Prevention, or CDC. We work closely with the military
6 services. Together we have developed a program evaluation
7 framework that aligns with the CDC's seven evidence-informed
8 strategies for suicide prevention, to track progress and
9 holistically measure our program effectiveness. We are also
10 taking action to ensure all service-level individual
11 programs are assessed for effectiveness, per GAO's
12 recommendation.

13 Last month, the Secretary of Defense directed the
14 creation of the Suicide Prevention and Response Independent
15 Review Committee to conduct a comprehensive review of the
16 Department's efforts to prevent suicide that will inform
17 long-term progress. He selected nine locations to increase
18 our understanding of the needs of servicemembers across
19 various geographies, including remote and OCONUS areas such
20 as Alaska, as well as across both our active and reserve
21 components. Likewise, we welcome forthcoming insights from
22 GAO regarding our remote and OCONUS communities.

23 DoD has many ongoing and new efforts underway,
24 including new research and several evidence-informed pilots
25 related to help-seeking, problem-solving, and means safety.

1 For example, we developed and piloted an interactive
2 training to address servicemembers' most common help-seeking
3 concerns and to encourage help-seeking early on using
4 resources before challenges become overwhelming. We are
5 currently expanding this training to ensure it meets the
6 needs of our remote and OCONUS servicemembers.

7 Our data tells us that suicide is often a sudden and
8 impulsive act, and that adding time and distance between an
9 individual with suicide risk and the lethal means can be
10 lifesaving. Our suite of evidence-informed tools reinforces
11 the positive impact of safely storing firearms and
12 medications. A concerted DoD-wide implementation of these
13 tools supplements our other efforts, such as training non-
14 medical providers about suicide risk and safe storage of
15 lethal means.

16 In closing, I thank you for your unwavering dedication
17 and support of the men, women, and their families who defend
18 our great nation. Efforts and insights from the SAS
19 Personnel Subcommittee, GAO, and the DoD IG have been
20 critical to our work. I fully recognize we have more work
21 to do, and I look forward to our discussion today.

22 [The prepared statement of Dr. Orvis follows:]

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1 Senator Gillibrand: Thank you, Dr. Orvis.

2 Now I would like to invite Dr. Mooney to give his
3 opening statement.

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1 STATEMENT OF RICHARD MOONEY, MD, ACTING DEPUTY
2 ASSISTANT SECRETARY OF DEFENSE FOR HEALTH SERVICES, POLICY,
3 AND OVERSIGHT, DEPARTMENT OF DEFENSE

4 Dr. Mooney: Chairwoman Gillibrand, Ranking Member
5 Tillis, members of the committee, good morning and thank you
6 for the opportunity to testify before you today.

7 First I would like to thank our GAO and DoD IG
8 colleagues for their ongoing work that fuels improvements
9 across the Department and larger government.

10 The bottom line is that every suicide is a tragedy that
11 weighs heavily on the Department of Defense and the broader
12 military community. Suicide rates among our servicemembers
13 and our military families are too high. Because DoD is
14 responsible for protecting our servicemembers, just as they
15 are responsible for defending our country, we must do
16 everything possible to prevent suicide in our military
17 community. We are doing this by encouraging help-seeking
18 behaviors, eliminating stigma, and enabling access to mental
19 health clinical services.

20 We are promoting the utilization of mental health
21 services even as we have a nationwide shortage of mental
22 health providers, which creates challenges in ensuring
23 access to care. The Defense Health Agency is working to
24 developing a staffing model to address these challenges in
25 order to provide timely mental health care with the goal of

1 treating 100 percent of active-duty servicemembers in the
2 direct care system.

3 To mitigate challenges in supply we continue to rely on
4 the civilian network, aiming to provide care within our
5 access to care standards. DoD also works to routinely
6 screen servicemembers for mental health concerns throughout
7 their service, from the first visit for new patients,
8 annually during the periodic health assessment, before and
9 after deployments, and prior to separation from military
10 services.

11 In terms of treatment, the DoD and VA co-developed
12 clinical practice guidelines to address suicide and
13 conditions that increase the risk of suicide, like PTSD,
14 traumatic brain injury, depression, and substance use
15 disorders. We know from research that suicide results from
16 a complex interaction of many factors so while there is no
17 single solution in suicide prevention the clinical practice
18 guidelines reduce unwanted variants in prevention and
19 treatment of those contemplating suicide.

20 While we remain vigilant in the effort to combat
21 stigma, data suggests we are trending in the right
22 direction. This is suggested by increasing demand for
23 mental health services, which indicates that servicemembers
24 feel less reluctant to get the help they need and deserve.
25 The American Psychological Association reports that

1 Generation Z, which represents our youngest and future
2 military force, views mental health differently from
3 previous generations. Generation Z is more open about their
4 mental health, more likely to report for mental health, and
5 more likely to seek mental health care. We must continue
6 our clinical and non-clinical stigma reduction efforts to
7 ensure this cultural shift continues and our servicemembers
8 are at ease in seeking mental health care.

9 We remain grateful for this committee's support for the
10 Department's suicide prevention efforts and the opportunity
11 to discuss the Department's clinically related suicide
12 prevention efforts today. We recognize we have more work to
13 do and much more progress to make to prevent this
14 devastating loss of life. Our efforts will continue to
15 address the many aspects of life that impact suicide, and we
16 are committing to addressing suicide through a comprehensive
17 public health approach.

18 Thank you.

19 [The prepared statement of Dr. Mooney follows:]
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1 Senator Gillibrand: Thank you.

2 I would now like to invite Mr. Roark for your opening
3 statement.

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1 STATEMENT OF MICHAEL ROARK, DEPUTY INSPECTOR GENERAL,
2 EVALUATIONS COMPONENT, DEPARTMENT OF DEFENSE

3 Mr. Roark: Good morning, Chairwoman Gillibrand,
4 Ranking Member Tillis, and distinguished members of the
5 subcommittee. Today I will discuss three reports: suicide
6 prevention for transitioning servicemembers, access to
7 mental health care, and the impact of the COVID-19 pandemic
8 on military treatment facilities.

9 First, I will discuss our November 2021, report on
10 suicide prevention for transitioning servicemembers. The
11 objective of this evaluation was to determine whether DoD
12 provided suicide prevention resources for transitioning
13 servicemembers as required by Executive Order 13822. Our
14 report found that the DoD did not consistently screen for
15 suicide risk or arrange for uninterrupted mental health care
16 for transitioning servicemembers as required by the
17 Executive order and DoD policy.

18 Specifically, the DoD did not establish and implement
19 oversight of mental health assessments and suicide risk
20 screening processes for transitioning servicemembers.
21 Additionally, DoD Instruction 6490.10 lacks a clear
22 definition of a warm handoff, provider training tools,
23 standardized documentation methods, and oversight procedures
24 to ensure compliance.

25 These challenges occurred because the Defense Health

1 Agency and the military services did not include a mental
2 health assessment and suicide risk screening as part of the
3 separation history physical exam, which is the medical exam
4 required to be administered to transitioning servicemembers.
5 Additionally, the DoD and the military services relied on
6 expired policy to govern suicide risk screening and referral
7 processes. The inability to identify suicide risk and
8 arrange for uninterrupted mental health care in
9 transitioning servicemembers may result in a lack of mental
10 health care, thus jeopardizing patient safety.

11 We made five recommends to address the deficiencies we
12 identified. We recommended that the DoD establish
13 consistent policies and procedures to manage suicide risk
14 screening and referral as part of the medical process for
15 transitioning servicemembers. We recommended that the DHA
16 identify the causes for breaks in arranging for continuous
17 mental health care for servicemembers who are transitioning
18 from the MHS to the VHA. We also recommended that the DoD
19 create and implement solutions to increase the number of
20 servicemembers who have continuous care arranged between the
21 MHS and the VHA at the time of transition.

22 Second, I will discuss our August 2020 report on access
23 to mental health care. We determined that the DoD did not
24 consistently meet outpatient mental health access to care
25 standards for active-duty servicemembers and their families.

1 Specifically, from December 2018 to June 2019, we found that
2 7 of the 13 MTFs we visited in the direct care system and
3 their supporting TRICARE network in the purchased care
4 system did not meet the specialty mental health access to
5 care standard each month, and an average of 53 percent of
6 all active-duty servicemembers and their families identified
7 as needing mental health care and referred to the purchased
8 care system did not receive care.

9 These challenges occurred because the DHA lacked an
10 MHS-wide model to identify appropriate levels of staffing in
11 direct care and purchased care, and published inconsistent
12 policies on access to mental health care. In addition, the
13 DHA did not have visibility over patients who attempted but
14 were unable to obtain mental health appointments in the
15 purchased care system and measured the 28-day specialty
16 access to care standard differently between the direct and
17 purchased care systems. As a result, thousands of active-
18 duty servicemembers and their families may have experienced
19 delays in obtaining mental health care.

20 We made 14 recommendations to the Assistant Secretary
21 of Defense for Health Affairs and to the DHA to improve
22 access to mental health care in the DoD.

23 Finally, for our third report, which we issued
24 yesterday, on April 5th, we issued this report discussing
25 the challenges that are facing MTFs at this stage in the

1 COVID-19 pandemic. Although this report focused on a wide
2 variety of challenges that the MTFs are facing, we asked
3 senior leadership at 30 MTFs, "What is the most serious
4 concern that might be encountered in the future by medical
5 personnel working at your MTF during the COVID-19 pandemic?"

6 Officials from 25 of the 30 MTFs discussed burnout of
7 medical personnel as a serious challenge. However,
8 officials from 11 of the 30 MTFs stated that staff burnout
9 and fatigue was the most serious concern that might be
10 encountered in the future. MTF officials told us that
11 burnout has caused some staff to quit, further exacerbating
12 staff shortages. In addition, MTF officials stated that
13 burnout has adversely affected staff members' psychological
14 health and caused them to use emergency mental health
15 services for their own behavioral health challenges.

16 This concludes my statement and I would be happy to
17 answer any questions you may have.

18 [The prepared statement of Mr. Roark follows:]
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1 Senator Gillibrand: Thank you.

2 I would now like to invite Ms. Farrell to give her
3 opening remarks.

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1 STATEMENT OF BRENDA FARRELL, DIRECTOR, DEFENSE
2 CAPABILITIES AND MANAGEMENT, GOVERNMENT ACCOUNTABILITY
3 OFFICE

4 Ms. Farrell: Chairwoman Gillibrand, Ranking Member
5 Tillis, and members of the subcommittee, thank you for the
6 opportunity to be here today to discuss our most recent work
7 related to suicide incidence at remote installations outside
8 the contiguous United States, OCONUS.

9 Suicide deaths and attempts within the military are
10 devastating events for families. They can also harm unit
11 morale, esprit de corps, and readiness, and increase the
12 risk for suicide among affected servicemembers and their
13 families. Remote OCONUS installations may pose challenges
14 that increase suicide risks. GAO's prior work found that
15 DoD's effort to prevent and respond to suicide deaths and
16 attempts have encountered challenges. Our prior work
17 addressed DoD mental stigma reduction efforts, effectiveness
18 of non-clinical prevention methods, inconsistent use of
19 suicide-related terms.

20 The NDAA for fiscal year 2021 included a provision for
21 us to review suicide prevention efforts at remote OCONUS
22 installations. My statement today is based on our work
23 being conducted in response to that statutory mandate. Now
24 I will briefly highlight four areas in my written statement.

25 First, my statement addresses what is known about the

1 incidence of suicide and related risk factors among
2 servicemembers at remote OCONUS installations. Our
3 preliminary analysis suggested that remote OCONUS
4 installations accounted for a slightly higher proportion for
5 suicide attempts but a lower proportion of suicide deaths
6 relative to the proportion of servicemembers assigned to
7 these locations during 2016 through 2020.

8 DoD officials told us that the extent of suicide deaths
9 at OCONUS installations may be lower because servicemembers
10 assigned to installations outside the U.S. have limited
11 access to non-military-issued firearms. We found that non-
12 military-issued firearms were involved in over half of
13 reported suicide deaths among members assigned to CONUS
14 installations and were involved in slightly over a quarter
15 or fewer among members assigned to OCONUS installations.

16 Separately, DoD service and installation officials we
17 interviewed identified risk factors for suicide and related
18 challenges that may be more pronounced at remote OCONUS
19 installation, such as less access to mental health services,
20 increased social isolation, and extreme weather conditions.
21 DoD does not have a process to assess suicide risk at these
22 installations. Establishing such as process could enhance
23 related suicide prevention efforts.

24 Second, we found that gaps exist in implementing some
25 prevention policies, programs, and activities for those

1 assigned to remote OCONUS installations. For example, three
2 services have not ensured implementation of some prevention
3 activities such as establishing required prevention teams at
4 installations. These services do not have mechanisms to
5 help ensure implementation. By establishing oversight
6 mechanisms these services may have greater assurance that
7 such activities are implemented across all installations,
8 including OCONUS installations.

9 Third, we also found that DoD has experienced staffing
10 shortages, as noted earlier today, for behavioral health
11 personnel, in part because it has not developed a strategy
12 to address hiring challenges. By developing such a
13 strategy, DoD may be able to enhance the provision of
14 behavioral health care to servicemembers and their
15 dependents.

16 Last, DoD has established some suicide response
17 guidance and training for key personnel but gaps exist. For
18 example, DoD has not established statutorily required
19 training for commanders on responding to suicide deaths and
20 attempts. By establishing such training for commanders, DoD
21 can better ensure that commanders are prepared to provide
22 support to suicide attempt survivors and the bereaved.

23 In summary, on March 1, 2022, we provided DoD with a
24 copy of our draft report along with the recommendations. We
25 will complete the work as soon as we receive DoD's review

1 and comment of that draft report.

2 Madam Chairwoman, I am pleased to take questions when
3 you are ready.

4 [The prepared statement of Ms. Farrell follows:]

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1 Senator Gillibrand: Thank you very much for your
2 testimony. Very challenging and difficult issues, and I
3 appreciate the expertise that you have developed.

4 I want to first talk about the lack of access to care.
5 Dr. Mooney, in 2020, the DoD inspector general found that as
6 a result of delays in required mental health care access for
7 active-duty servicemembers and their families numerous
8 members were not able to see the right provider at the right
9 time, obtain mental health care, or receive timely follow-up
10 treatment.

11 What steps is the Department taking to address these
12 barriers accessing needed care, and second, related, how
13 does the DoD track the time between the patient request or
14 referral for mental health care to the time of the mental
15 health assessment? Have you seen long waits, and what steps
16 are you taking to improve that?

17 Dr. Mooney: Yes, ma'am. Thank you. So to your first
18 question on access to care and how we are approaching that,
19 you know, we have a nationwide shortage of behavioral health
20 providers, as has been mentioned in this hearing already,
21 and so to that end we have worked to build a staffing model
22 that will match supply with demand by provider type, and the
23 goal will be 100 percent of active-duty servicemembers in
24 the direct care system being seen on base. And that
25 staffing model we anticipate to pilot this fall, and it will

1 impact 100,000 beneficiaries.

2 With regard to making sure the provider type is matched
3 with the patient, active review and management of
4 appointment schedules, 24 to 72 hours before each
5 appointment to ensure the right patient with the right
6 appointment and the right provider. To increase access to
7 care we are also adding extenders -- PAs, nurse
8 practitioners, licensed mental health counselors -- and also
9 entertaining adding new provider types, credentialing new
10 provider types to include licensed professional counselors
11 and licensed family and marriage therapists.

12 Additionally to increase access to care we are doing a
13 massive expansion of telehealth. That is one of the top
14 priorities for the Defense Health Agency. Our SMEs suggest
15 that between 50 to 75 percent of behavioral health
16 conditions can be treated virtually, depending on acuity.
17 That would free up time to manage more severe cases in
18 person. This expansion will add 63,500 virtual appointments
19 by the fall of 2022. Those are central appointments that
20 can be used worldwide.

21 So with regard to access and how that is measured, for
22 a given clinic your access to care, basically in the system
23 there is an appointment-made date and an appointment-seen
24 date, and that, across the clinic for that particular month
25 or period of time you are looking at, that average for all

1 patients seen there becomes your access to care. The
2 standard for access to care for a routine appointment in
3 behavioral health is 28 days. That means routine. If you
4 have an acute issue you can go and are seen earlier.
5 Usually acutes are within 24 hours. They can be seen in the
6 clinics or in the hospital, in the emergency department. So
7 we want to make sure we have that distinction between a 24-
8 hour acute type of visit versus a routine visit.

9 Senator Gillibrand: That still seems very long.

10 You mentioned in the testimony, several of you, about
11 staff shortages. Dr. Orvis, you can start. There has been
12 a great deal of reporting lately on staff shortages of
13 mental health professionals, specifically on and around
14 military bases. What are the biggest challenges military
15 installations are reporting in ensuring access to adequate
16 treatment in a timely manner, and what steps is DoD taking
17 to increase the number of mental health professionals
18 available to provide supports to servicemembers and their
19 family members?

20 Dr. Orvis: Certainly. I would want to defer to my
21 colleague, Dr. Mooney, in terms of mental health
22 professionals because that falls in the purview of Health
23 Affairs. But what I can offer in terms of non-medical
24 providers, we have other help-seeking resources for our
25 servicemembers, and so we are really looking not only in

1 terms of behavioral health professionals but encouraging our
2 servicemembers and our family members to seek out help when
3 they need it, from a resource that is right for them. It
4 may be a behavioral health provider. It may be a chaplain.
5 It may be a military one-source counselor or a military
6 family life counselor, or even Veterans and Military Crisis
7 line.

8 And I will just give one example within that, or an
9 external provider as well. Give an Hour is just one example
10 but we have many wonderful partners in the community that
11 would be potentially a great resource as well.

12 Within the military community and non-medical
13 providers, military family life counselors are available on
14 installations, and they are also available for surges. So
15 if there are particular locations that need additional
16 support, maybe after a loss of a servicemember due to a
17 suicide, additional personnel can also be brought into that
18 unit or to that installation to provide further support.

19 And I will defer to Dr. Mooney for mental health.

20 Dr. Mooney: Yes, ma'am. Thank you. With regard to
21 our ability to recruit and retain, there are pay
22 flexibilities in the 2021 NDAA that have increased special
23 and incentive pays for our uniformed servicemembers, and DHA
24 is working with the military departments to understand how
25 that is impacting the ability to retain that talent, and it

1 will adjust as indicated.

2 With regard to being able to hire civilian providers,
3 behavioral health providers, there are some Title 5 pay caps
4 that maybe a way to be more competitive with some of the
5 civilian counterparts. Some of these areas where you have a
6 significant shortage you have a difficult time competing
7 with the civilian sector's ability to pay salaries to
8 behavioral health providers.

9 Senator Gillibrand: Thank you. Senator Tillis.

10 Senator Tillis: Thank you, Senator Gillibrand. Again,
11 thank you all for being here.

12 Dr. Mooney -- and Mr. Roark, you may want to contribute
13 to this -- I know that with our response to the pandemic we
14 saw medical professionals deployed out of the DoD into the
15 civilians sector to help marshal resources for the pandemic.
16 To what extent did that affect the provider population
17 within the DoD?

18 Dr. Mooney: So with the provider teams that were
19 deployed, that segment of our population that was deployed
20 were more acute care, you know, your pulmonary, critical
21 care specialty, that sort of group. So with regard to
22 behavioral health, I am not sure there was as much of an
23 impact there on staffing. But I think that we are all
24 concerned -- I have read the recent IG report on the impact
25 of pandemic on the services --

1 Senator Tillis: Certainly increased caseload.

2 Dr. Mooney: Yes, sir. Yes, sir. And also it led to a
3 referral to our purchased care network, because just as in
4 wartime when your staff deploys, similarly here when the
5 staff deployed to support our civilian hospitals, the
6 TRICARE network was our relief valve.

7 Senator Tillis: I wanted to talk about, particularly
8 when people experience profound behavioral health challenges
9 maybe for the first time in their life, and you are not able
10 to provide care within the DoD, and you provide a referral,
11 I worry that without a warm handoff -- I want to talk a
12 little bit about the warm handoff to TRICARE. Give me a
13 sense of what we can do better to make sure that when
14 someone gets a referral they actually get the care. Because
15 in my research on this, if you do not have family members or
16 caregivers or other people engaged in that, or the DoD
17 engaged in that, and to know that after a referral is made
18 that they have actually sought the care, how are we doing a
19 better job to make sure that referral has resulted in a
20 positive outcome in terms of getting the care that they have
21 been referred for?

22 Dr. Mooney: Sure. No, that is a great question. I
23 think that stepping back, with regard to mental health
24 assessments and the warm handoff, we are working a directive
25 type memorandum that will implement a one-separation health

1 assessment between the DoD and VA. With that directive type
2 memorandum, which will be placed in policy, the 6490.10 that
3 he mentioned, this will ensure the warm handoff. This will
4 connect through the in-transition program to the VA. It
5 also will ensure a mental health screen occurs, and there
6 are flow diagrams in this policy that give instructions to
7 the providers on what to do -- if-then statements -- what to
8 do with the results you have and how you ensure proper care
9 and handoff in the transition process.

10 Senator Tillis: Mr. Roark, do you have anything to add
11 to that?

12 Mr. Roark: Yes. As Dr. Mooney said, there is a role
13 for the servicemembers to play in making sure that their
14 care continues as they transition. However, we have tried
15 to recommend solutions to the Department of ways that we
16 could make that as user friendly as possible. And so we
17 have been working with Dr. Mooney and his staff to determine
18 how quickly the implementations that we recommended in our
19 report are being implemented, and I think that the steps
20 that he discussed are the major improvements that we are
21 following, in terms of things that could be done better in
22 the future.

23 Senator Tillis: Yeah. You know, I agree that there is
24 a role the servicemember has to play, but you also have to
25 understand the conditions that they are operating in. And

1 if we do not have a greater touch on that, you know, it is
2 my understanding, at least in the literature that I have
3 read, that when you first experience it you may not be
4 behaving rationally to begin with, and now you are asking
5 them to take an added step to get care, which can, by
6 itself, be traumatizing. So it is one thing to expect them
7 to get that care and it is another thing to see whether or
8 not they will follow through with their responsibilities.

9 And I do have some questions for a second round, but
10 Madam Chair, I will defer for now.

11 Senator Gillibrand: Senator Tuberville.

12 Senator Tuberville: Thank you very much. Thank you
13 for being here today on such an important and progressing
14 problem that we have.

15 I am on the VA Committee, and I have been pushing some
16 non-traditional types of therapy. In my former life of
17 being a football coach I had a lot of brain injuries, and we
18 were fairly successful using hyperbaric therapy with a lot
19 of our football players. I have seen enough of physical
20 drugs in my lifetime to try to cure a lot of these problems
21 that we are having. Sometimes it works; more than not it
22 does not.

23 Dr. Mooney, what do you think about non-traditional
24 therapies such as hyperbaric therapy, through the DoD?

25 Dr. Mooney: Sure. I think that, you know, anything

1 that we do system-wide we need to study and evaluate and
2 understand the impact. And I have had several cases myself,
3 from traumatic brain injury, hyperbaric seemed to make a
4 difference. But I think more study needs to take place
5 before that can be endorsed more broadly.

6 But no, I am in favor of any of the innovative
7 approaches. I mean, it is a matter of understanding if
8 there are other unintended outcomes from those approaches.
9 So it is the systematic evaluation and then the rollout.

10 Senator Tuberville: Anybody else have any thoughts
11 about non-traditional therapy? Anybody.

12 Do you collaborate with the VA on things like this?

13 Dr. Mooney: Yes, sir. We have an entire organization,
14 the Health Executive Committee, that works with the VA. I
15 am the business line lead for three of the business lines,
16 so there is a lot of work underway collaboratively.

17 Senator Tuberville: Thank you. Dr. Orvis, University
18 of Alabama is currently conducting a study titled "Operation
19 Deep Dive" to review state death data, cross-reference it
20 against the DoD military service and the VA. I would like
21 to thank you for your involvement in this study and for the
22 wisdom that you share with the students in Alabama. Thank
23 you very much that.

24 Preliminary data from Operational Deep Dive is showing
25 that members of the National Guard have 10 percent higher

1 suicide rate, and reservists 45 percent higher suicide rate
2 than their active-duty counterparts. What insight can you
3 share with us on these findings of Operation Deep Dive?

4 Dr. Orvis: I appreciate the question and I appreciate
5 the work that is going on. A really important study. This
6 and other research, of course, that goes on helps us. It
7 helps us uncover gaps that we may not be aware of or new
8 pieces of information that add to our puzzle and help us
9 identify what do we need to do differently to make a
10 difference. So I very much appreciate the work that is
11 going on.

12 You know, when we are looking at our Reserve component
13 members, our National Guard members and Reserve members, we
14 really have been looking to understand why there may be
15 differences and it may be different compared to active
16 component servicemembers. And certainly even in terms of
17 thinking about the timing or the manner of death, for our
18 active component servicemembers they are on active duty at
19 the time. For our National Guard and Reserve members, the
20 majority of individuals are dying by suicide when they are
21 on non-active-duty status, about 75 percent both in the
22 Reserve and the National Guard, and we see that pretty
23 consistently.

24 So we know it is perhaps even more complicated for our
25 National Guard and Reserve members, two lives that they are

1 traversing, their military life and their civilian life, and
2 the military role and their civilian job. But we also know
3 that there are commonalities across our servicemembers and
4 across individuals throughout the U.S. in terms of causes of
5 suicide. We know financial challenges, when coupled with
6 other things, can influence risk for suicide.

7 Do we have a protective environment for the
8 individuals? We are really focused in at the DoD,
9 particularly right now, on safe storage of lethal means --
10 firearms, medications, other lethal means. And data from
11 our broader U.S. populations, of our U.S. civilians, does
12 indicate that there are certain regions within the U.S. that
13 have higher access to personal firearms, other lethal means,
14 and that may also be a contributing factor.

15 Senator Tuberville: It has got to be a pretty good
16 shock to be a National Guardist or reservist. One day you
17 have got a job and the next day you are in harm's way, and
18 on their family too. So thank you for that.

19 I have got a couple more questions. I will wait on the
20 second round.

21 Senator Gillibrand: Thank you. I want to talk a
22 little bit about reducing stigma. You mentioned in some of
23 your opening statements. [Inaudible] servicemembers to
24 speak up confidentially and if needed outside the chain of
25 command.

1 Dr. Orvis and Dr. Mooney, can you talk about DoD's
2 planned implementation of that policy and what, if any,
3 impact you have seen or expect to see in assuring needed
4 treatment is sought out. And Ms. Farrell, in the 2016 GAO
5 report, what additional actions were needed to enhance DoD's
6 efforts to address mental health care stigma. Has anything
7 been done to de-stigmatize mental health care treatment
8 since that time, and what additional steps would you
9 recommend?

10 Dr. Mooney: Yes, ma'am. So the Brandon Act, Section
11 704 of NDAA 2022 will make a big difference, I believe, in
12 reducing stigma and enabling our servicemembers to feel
13 comfortable in discussing and triggering a referral with
14 their commander to get medical care.

15 We are in the midst of socializing the directive type
16 memorandum that will launch this program, and we
17 anticipating that directive type memorandum into
18 coordination in May of 2022. And the current medical
19 policies covering referrals include DoD 6490.08, command
20 notification requirements to dispel stigma and providing
21 mental health care to servicemembers, and 6490.04, mental
22 health evaluations of members in military operations.

23 Senator Gillibrand: Dr. Orvis?

24 Dr. Orvis: Yes. We are in support of Health Affairs
25 in terms of their implementation of this important new

1 provision. As I mentioned before, we are really looking to
2 identify how can we encourage, in any way, help-seeking and
3 to reduce the stigma that we know is associated with seeking
4 help, whether it is mental health care or other types of
5 help-seeking, not only in the military but also more
6 broadly.

7 I would just offer, as a few other things that we are
8 doing which is outside of this provision. From the highest
9 levels of our leadership, from Secretary Austin to Deputy
10 Hicks, we are really trying to look at different ways in
11 which to help to reduce the stigma among our servicemembers
12 and families. You had referenced outreach and efforts that
13 we are doing and ramping those up, and most certainly we
14 are.

15 We also, recently Deputy Hicks directed a stand-up of a
16 new interdisciplinary working group that is an intersection
17 of suicide, mental health, and the intelligence and security
18 expertise within the Department. We know that our
19 servicemembers have concerns about career impacts associated
20 with help-seeking, and we know that -- and this is very
21 complex -- there is data that suggests that at least in
22 terms of security clearances, for instance, that really is a
23 very small, less than 1 percent, likelihood that someone
24 seeking mental health treatment that it would have an impact
25 on their security clearance. But yet that kind of

1 misconception exists, so how do we get after that, and how
2 do we understand the various assignments or deployment
3 requirements that might be associated with mental health and
4 concerns about not seeking help because of impacts on
5 assignments that an individual might have.

6 So there is a new working group that was just recently
7 stood up that is really looking at this, making
8 recommendations of what do we need to do in terms of
9 changing policy and/or changing training for commanders for
10 the workforce, for our servicemembers and family members, to
11 get after that one piece of stigma of the larger stigma
12 puzzle.

13 Senator Gillibrand: Ms. Farrell?

14 Ms. Farrell: Thank you for mentioning the 2016 GAO
15 report. I am happy to say that all of the seven
16 recommendations in that report have been implemented as of
17 last year. It is hard to believe but in 2016 there was not
18 a consistent definition of what are these barriers that
19 prevent people from seeking health care that is generally
20 referred to as stigma. So that was a huge step for DoD to
21 look at those barriers and define them.

22 They have done other actions such as destigmatizing
23 policies -- one was mentioned about security clearances --
24 that the policies could have wording that could also present
25 barriers. So they revisited those policies and taken

1 action. They have established a coordinating entity to
2 collaborate with others and oversee the destigmatizing
3 efforts. They are now in a good place in terms of
4 establishing goals and measures, which we know they have
5 done, to actually measure the effect of their efforts to
6 address stigma. So that will be the next focus, is to look
7 at what they are doing and see what is working and what is
8 not working, and refocus if necessary.

9 Senator Gillibrand: Thank you. Senator Tillis.

10 Senator Tillis: Thank you, Senator Gillibrand. Dr.
11 Orvis, the Suicide Prevention and Response Independent
12 Review Committee is going to focus on nine military
13 installations as a part of the process. Can you give me an
14 idea of how they went about choosing the nine military
15 installations that would be a part of the review?

16 Dr. Orvis: Sure. Absolutely. The nine locations were
17 selected using data-driven methodology, which I can speak a
18 little bit more, and we also ensured that we coordinated
19 with the military departments to gather their insights as
20 well.

21 We wanted to make sure that -- and per the Secretary's
22 direction -- that we were addressing various needs of our
23 servicemembers, so looking at various geographies, to
24 include remote and OCONUS areas. In terms of the data-
25 driven methodology, we looked at both suicide data as well

1 as command climate data to identify installations that were
2 higher in terms of risk factors for suicide and lower in
3 terms of protective factors. And so that drove the
4 recommendations for those nine installations, as well as we
5 wanted to ensure that we were representing all of the
6 military departments and representing both active and
7 reserve components of our servicemembers.

8 Senator Tillis: Your comment about command climate,
9 when was the last time, if ever, that we have done a command
10 climate survey on issues related to eliminating the stigma,
11 of providing more access to care? Has that ever occurred?
12 What made me think about it is we just recently were briefed
13 on military sexual assault command climate survey. There
14 were a lot of action items coming out of that, and it would
15 just seem to me that this would be a natural part of
16 building on the recommendations from the GAO report. And I
17 was just curious, has that been done before?

18 Dr. Orvis: I would have to take for the record if that
19 occurred and when those particular items might have been
20 included in a systematic way. Within the current redesigned
21 command climate survey it is looking at various risk and
22 protective factors that contribute to healthy and unhealthy
23 climates. And then there is also an opportunity within the
24 survey to be able to have commanders ask specific questions
25 that they are interested in being able to gather more

1 information on. So that may have occurred in individual
2 surveys for particular commanders.

3 What I would also offer is we have the status of forces
4 survey that is an annual survey, and consistent items within
5 that status of forces each year is asking about barriers to
6 care, stigma. So we do have robust data from our
7 servicemembers in understanding their perceptions on what is
8 holding them back from seeking care, if they would seek care
9 who would they be willing to -- you know, which source would
10 they be willing to seek out care from.

11 Senator Tillis: Well thank you for that. I think it
12 would be helpful. One of the findings that I took away in
13 the review for military sexual assault is it tends to have
14 more to do with the climate created by current command
15 rather than a continuity of culture, and we have got to get
16 that cultural foundation in place.

17 Before I go to Dr. Mooney, Mr. Roark, you had talked
18 about some of the challenges have to do with transition and
19 post-transition stickiness. I feel like this is an area
20 where we have so much work to do in our Transition
21 Assistance Program, and making sure that is not just being
22 well-informed when someone is transitioning. But it is very
23 similar to what I was talking about with the warm handoff
24 for referrals. When we know that there is a serious or
25 potentially serious challenge out there we have to do a

1 better job, on an interagency basis, of tracking and
2 determining whether or not they are actually getting care
3 that we suspect that they need at the point of transition.

4 Did your report point out any recommendations or
5 actions that the Department should take?

6 Mr. Roark: Yes, and an important point about our
7 suicide prevention report was that we developed the concept
8 for that evaluation in concert with the Veterans Affairs
9 OIG. And so working collaboratively we determined that
10 transition period, one year prior to transition and then
11 one-year post-transition, is such a critical time for
12 suicide and mental health continuity of care and suicide
13 prevention. So that was kind of the overall umbrella under
14 which this work was done by our agency.

15 Two points that we mentioned in our report, which I
16 think are really important, are the mental health screening
17 that was required by the Executive order. In 2020, only 34
18 percent of transitioning servicemembers received that. And
19 then secondarily, on the separation health, physical exam,
20 only about 70 percent in 2020 completed that exam. So in
21 terms of items that would put the VA in the best possible
22 position, if the DoD can --

23 Senator Tillis: They do not know what they do not
24 know.

25 Mr. Roark: Exactly. If the DoD can put both the

1 servicemember and the VA in kind of the best possible
2 situation as they leave the Department, then that is the
3 goal. And we made recommendations to the Department, and
4 that is what Dr. Mooney was discussing earlier, in terms of
5 some of the changes that they have in the works to try to
6 improve that.

7 Dr. Mooney: Yes, sir. The one Separation Health
8 Assessment between the DoD-VA has a lot of protections. It
9 ensures understanding of the requirement for the behavioral
10 health evaluation. It also has a linkage to the in-
11 transition program so that the warm handoff can occur to
12 ensure care.

13 One piece, though, is that not every servicemember who
14 retires or separates seeks care at the VA. They go off to
15 other providers. So that is another area for concern and
16 for work.

17 Senator Tillis: Thank you.

18 Senator Gillibrand: Senator Tuberville.

19 Senator Tuberville: I am just curious, and there might
20 not have been enough time. But has there been an uptick in
21 suicides since the fall of Afghanistan last August? Does
22 anybody have any data on that?

23 Dr. Orvis: Thus far our data does not support that,
24 but we are looking to see what may occur. I am working
25 closely with the Department of Veterans Affairs as well, as

1 it may be impacting our veterans.

2 Senator Tuberville: Okay. Thank you.

3 You know, our military is a tool of national power and
4 we, as lawmakers, sometimes have the ability to send people
5 in harm's way. What resources does the DoD, Dr. Mooney,
6 make known and available to the servicemembers, to their
7 families, and their friends, you know, marriage counseling?
8 Is there anything that we offer to our men and women? Or
9 anybody can answer this. I am just looking for answers.

10 Dr. Mooney: Sure. Most of that is probably in Karen's
11 lane, but I can tell you, as a person who has deployed in
12 the past there are deployment lines, there are chaplains,
13 there are other folks there that coordinate and provide
14 resources for the servicemember and for the family.

15 Senator Tuberville: Okay. Thank you. Anybody else?

16 Dr. Orvis: Sure. I will add to that as well.
17 Absolutely, both in terms of our servicemembers and family
18 members. We have a host of resources in terms of helping
19 with kind of everyday life and life challenges, so have
20 strong financial supports in terms of not only financial
21 education across the military lifecycle but also free
22 resources available both on installation and virtually,
23 online, for assisting with financial health and challenges.

24 We also have, as I had mentioned earlier, Military
25 OneSource and the military family life counselors. They are

1 really designed to be able to help with those everyday life
2 challenges as well. It could be finances. It could be
3 relationship challenges, whether that is in significant
4 partner relationships, parenting challenges. They support
5 with relocation or with deployment challenges and
6 reintegration challenges coming back, and offer free
7 resources to our servicemembers there.

8 And then, of course, there are community resources
9 available as well that we have partnerships with, just as a
10 few examples.

11 Senator Tuberville: Ms. Farrell, do you have anything
12 to add to that?

13 Ms. Farrell: I do. Thank you. There is no doubt that
14 DoD has a management framework in place that is very
15 comprehensive, with a governance structure, part of the
16 governance structure sitting at this table as well as
17 collecting the relevant data and assessing it and putting
18 forth strategies.

19 But our work looking at remote OCONUS locations found
20 that sometimes the implementation was not what it should be,
21 and there were gaps in the policies and the programs and the
22 activities at those remote OCONUS locations. I do not know
23 about all the CONUS locations, but, you know, it comes down
24 to actually having the boots on the ground implementing
25 those activities that are prevention activities or specific

1 key personnel that should be assigned at those locations
2 that coordinate the clinical and the non-clinical, for
3 example. So that is an area that we have made
4 recommendations for DoD to oversight mechanisms in place,
5 among other things.

6 Senator Tuberville: Thank you. Thank you, Madam
7 Chair.

8 Senator Gillibrand: Mr. Roark.

9 Mr. Roark: Yes. So in our suicide prevention report
10 we did identify and review some of the programs that are
11 available to some individuals who are transitioning, such as
12 members who have a disability and are going through the
13 board process to be separated from the military. Also the
14 in-transition program for folks that have prior mental
15 health care in the last year.

16 However, although there were good things occurring in
17 those particular programs, the overall population of active-
18 duty servicemembers transitioning was at least 160,000 per
19 year. So although there are some programs that are
20 effective in certain populations, it is important to think
21 about the larger population as well, and to make sure that
22 some of those lessons learned can be spread to the larger
23 population.

24 Senator Gillibrand: Any other recommendations that the
25 panel would like to give before we close out the panel, on

1 any questions that have been asked so far?

2 Senator Tillis: Madam Chair, before we close. I mean,
3 there is no question in my mind that the DoD would like to
4 end suicide. We have challenges. The OIG has pointed out
5 some. The GAO has made recommendations. What would be very
6 helpful for this committee is the extent to which, as we
7 move into the NDA, any authorities or focus that we should
8 place on this to give you more enablers to do the job I know
9 you want to do.

10 And then I do have several questions for the record
11 that I would appreciate your attention to.

12 Senator Gillibrand: And please be specific in your
13 recommendations. I mean, we have heard a lot of challenges
14 -- not enough staff, not enough staff where they are needed,
15 very long wait times. Having a normal wait time of 28 days
16 is fine if you are not in trauma or in distress, but if
17 these individuals cannot self-identify that then it is a
18 failure. They need that intervention.

19 So please take the time to make specific
20 recommendations for money that you need, personnel that you
21 need, support for programs that already exist, additional
22 research. Whatever it is, I would like a direct
23 recommendation of things you would like in this year's NDAA
24 to address the problems that we still have. Given all the
25 good work that we have already done, given all the things we

1 have put in place, we need direct recommendations and
2 requests to guide us in writing this personnel markup. So
3 thank you.

4 Any other questions from the Senators?

5 Thank you very much.

6 [Pause.]

7 Senator Gillibrand: While the next panel gets settled
8 I will just introduce everyone. We will have Dr. Beth
9 Zimmer Carter joining us, as well as Mr. Chris Ford, Chief
10 Executive Officer, Stop Soldier Suicide; Dr. P. Murali
11 Doraiswamy, Professor of Psychiatry and Medicine, Duke
12 University School of Medicine; Dr. Craig J. Bryan, Director,
13 Division of Recovery and Resilience and Science Prevention
14 Program, the Ohio State University College of Medicine.

15 So we would like to hear first from Dr. Carter.

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1 STATEMENT OF DR. BETH ZIMMER CARTER

2 Dr. Carter: Chairwoman Gillibrand, Ranking Member
3 Tillis, and distinguished subcommittee members, thank you
4 for this opportunity to testify.

5 I am Dr. Beth Zimmer Carter, and I come to you with a
6 unique perspective. I am a family physician, retired Army
7 lieutenant colonel with command experience, and proud mother
8 of Special Forces Army Ranger Christopher Carter, who died
9 by suicide at age 22.

10 Chris, my only child, was vivacious, bright, funny,
11 handsome, and fulfilled his lifelong dream of being an Army
12 Ranger. He was well-liked, well-decorated, and deployed
13 four times to Afghanistan with almost 100 Special Operations
14 missions. On his first deployment, he witnessed the
15 grotesque deaths of his buddy, his interpreter, and a female
16 Special Forces member. Chris sustained two close-range
17 concussive blasts in that encounter, as well as numerous
18 training blast exposures.

19 During his transition period at the end of his Army
20 commitment Chris was self-medicating with marijuana, legal
21 in his state, to control anxiety and insomnia after medical
22 and mental health treatments failed. He self-admitted this
23 to his new command, who later stated to me they "felt the
24 need to make an example of Chris," as he was in a leadership
25 position, and many others in the unit were also using

1 marijuana. He was demoted, sacrificed a month's pay, made
2 to do humiliating work, confined to the compound, and they
3 initiated "other-than honorable" discharge proceedings.
4 Chris was already anxious, dealing with PTSD symptoms, and
5 now humiliated and devastated. He attempted suicide for the
6 first time.

7 My husband and I flew across the country to confer with
8 Chris' battalion commander. Despite a commendable record,
9 we were told to our face that they "really didn't believe
10 Chris was suicidal" and thought he was just trying to get
11 out of his disciplinary proceedings. Even after a
12 hospitalization for the suicide attempt, they resumed
13 restrictions, prohibiting him from leaving the compound,
14 forbid any socialization, canceled his Christmas leave, and
15 continued discharge proceedings. Chris was required to re-
16 enlist for another year as there was a several-months wait
17 for his medical board determination. He was isolated in the
18 supply room, cleaned latrines, and called "pot-head."
19 Unbelievably, they did all of this just after losing another
20 battalion member to suicide.

21 The morning of his death, I knew Chris was severely
22 struggling while on duty, and I attempted to contact his
23 superiors to notify them and request their assistance. Even
24 though I am a retired Army commander, I was told, "The
25 command speaks to soldiers, not moms." Chris proved his

1 suicide sincerity that afternoon on Feb 12, 2015. We buried
2 him on his 23rd birthday.

3 There were multiple opportunities for the military to
4 recognize the risks and invoke alternate lifesaving
5 approaches, as Chris had several blast concussive exposures
6 known to cause traumatic brain injury; been diagnosed with
7 multiple high-risk mental health conditions; felt trapped
8 and hopeless, having to re-enlist in another year in a toxic
9 environment; had humiliation, financial consequences, and
10 legal ramifications due to his help-seeking, self-
11 acknowledgement of his marijuana use; survivor guilt after
12 losing his buddy and teammates; and recent exposure to the
13 suicide of someone he identified. Instead, many of the
14 military's actions are known to increase suicidal risks.

15 Commanders need to courage, support, and reward self-
16 help. Those that stigmatize, isolate, and punish should be
17 held accountable; require mandatory group or personal mental
18 health intervention after a traumatic event, especially one
19 with personnel loss; embed mental health providers in units,
20 to normalize mental health and ease of access, just as with
21 physical health medics and sick bays. Commanders need to
22 communicate to distant-dwelling families how to enlist
23 support when concerned.

24 Military medicine should get upstream in prevention.
25 Require mandatory annual mental check-ups just like physical

1 check-ups; better recognize symptoms and use evidence-based
2 treatments for PTSD and suicide care; improve substance
3 abuse treatment options; expedite the Medical Board process,
4 to a 30-day maximum wait.

5 Military institutions must destigmatize, normalize, and
6 improve access to and use of mental health care; avoid
7 compromising careers for those seeking help; ensure eligible
8 service members are referred to the Warrior Care Programs;
9 continue investigating TBI blast exposure risks and improve
10 prevention, identification, and care; advance TRICARE
11 coverage of evidence-based care methods.

12 Sadly, 7 years later, I know from my charity,
13 government, and survivor contacts many of the same
14 deficiencies continue and some issues have tragically
15 reversed progress.

16 I am grateful to organizations such as TAPS, the world
17 leader in assisting those who have lost a military loved
18 one. TAPS has been instrumental in support of me and the
19 tens of thousands of military suicide loss survivors.

20 I appreciate the opportunity to share Chris's story.
21 He was an extraordinary young man with a bright future and
22 will be forever loved and missed.

23 Thank you for considering these insights and
24 recommendations to reduce the preventable devastation caused
25 by a death from suicide.

[The prepared statement of Dr. Carter follows:]

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1 Senator Gillibrand: Thank you very much.

2 Mr. Ford?

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1 STATEMENT OF CHRIS FORD, CHIEF EXECUTIVE OFFICER, STOP
2 SOLDIER SUICIDE

3 Mr. Ford: Chairwoman Gillibrand, Ranking Member
4 Tillis, and distinguished members of the subcommittee, on
5 behalf of my time at Stop Soldier Suicide and the clients we
6 serve thank you for the humbling opportunity to share our
7 experiences and perspectives on this critical readiness
8 issue. I am especially honored to sit alongside Dr. Craig
9 Bryan, a fellow Air Force veteran and an esteemed member of
10 Stop Soldier Suicide's Scientific Advisory Committee.

11 To Dr. Zimmer Carter, please accept my deepest
12 condolences in the loss of your son.

13 To be clear, I am neither a psychologist nor a suicide
14 prevention researcher, but I am a 20-year Air Force veteran
15 with combat tours supporting Operations Enduring and Iraqi
16 Freedom, with two additional tours at the Pentagon where I
17 retired from the Joint Staff leading efforts to improve
18 servicemember transition and integration via community-based
19 approaches. I have experienced firsthand the challenges of
20 military service, combat, transition into society, and in
21 the worst moments, the challenges and grief surrounding
22 untimely deaths.

23 Most recently, I am honored to serve as the CEO of Stop
24 Soldier Suicide, the nation's largest nonprofit organization
25 exclusively focused on reducing military suicide rates to

1 match national parity by 2030. In this role, I have not
2 only seen the complexity of suicide and grief it causes but
3 also the hope and joy that comes from helping servicemembers
4 and veterans move from struggling to thriving as a direct
5 result of our work.

6 Sadly, since 2001, more than 120,000 servicemembers and
7 veterans have died by suicide, enough to empty Washington
8 Nationals Park three times. Leading research indicates each
9 suicide affects 135 lives, meaning these untimely deaths
10 have affected more than 16 million Americans in the last two
11 decades, two times the population of New York City.

12 Statistically, we know these tragic deaths are most
13 common amongst young men, often ages 18 to 34, and likely
14 experiencing a combination of factors such as intimate
15 partner problems, substance use, financial strain, and more.
16 It is easy at this level to focus on this problem in terms
17 of numbers and percentages but these are real people who had
18 friends, family, and loved ones. We must do better.

19 We need to ensure DoD leaders at all levels view mental
20 fitness on par with marksmanship, physical fitness, and
21 warfighting skills. Leaders embrace, if not evangelize, the
22 need for strength, endurance, and expertise in fighting and
23 winning our nation's wars. Likewise, leaders must embrace
24 mental fitness as the last spoke on the wheel required for
25 military readiness.

1 I fear our society views suicide as an intractable part
2 of the human condition instead of viewing it as a complex
3 problem we can collectively solve and possibly eliminate.
4 Just like our aspirations to rid this planet of cancer, so
5 too should we aspire to eliminate suicide from the U.S.
6 military.

7 My team at Stop Soldier Suicide works tirelessly every
8 day aiming towards that lofty goal. Since 2010, Stop
9 Soldier Suicide has served more than 3,500 clients with an
10 average duration of care of 8.5 months. Last year alone, we
11 served more than 1,000 clients, delivering more than 17,000
12 man-hours of care and ultimately saving 147 lives. To date,
13 zero active clients have died by suicide. We do this by
14 providing free, confidential, trauma-informed care using
15 leading treatments that reduce suicidal thoughts and
16 behaviors via telehealth solutions in all 50 states.

17 Using suicide-specific modalities, our clinicians can
18 effectively save lives as evidenced by our recent program
19 evaluation finding that 97 percent of our program graduates
20 experience reduced and stable risk.

21 Take Emily, for example. Emily, age 22, served in the
22 Army for 4 years and was medically separated in 2021, after
23 a military sexual trauma. When she told her chain of
24 command about her trauma, leaders tried to talk her out of
25 reporting the crime, stating the perpetrator was a "good

1 soldier." She separated from the Army and quickly found
2 herself homeless and disenfranchised from her family. Since
3 working with our team, we have helped reduce Emily's suicide
4 risk, improved her family relationships, helped her secure a
5 job, and we are connecting her to her VA benefits. Emily
6 has a long road ahead, but we have reversed her course from
7 heading towards suicide to a life worth living. She is just
8 one of the 520 active clients we are working with today.

9 Based on this case and others over the last 11 years I
10 offer the following recommendations to the DoD and to this
11 committee:

12 (1) Increase access to suicide-specific care;

13 (2) Eliminate mandatory reporting requirements for care
14 providers;

15 (3) Better understand trauma and risks in
16 servicemembers that occur prior to military experience;

17 (4) Conduct annual behavioral health checkups;

18 (5) Destigmatize help-seeking behaviors and protection
19 servicemembers from negative career implications for having
20 the courage to ask for help;

21 (6) Re-examine the timing of screening;

22 (7) Place increased emphasis on lethal means safety;

23 and

24 (8) Improve transition experiences for separating and
25 retiring servicemembers.

1 I thank you for this opportunity and I look forward to
2 your questions.

3 [The prepared statement of Mr. Ford follows:]

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1 Senator Gillibrand: Thank you.

2 Dr. Doraiswamy.

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1 STATEMENT OF P. MURALI DORAISWAMY, MD, PROFESSOR OF
2 PSYCHIATRY AND MEDICINE, DUKE UNIVERSITY SCHOOL OF MEDICINE

3 Dr. Doraiswamy: Chairwoman Gillibrand, Ranking Member
4 Tillis, and members of the Personnel Subcommittee, thank you
5 for inviting me to testify on this very important topic. As
6 mentioned, I am a Professor of Psychiatry and Duke, but I am
7 here testifying in my personal capacity.

8 I do not work directly in military mental health. My
9 views are informed by my experience as a leading expert in
10 evidence generation, in deploying technology, and as a
11 physician caring for patients. I share all of your concerns
12 over the problems of rising suicide rates, especially
13 amongst young enlisted servicemembers.

14 One metric that has not been mentioned today is
15 suicidal ideation, or suicidal thoughts. At the peak of the
16 pandemic, the CDC estimated that nearly 1 in 4 young adults
17 were experiencing suicidal thoughts. That is roughly 30
18 million Americans. If those thoughts do not abate and
19 persist or increase over time, then we can expect to see a
20 further increase in suicide rates in coming years.

21 Over half of those who commit or attempt suicide have
22 never sought professional help, and this is the group that I
23 feel we have not really paid attention to. Young men are
24 the least likely of any group to seek help through
25 traditional pathways. Some of the key reasons have already

1 been discussed -- stigma, career impacts, and a fear of
2 being seen as falling short of cultural standards. Further,
3 interventions or questionnaires that servicemembers perceive
4 as having punitive consequences may discourage correct
5 answers or further care-seeking, especially during
6 transitions or enlistment.

7 I am pleased to hear of the many steps that the
8 Department of Defense has already put in place or is
9 considering, but I want to highlight one modality that is
10 particularly well-suited for young adults, namely digital
11 health, the use of smartphone and Web-based tools for mental
12 health which I feel has not been scaled for maximum impact
13 yet.

14 We are in the midst of a technology revolution, where
15 the smartphone is at the core of not only our social
16 connections and entertainment but also where we go to seek
17 health care knowledge. Surveys show young adults are much
18 more comfortable with text messaging on WhatsApp or
19 Instagram than making or receiving phone calls. They are
20 more willing to reveal mental health information on digital
21 surveys or even to a chatbot than to a human clinician.

22 In 2019, prior to the pandemic, I co-led a report to
23 spotlight, through expert knowledge and case studies, the
24 most promising technologies available today to meet gaps in
25 mental health care as well as forthcoming innovations that

1 may transform future mental health care. I have made this
2 report available to the subcommittee.

3 The pandemic resolved a two-decade debate about the
4 value of virtual medical visits. Once regulations were
5 relaxed, almost overnight telehealth became essential and
6 proved it could improve no-show rates in some cases by 50
7 percent without any adverse consequences, either in terms of
8 data breach or patient harm.

9 There are many other digital health tools that have
10 equal or higher potential to be scaled. These include
11 smartphone-based symptom rating scales, chatbots, clinical
12 decision support software, better use of data, apps for
13 psychological or peer support, text messaging-based
14 counseling services, and digital therapeutics.

15 I want to highlight one such success story, which is
16 Crisis Text Line -- the number is 741741, which is the
17 easiest numbers you can find on your smartphone -- which is
18 a U.S.-based nonprofit, which provides free, 24/7 counseling
19 to young people in crisis throughout the United States via
20 text messages or WhatsApp. It has facilitated over 100
21 million messages over 5 years, and trained some 20,000
22 crisis counselors. Over half of its users had never spoken
23 to any other mental health professional.

24 The top areas users seek help for are relationship
25 issues, sadness, suicide, and loneliness, many of the same

1 issues confronting our young enlisted men. Users under 25
2 most frequently seek help late at night, which this system
3 facilitates.

4 Although there are hundreds of other promising
5 technologies and commercial apps in the mental health field,
6 the incentives and regulations are not aligned for them to
7 generate high-quality evidence. Remarkably, only four
8 mental health apps have generated the evidence needed to be
9 cleared by the FDA to date to treat mental health disorders.

10 I am not suggesting that technologies replace face-to-
11 face or the human touch, but they can serve as a bridge
12 between what we have and what we need to have so that people
13 can get the care, anytime, anywhere.

14 I recommend that the DoD take a leadership role to
15 evaluate the performance of digital tools to better
16 understand where they contribute the most, what factors
17 correlated with success, as well as which patients were not
18 served well by digital approaches. Likewise, they can take
19 a leadership role to see how we can better use big data
20 analytics to help our enlisted servicemen. Any
21 implementation pilot should be intentional about not causing
22 harm. Such data would also benefit millions of civilians.

23 Today most of us cannot think of life without the
24 internet, digital cameras, or GPS, all innovations pioneered
25 and implemented by the military first. I believe the DoD is

1 similarly uniquely positioned to bring human values and the
2 digital revolution together to save lives.

3 I want to thank the chair and the ranking member for
4 the opportunity to share these thoughts with you and your
5 subcommittee, and I look forward to answering your
6 questions.

7 [The prepared statement of Dr. Doraiswamy follows:]

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1 Senator Gillibrand: Thank you.

2 Dr. Bryan?

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1 STATEMENT OF CRAIG BRYAN, PsyD, DIRECTOR, DIVISION OF
2 RECOVERY AND RESILIENCE AND SUICIDE PREVENTION PROGRAM, THE
3 OHIO STATE UNIVERSITY COLLEGE OF MEDICINE

4 Dr. Bryan: Thank you for the invitation to join you
5 today to talk about this important issue. I am a clinical
6 psychologist and veteran of the U.S. military who deployed
7 to Iraq in 2009, and has spent the years since devoted to
8 understanding and preventing suicide amongst my fellow
9 servicemembers. This work has afforded me the opportunity
10 to visit and collaborate with military leaders and
11 servicemembers around the world.

12 During one recent visit to a military installation at
13 Fort Drum a senior NCO shared with me an important story
14 about a junior enlisted soldier who asked him for help
15 several years before. This soldier's mother had recently
16 called to tell him that her basement was flooded and she did
17 not know what to do. The soldier could not afford an out-
18 of-state flight to visit her, and his supervisor would not
19 authorize enough leave for him to drive home to help.

20 Increasingly frustrated and despairing, he exclaimed to
21 his senior NCO, "I can't take this anymore. I just want to
22 kill myself." The senior NCO listened to the soldier's
23 problems and helped him develop a plan to assist his mother,
24 one piece of which was convincing the supervisor to approve
25 the leave request. A solution and plan now in place, the

1 soldier expressed relief and gratitude and the problem and
2 crisis was solved.

3 When the senior NCO notified his chain of command about
4 the situation, however, he was told the soldier needed to be
5 transported to a local hospital for a mental health
6 evaluation. The senior NCO argued against that. It seemed
7 unnecessary. "It is policy, though," he was told.

8 Emergency services were called and the soldier was
9 transported against his will to a local emergency department
10 to be evaluated. No longer in crisis, the soldier was
11 nonetheless coerced into starting mental health treatment
12 out of concern that he was concealing or under-reporting the
13 full extent of his crisis and possible depression. The
14 soldier was not allowed to go on leave until he was cleared
15 by a mental health professional. This delayed the soldier's
16 ability to help his mother. Understandably, this increased
17 his stress and frustration and created a new suicidal crisis
18 that counteracted the good work achieved by the senior NCO.

19 Luckily, a military mental health professional provided
20 the clearance needed for the soldier to go on leave, and in
21 the end it all worked out, but at what cost?

22 The experience left a very negative impression on both
23 the senior NCO and the soldier. The soldier's experience
24 was bad enough that he expressed the intent to never ask for
25 help again. The impact on the other soldiers in the unit

1 cannot be measured as well.

2 I want to emphasize that this story is not unique to
3 any particular installation. In the past decade and a half,
4 I found stories like this coming up more and more often. I
5 shared this story because it uniquely highlights how the
6 military can effectively prevent suicide and also fail at
7 the same time.

8 The senior NCO's actions serve as an exemplar of how to
9 effectively intervene in the right way, at the right time,
10 for the right person. He listened; he quickly developed a
11 plan of action that directly solved the problem. The senior
12 NCO correctly recognized that this soldier's crisis could
13 best be resolved through pragmatic problem-solving, not
14 mental health treatment.

15 The larger organization response, by contrast,
16 demonstrate how institutional policy and cultural norms can
17 make things worse. I suspect the policy sided to justify
18 the coercive transport for involuntary mental health care
19 was not a formal policy per se but rather was an unwritten
20 rule or an organizational norm that had emerged over time,
21 due to growing fear and anxiety about liability. Better-
22 safe-than-sorry rules, though well intentioned, can
23 paradoxically make things worse. These rules fail because
24 they prioritize liability management at the expense of
25 individual servicemembers' well-being.

1 In my written testimony submitted for today's hearing I
2 outlined three evidence-based strategies that could improve
3 suicide prevention efforts within the DoD and propose
4 several possible policy actions that align with each
5 strategy. All three strategies involve system-level reforms
6 and change.

7 We do not need more awareness curriculum, more
8 resilience trainings, more suicide prevention briefings, or
9 more suicide risk screening. We need to eliminate or remove
10 policies, procedures, and unwritten rules of thumb that
11 degrade quality of life, that strain the mental health care
12 system, and increase the use of coercive and potentially
13 harmful practices.

14 Suicide prevention does not mean that everyone needs to
15 be conducting suicide risk screenings and repeatedly
16 imploring servicemembers to go get mental health care.
17 Rather, it means we should be working every day to create
18 lives that are worth living.

19 Thank you, and I look forward to your questions.

20 [The prepared statement of Dr. Bryan follows:]

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1 Senator Gillibrand: Thank you, Mr. Bryan.

2 Dr. Carter, thank you for sharing your family's
3 experience, and I offer my deepest condolences for the loss
4 of your son. I cannot imagine the horror you have had to go
5 through.

6 Could you talk a little bit more about the barriers
7 that your son faced? It sounded fundamentally like a grave
8 injustice. The right people did not talk to him at the
9 right time. And I have heard that marijuana is extremely
10 effective for PTSD and for pain management.

11 So can you talk a little bit about what barriers he
12 had, that he had to seek self-medication, that he could not
13 find any other means medically to alleviate his depression,
14 anxiety, and what barriers you had as a parent trying to get
15 him the care he needed?

16 Dr. Carter: Yes. Thank you very much, and I really
17 want to thank all of the subcommittee's insight into this
18 and these questions, and both the first committee and this
19 have been very heartening, as well as many of the responses
20 from the first committee, as things hopefully have improved
21 in some merits.

22 Chris was first having some mental health anxiety
23 issues after his third deployment. When he sought care
24 first through his local sick bay he was told to keep it
25 quiet or he would not be able to deploy on his fourth

1 deployment. And as a gung-ho leader he did not let his
2 unit, and they were his team, down.

3 He was tried on various medications for depression,
4 which actually sometimes made his anxiety worse. He also
5 was attempting and did seek mental health care. They did
6 have an embedded mental health provider, who I highly
7 recommended, because it really worked well for their
8 accessibility. But follow-up was difficult while training,
9 and again, his care was not necessarily ever addressed from
10 a suicide standpoint. It was addressed for his anxiety, his
11 insomnia, his PTSD symptoms, but not actually looking at the
12 suicidal.

13 And no care plan was ever made that I ever found in his
14 record, things that we now know are just basic evidence-
15 based treatments. So even though he was getting a
16 knowledgeable mental health provider, they were not
17 addressing suicide care, and that was one of the things that
18 I was hearing on the first, is that we need to make sure all
19 our mental care providers, those civilian as well as
20 military, are working better at understanding suicide
21 treatment, not just mental health general treatment.

22 There was the access. There was the stigma. After the
23 suicide death of one of his cohorts -- and he told me that
24 he identified, and I actually happened to be on base and
25 went to that funeral for that young soldier. I went to the

1 memorial service given on the base. It was very much almost
2 a blame type of service. The commander -- and it was a new
3 commander -- but the commander pretty much said, "You know,
4 you do not need to do this, guys. If you do this, you are
5 weak," you know, kind of statement, instead of again seeking
6 that self-help and support.

7 They did have a meeting and they brought someone in,
8 and again, they literally called him -- and I will not say
9 the word, but a negative word, for pulling the trigger. So
10 again, instead of looking at this as a method to help and
11 support and find, it actually made the fellow soldiers quiet
12 down and not want to look like they were the weak one in the
13 unit.

14 He was in his transition period, and therefore he was
15 not deployable, so he had kind of lost some of his -- he had
16 no real work level so he was somewhat lost. And they also,
17 because of this, were putting him extremely humiliating
18 positions. He was cleaning latrines and picking up leaves
19 off the parking lot by hand, were the jobs that he was put
20 in. Some of this was because of his disciplinary status
21 because he had self-admitted the marijuana use and they were
22 actually going through with this potential for other-than-
23 honorable discharge, but also some of it was to protect him,
24 to keep him safe. They would lock him in the supply room to
25 count supplies, so that he could not hurt himself. They

1 also were making him sleep on a private's floor at night, in
2 his barracks, because they again were watching him to make
3 sure that he was being safe to himself, all things that we
4 know increase his burdensomeness feelings, increase his
5 humiliation, increase the suicidal risk.

6 I was aware of a lot of this. I came forward and I was
7 able to convince them, convince command to let him move off-
8 post with me, and he did live with me the last few months,
9 in an apartment off-post. But again, I had the means to fly
10 across the country, pick up an apartment, and try to help
11 support with that.

12 The day he actually died he was working to get into a
13 Warrior Transition Program that was being set up for
14 transitioning servicemembers to help with this kind of
15 getting job placement and support. And he applied, he was
16 accepted, he had a job lined up as a draftsman, and he was
17 looking at an architectural future, so that would kind of
18 work all out. And his command told him that he would be
19 unable to do this because of his disciplinary proceedings
20 that were pending. So that was the last of the last straws,
21 and we know there are multi reasons why people die by
22 suicide. It is not just one reason, but that was the
23 majority of the conflicts. And even though I was a military
24 person myself, I was a doctor, it was very difficult for me
25 to get through. Even some of the NCOs were standing there,

1 literally saying to my face, "We do not believe you. We do
2 not believe he is suicidal." And again, this kind of was
3 astonishing. I mean, I would not believe this story if it
4 was not true for me, but it was. And all these factors
5 continued to add until the final demise.

6 Senator Gillibrand: Thank you so much, Dr. Carter.
7 Senator Tillis.

8 Senator Tillis: Thank you all for being here, and Dr.
9 Carter, you made a comment in your opening statement and you
10 alluded to it in your final comments there that you had a
11 commander say they talked the soldiers, not moms.

12 Dr. Carter: Yes. That was the last day. I was trying
13 to get through to his command. Now in their defense the
14 commander and the majority of the battalion had just
15 deployed over, again, to Afghanistan, and so it was kind of
16 a backup command that was left behind. But when I left a
17 message and I said, you know, "Why can't I talk to someone?
18 I need to talk to someone," that was what was stated to me.

19 Senator Tillis: Well, it raises a question whether or
20 not we need to make it clear through the NDA process if the
21 person who is in crisis is comfortable with a provider or a
22 caregiver talking to the command that they should, in fact,
23 be required to do that, and we will look into that as a
24 matter of policy.

25 Dr. Doraiswamy, thank you for the time in my office

1 this morning. You have a unique blend of medical practice
2 and the discipline and a focus on technology. You and I
3 talked about maybe being able to accelerate. The biggest
4 challenge we have right now with so many options being
5 available -- I did write down that number of the Crisis Text
6 Line and I looked it up after you gave it to me, 741741. It
7 looks like an impressive, easy-to-use platform, particularly
8 for ideation it would seem to me it is going to be the most
9 effective tool to get out there if somebody is just
10 experiencing that.

11 But what I would like to do is, we may have a second
12 round and I hope we do, but I do want to discuss how we can
13 potentially get a group effort to come up -- you and I
14 talked about the Hackathon in the office -- specifically on
15 maybe coming up with some best practices or ideas to better
16 serve the broader community, particularly the community that
17 is really untouched now who are going through ideation.

18 I am also very interested in just stating for the
19 record, I think COVID has solved the argument over whether
20 or not telehealth has efficacy. I do not believe anyone who
21 has been here for the last 2 years can honestly believe that
22 it does not. We had a successful pilot in the VA for
23 behavioral health triaging that makes me believe that we can
24 make a lot of progress there.

25 So I guess just a quick question on the barriers that

1 we are even seeing in the private sector. What should we
2 look at or put our foot on the accelerator for, for making
3 sure that we codify or expand the use of telehealth for
4 behavioral health and general health needs?

5 Dr. Doraiswamy: Thank you, Senator, for this very
6 important question. I totally agree with you that
7 telehealth is now essential infrastructure for the country.

8 So it was the relaxation of HIPAA standards, as you
9 know, that sort of literally overnight transformed
10 telehealth into something that was practical and widely
11 used. If those authorization are revoked then insurance
12 companies will piecemeal determine what is necessary and not
13 necessary and set different pricing standards. Currently it
14 is reimbursed at the same rate as face-to-face, in-person
15 visits. I think it is very, very important to continue
16 telehealth the way it is, because otherwise you do not want
17 it to go back to where it was before the pandemic.

18 And then the second issue is there is still a
19 substantial portion, perhaps 10 percent, of individuals who
20 may not have access to broadband, who may not even have
21 access to smartphones or computers. I think it is really
22 very important to see how we can reach out to those
23 individuals to reduce health disparities.

24 The third is I do agree with you that telehealth has
25 not produced significant harms. The real question is, has

1 it actually produced substantial gains over conventional
2 treatment because it has reduced dropout rates? And if it
3 reduces dropout rates then you would expect the outcomes to
4 be better. I have not seen randomized studies or big data
5 analytics from telehealth to look at actual outcomes
6 compared to face-to-face, historical face-to-face outcomes.

7 The last is it has been very difficult to implement
8 rating scales, because as you know, you cannot manage what
9 you cannot measure. There are more than 500 different
10 outcome measures that can be used in mental health. It has
11 been very difficult to implement and integrate them into
12 telehealth for a variety of reasons, but I think we need to
13 do that in order to be able to, 2 years down the road, to
14 see how effective we are, what the gaps are, and how we can
15 remedy those gaps.

16 Senator Tillis: And Dr. Carter, Mr. Ford, and Dr.
17 Bryan, thank you for your past service.

18 Mr. Ford, thank you for the work you are doing. I know
19 you are down in Durham. How do you connect to your clients?
20 How do they know about you? How do they come to you?

21 Mr. Ford: That is a great question. We use
22 proprietary information about the behaviors of
23 servicemembers and veterans that indicate they are
24 expressing mental distress and maybe headed towards suicide.
25 So it is a very multi-touch marketing effort, much like you

1 would have in commercial enterprises. If you are shopping
2 for a new pair of shoes on a website, you are going to see
3 ads for those types of shoes everywhere thereafter.

4 So we use a lot of keyword identifiers and demographic
5 information to push advertisements digitally to people we
6 know that they are exhibiting the behaviors of concern that
7 would benefit from our service. Whereas fixed facility
8 models would say "we are here if you need us," we are
9 knocking on people's digital doors saying "we are here
10 because we know you need us."

11 Senator Tillis: Thank you.

12 Senator Gillibrand: Senator Hawley.

13 Senator Hawley: Thank you, Madam Chair. Thanks to all
14 of you for being here.

15 Dr. Carter, I want to start by thanking you for being
16 willing to be here and to share your story and your son's
17 story, Corporal Carter. It is always good to see somebody
18 from Missouri, so thank you for being here for that reason.
19 I understand that Chris was laid to rest in St. Charles, I
20 think it was. Is that right, your son?

21 Dr. Carter: Actually he is in Jefferson Barracks.

22 Senator Hawley: Okay. In Jefferson Barracks. Got it.
23 Well, thank you for being willing to share. And I just -- I
24 am now a father myself and when I was your son's age I lost
25 my best friend, who was the same age I was, to suicide, and

1 that has been 20 years ago now. But I saw what his family
2 went through, and as a father -- of course, I was a young
3 man then -- as a father now myself of three small children I
4 just cannot begin to imagine what it was like. So thank you
5 for being willing to talk about it and share about it in the
6 end, and allow your heartbreak and devastation to help other
7 families. That is just incredible. So thank you for being
8 willing to do that.

9 I just want to ask you, in that regard, in your
10 experience you talked about some of the stigma that your son
11 encountered. What have you seen in terms of best practices
12 that are effective at reducing stigma, in being willing to
13 say, "Hey, I am struggling," being willing to say, "I need
14 to get some help"? I mean, have you seen anything that you
15 would recommend or you could share with us?

16 Dr. Carter: Yes. Best practices is a hard word
17 because that means evidence-based usually, and so this is
18 going to be my personal.

19 Senator Hawley: Fair enough.

20 Dr. Carter: The one factor I think that seems to have
21 the most credence and seems to get the most effect from
22 those that I have talked to -- and I still keep contact with
23 many of my son's military buddies who are still active duty
24 -- is those in higher-ranking status who come forward and
25 speak on the fact that they have sought mental health care,

1 that they have suffered problems, and that their career has
2 not been jeopardized by that process. And that being passed
3 down, as well as those that then speak out. When we hear of
4 group treatment where here we are in a post-suicide, mental
5 health program and somebody is calling this servicemember,
6 you know, a demeaning name, those folks come forward and put
7 their foot down. Tell it like it is. State how it is not a
8 weakness that they are getting help or that they would come
9 forward for help, but it is a positive.

10 And I loved the way you stated it with having it part
11 of those five members of readiness is mental health
12 readiness, so being supportive on that line.

13 Senator Hawley: That is good. That is very helpful.
14 Thank you.

15 Here is a broader question for anybody on the panel.
16 Just looking at the Department, DoD's own Annual Suicide
17 Report from 2015 to 2020, that report determined a
18 significant increase -- significant increase -- in suicide
19 across all the services, among their active component. What
20 is your views -- and theories are fine. I mean, I am not
21 going to hold you to this, but I am just curious, what do we
22 think is driving this very significant increase? Because it
23 is not 1 year, it is not 2 years. It is now, over time.
24 And I realize it is a society-wide problem, maybe especially
25 with men, maybe especially with young men. But putting the

1 larger society issue to one side, looking at active-duty
2 servicemembers, does anybody have a view as to what is
3 driving this? We are reaching sort of epidemic levels here.

4 Dr. Bryan: I suspect the honest answer is no one
5 really knows. I think what we understand about suicide,
6 though, is that it is caused by many different things, so
7 there are probably actually multiple factors driving it.

8 One issue that I have become increasingly conscious of
9 is that we have almost pigeon-holed our perspective of
10 suicide as a symptom of mental illness or as a mental health
11 outcome, when we know that the majority of servicemembers
12 who die by suicide do not have a mental health condition.
13 This tracks on U.S. general population rates as a whole.
14 And this is where I think a lot of the work that we have
15 been doing is focusing more on things like needs restriction
16 as well as quality of life issues. Because I think for
17 decades we have doubled down on the "get help, get help,
18 mental health, mental health," and that is just one piece of
19 the puzzle.

20 Senator Hawley: You mentioned that just a second ago,
21 Dr. Bryan, in your opening statement, and it caught my
22 attention when you said it then, when you talked about
23 quality of life and about how it is important to promote --
24 this is my gloss on it now -- but it is important to promote
25 a sense of purposefulness and meaningful, as opposed to

1 saying, "Well, it is just a mental health issue and we will
2 fix that." But it is really about how you see your whole
3 life. Can you just expound on that?

4 Dr. Bryan: Yes, and I provide a little bit more in
5 detail in my written testimony. But what we are starting to
6 recognize now as suicide researchers is that suicide can
7 more usefully be understood as a behavior that is
8 independent of mental wellness, mental health conditions.
9 And there is neural research, there is no psychological
10 research showing that in the moment of sort of the decision
11 it is sort of "Do I live? Do I die?" There is this
12 ambivalence or this mulling that happens. And we see that
13 the parts of the brain that are most closely associated with
14 the decision to act or not act involve reward centers,
15 perceptions of reward versus punishment. And if life is not
16 rewarding, if life is punishing, if the idea of staying
17 alive means dealing with toxic work environments, strain,
18 stress, then the value of suicide as an escape from that
19 suffering increases and the probability begins.

20 So that is where mental health treatment, now we are
21 starting to understand part of the reason suicide-focused
22 therapies are effective, is because we teach people how to
23 change that decision process. But I think we need to move
24 beyond that, because the majority of servicemembers dying by
25 suicide do not have mental health conditions and are not

1 coming for treatment. And so if life is worth living it
2 adjusts that balance and that decision.

3 Senator Hawley: Thank you.

4 Senator Gillibrand: I would like to continue that line
5 of questioning for all the panelists. I have also heard of
6 a problem with overprescribing medication, so that if
7 somebody is identified as having suicide ideation the first
8 response is medication. And in many instances,
9 overprescribing and poor prescription management, not
10 dealing with the more holistic approach to how do you create
11 wellness, and in your words, quality of life, Dr. Bryan.

12 But for each of the panelists, can you talk a little
13 bit about how we should be looking at the whole of the
14 patient, not just the clinical diagnosis and the medication
15 given, to make sure that they are being supported? Dr.
16 Carter, in your son's case, they instigated shame. I cannot
17 believe the punishments they were giving to somebody with
18 suicidal ideations. Everything that Dr. Bryan just said
19 would make life not worth living, undermining all of his
20 connections to family, friends, mission, purpose. And then
21 the belittling is just inexcusable. I mean, it is not
22 acceptable.

23 So I would like to talk a little bit about the
24 interventions that work, this notion of holistic approach,
25 what is working, what is not working, what have you seen in

1 practice, and what recommendations specifically would you
2 like us to look at for the NDAA?

3 Mr. Ford, why don't you start, and then Dr. Carter, and
4 then Dr. Doraiswamy, and then Dr. Bryan.

5 Mr. Ford: Thank you so much. I think in our work over
6 the last 11 years, and more specifically in the last few
7 years, we find that suicide-specific treatments work.
8 Again, 3,500 clients, no active client dying by suicide, 97
9 percent of them with reduced and stable risk -- all via
10 telehealth, mind you -- shows that there are ways to help
11 people who have the courage to raise their hand. These
12 modalities that we use, some of which pioneered by Dr. Bryan
13 and Dr. Rudd, BCBT, in particular, focus on more than just
14 the mental health of the person. They focus on social
15 determinants of health, relationships, support networks,
16 financial stability.

17 So we find that in our care for our clients, as we try
18 to resolve underlying comorbid conditions, that having a
19 healthy environment with improved relationships, more
20 financial stability, less external strain on their mental
21 health really reduces the suicide risks, which can be short-
22 lived and acute but severe at time.

23 I think a really important component of our model as
24 well is contingency planning, especially around lethal means
25 safety. We know that when firearms are used in suicide they

1 are 83 percent better in being lethal. We need to create
2 more time and distance between people who are at high-risk
3 states for suicide so they have time to manage those risks
4 and prevent them from making a permanent decision to a
5 temporary problem.

6 Senator Gillibrand: Thank you. Anyone else? Go
7 ahead, Dr. Carter.

8 Dr. Carter: Yes. I would like to piggyback on that.
9 The combination of what you two just stated so eloquently is
10 perfect, is that we need to find the environment and support
11 the environment that is a positive support. And that means
12 all of us, probably, could use better training on what to do
13 and how to help our fellow man, and as well as continue to
14 outreach to each other and look for questions and responses
15 that might make us more concerned and push a little harder.
16 But that environment needs to be a norm for us all.

17 The other, and this kind of goes back to your question
18 too, Senator Hawley, about why now. You know, there was a
19 lot more, I think, stress on redeployment, is what I am
20 hearing, especially -- well, I know the special forces
21 especially.

22 And then another area that I think we have not really
23 touched a lot on is traumatic brain injury. A lot more
24 concussive exposures in these more recent wars, and we now
25 know that that can cause biological changes that we are

1 discovering that can make some differences.

2 So other methods or things that might be outside the
3 box -- and sometimes I have to take off my doctor hat when I
4 talk about the outside-the-box things -- but we know
5 ketamine, although it is a drug, does have some immediate
6 decrease in suicidal tendencies for those who experience it.
7 SGB, stellate ganglion blocks, is a new and upcoming method
8 of looking at methods to interact with the biological manner
9 of reducing some of the extreme, especially in PTSD, effects
10 for soldiers or anyone who has PTSD. It can reduce and has
11 a calming effect so that, therefore, they can address some
12 of the other psychological issues more comfortably.

13 There are new methods looking at MRI types of
14 therapies, which we know in depression has some effect. I
15 had a recent ex-servicemember who we helped support in a
16 float chamber, and again, these seem like strange things,
17 but in this case it was very helpful for him, and a calming
18 effect, I guess much like meditation and yoga would be.

19 So again, methods that we use that could become just
20 the norm of our treatment. I mean, yes, football players
21 can do yoga and so can servicemembers, and things that will
22 help all of us feel healthier and happier.

23 Senator Gillibrand: And Dr. Doraiswamy and Dr. Bryan.
24 Be brief because I am out of time.

25 Dr. Doraiswamy: Sure. Thank you. This is a really

1 important area. I often make a comment, "Citibank can
2 predict suicides better than clinicians can." That is
3 because they are probably multifactorial -- economic crises,
4 it could be criminal issues, it could be relationship
5 issues, alienation, loneliness. Many of those are not
6 captured fully by the medical system.

7 I believe we need to find ways to track those in a way
8 that is not threatening to the individual and address them.
9 I think otherwise we will never be able to fully address the
10 suicide risk, especially in the impulsive, last-minute
11 suicides.

12 Dr. Bryan: I think with your question regarding
13 medication, a meta-analysis published by Katrina Fox
14 published a couple of years ago showed that the amount of
15 therapy medication has a very small benefit for suicide
16 risk, not nearly as pronounced as like cognitive behavioral
17 therapy for suicide prevention.

18 I think one of the reasons why we see high rates of
19 medication is because, as we mentioned in the previous
20 panel, the mental health care system is overwhelmed in the
21 DoD, and so prescribing medication where you can have a 15-
22 minute appointment and meet with someone every 6 to 8 weeks
23 to monitor becomes much more sort of practical within an
24 overwhelmed system than meeting with someone every single
25 week for an hour. And so I think that is a major factor

1 contributing to higher rates of medication.

2 The second thing, and the last thing I will say is that
3 these treatments that we have been talking about, these
4 suicide-focused treatments, many of those have been tested
5 in the DoD. They reduce suicide attempts amongst active-
6 duty personnel by 60 to 76 percent. They are astronomically
7 better than traditional mental health treatments.

8 What we are finding now is that there is no sort of
9 systematic training or implementation program to help push
10 this out into DoD MTFs, but secondly, there are, again, some
11 other sort of institutional, bureaucratic burdens to
12 implementing those treatments. Clinicians do not have
13 enough time to schedule appointments on a regular basis, and
14 the paperwork and administrative and bureaucratic demands
15 are crushing the will and the soul of our mental health
16 professionals, and it detracts, it eats into face-to-face
17 clinical time because they are having to fill out more forms
18 and they are having to fill out more paperwork to meet
19 regulatory requirements.

20 Senator Gillibrand: Senator Tillis?

21 Senator Tillis: Thank you all. On BCBT, I think that
22 particular treatment has efficacy of about 60 percent on
23 avoiding suicides. To what extent is that implemented in
24 practice in the DoD now?

25 Dr. Bryan: So it is not widely used, and part of it is

1 for the reasons I just mentioned. And right now, you know,
2 we conduct trainings for different MTFs periodically, but it
3 is largely just based on if they have money left over at the
4 end of the fiscal year.

5 Senator Tillis: I see Senator Sullivan has arrived and
6 we are going to have a vote shortly. But I am particularly
7 interested, as a follow-up, we can have a broader discussion
8 about general health care systems and paperwork burdens, but
9 to the extent that we can identify procedural requirements
10 that are not adding value but putting care further away, I
11 would be very interested in getting that for the purposes of
12 any considerations that we should have for either pilots or
13 just policy decisions with respect to the DoD and DHA.

14 Thank you all.

15 Senator Gillibrand: Senator Sullivan.

16 Senator Sullivan: Thank you, Madam Chair. Thank you
17 for holding this hearing, and thank you to the witnesses.

18 You know, my state, Alaska, has a wonderful veteran and
19 military population. We also have a huge suicide problem.
20 And Madam Chair, I would like to submit for the record a
21 recent USA Today article, very extensive, on the problems
22 that we have had in the Alaska military. I would like to
23 submit that for the record.

24 Senator Gillibrand: No objection.

25 [The information follows:]

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1 Senator Sullivan: So we have had about, I think the
2 number is 38 in the last 4 years, in one state. That is
3 more members of the whole U.S. military that were killed in
4 Afghanistan during the same time, killed in Alaska. And it
5 is everybody from enlisted to even sergeant majors, so it is
6 a big problem.

7 One of the things that article highlights is -- and I
8 know the subcommittee here has been talking about resources,
9 and this big issue of, hey, when a soldier actually has the
10 courage to say, "Hey, I need help," a lot of times the
11 answer is like, "All right. You have got to wait for 60
12 days." Well, as you guys know more than most, a lot of
13 times these people, these great young Americans, do not have
14 60 days.

15 So from my perspective, what do we do? I will just
16 give you one example of something I am thinking about. One
17 of the military's answers is, well, it is hard to find
18 mental health professionals, civilians, who can do that kind
19 of work in a remote area in Fairbanks, Alaska. My view is
20 it should be a priority of the military. So you actually
21 bring the active-duty forces to do this on a regular basis,
22 to be with the troops, and not have to wait 60 days. What
23 do you guys think on that issue, and how often do you see
24 that as a problem?

25 Mr. Ford: I am 100 percent aligned, Senator, that

1 bringing more resources to bear immediately should be a
2 priority. I can tell you that when we became aware of this
3 issue and talked with leadership at the command, they asked
4 for help from us.

5 Senator Sullivan: You mean in Alaska?

6 Mr. Ford: In Alaska. And on March 22nd, we launched a
7 digital ad campaign to let servicemembers and their families
8 know that we are a trusted, confidential, evidence-based
9 resources for their care. And we have already had 24,000
10 impressions on those advertisements, 78 people have visited
11 our site, and we already have 1 new client. That is just
12 starting to scratch the surface.

13 But we are going to keep pouring our efforts and money
14 into doing that. We are relocating one of our clinicians
15 from Colorado to Alaska as we speak --

16 Senator Sullivan: Oh, good.

17 Mr. Ford: -- to provide that care. We are a
18 telehealth solution but also having that person in-state
19 will improve our efficacy and delivery.

20 But it is a tough environment. I cannot solve all that
21 through telehealth -- the darkness, the long days, the
22 frigidity -- but we are doing everything we can as a
23 community-based provider to offer care, and we would welcome
24 the opportunity with the DoD to improve access to our
25 lifesaving care.

1 Senator Sullivan: Good. Let me ask another question.
2 I know you have already touched on it. It is the stigma.
3 And I want to hit this in two ways. So I am a marine. I
4 have been in 28 years. I was in a recon unit for a number
5 of years. The SF community, special forces, recon community
6 in particular, has a toughness to it, and yet they have seen
7 a lot.

8 I went to one of the hospitals here with Vice President
9 Pence and Senator Manchin about 4 years ago, and all the
10 discussions we had was how hard it was for these warriors
11 who have seen a lot to finally raise their hand and say,
12 "Hey, I need help." Because the culture in the military,
13 particularly the SOF community, is you never ask for help,
14 and if you are asking for help, you are weak. And to be
15 honest, if you are asking for help in certain units they
16 actually get rid of you. That is bad.

17 But let me give you a flip-side one, that I am working
18 on legislation right now and I would love to work with this
19 subcommittee on. I have constituents -- we have a great
20 military ethos in Alaska, more veterans per capita than any
21 state in the country -- I have constituents whose lifelong
22 dream is to join the Air Force, the Army, the Marines. And
23 when they have gone to OCS or when they have applied and
24 they are asked, "Have you taken medicine, prescribed
25 medicine, for depression?" and they say yes, guess what the

1 rules are in the U.S. military? You are not qualified to be
2 an officer in the U.S. Marine Corps. You are not qualified
3 to be an officer in the U.S. Air Force.

4 So we are telling the young teenagers of America -- and
5 you guys know there is a teenage suicide crisis, a lot of
6 factors, COVID -- but we are telling young Americans right
7 now, if your dream is to be an Air Force pilot, and you have
8 depression, as a 16-year-old young girl, teenage girl, you
9 either need to not go get help, or if you did go get help
10 and were prescribed drugs, and then you applied to be an Air
11 Force pilot, you have got to lie. I think that is so wrong.
12 That is happening right now.

13 What do you guys think of both of those issues? Sorry,
14 Madam Chair. I went a little long. And we are working on
15 legislation right now on that because I just think it is
16 wrong. That 16-year-old girl who wants to be an Air Force
17 pilot, A, if she has got a problem with depression and she
18 is 16, she should go seek treatment, but that should not
19 disqualify her when she is 22 to be an F-35 pilot. But
20 right now that is the rule. I have examples of this. I do
21 not want to embarrass any of my constituents, but it is
22 happening.

23 Dr. Bryan: Yeah, this is a great example of another
24 sort of policy institutional barrier to the intended outcome
25 and goal. We want, on the one hand, for people to seek out

1 help, and at the same time we, in essence, punish them when
2 they do so.

3 Senator Sullivan: In the active force --

4 Dr. Bryan: Correct.

5 Senator Sullivan: -- but people who want to be pilots
6 or officers --

7 Dr. Bryan: Exactly.

8 Senator Sullivan: -- or enlisted.

9 Dr. Bryan: So this is where I think, you know, there
10 is no amount of therapy and medication that is going to
11 solve that problem. This is where looking at systemic
12 change and reform, institutional policies and practice, that
13 is where we would need to be able to target in order to open
14 up the pathway for these other ideal, potentially lifesaving
15 interventions.

16 Dr. Doraiswamy: I agree, 100 percent. This is
17 probably the only institution where such a practice exists
18 that I know of. We have more than three decades of
19 experience now with antidepressants. There is no evidence
20 whatsoever to indicate that it impairs performance or --

21 Senator Sullivan: Or they make you unreliable or --

22 Dr. Doraiswamy: -- exactly, or, in fact, if anything,
23 they reverse.

24 Dr. Carter: Thank you for your service. Thank you for
25 that question. Amen, exactly. That is all I can say. That

1 is exactly my story with my son, and I just appreciate the
2 fact that you understand. And as far as back to your
3 question of stigma and what else can we do, that is another
4 stigma-builder from the very get-go. Yep.

5 Senator Gillibrand: Well, Senator Sullivan [inaudible]
6 and they are going to write a letter each to the committee.
7 I would like you to put this in writing, of your five
8 recommendations for laws we should change. So the
9 structural stuff you are talking about, Dr. Bryan, we want
10 to do. We are the Personnel Subcommittee. This is our job.
11 And Dr. Doraiswamy, using not only apps -- some of this was
12 so helpful, Senator Sullivan, about the way they are
13 treating current patients effectively to allow these risk
14 factors to be identified quicker. Like I broke up with my
15 girlfriend, I have massive debt, parents just separated --
16 all these stressors. And if you have a checklist of are you
17 undergoing any of these stressors, and there are 15 of them,
18 and you have checked them all, that is going to create an
19 opportunity for someone, hopefully the right person, to then
20 get them the kind of support they need, without undermining
21 their career, without undermining their deployability,
22 without, you know, as what happened in Dr. Carter's son's
23 case, enormous, absolutely outrageous response of demeaning
24 this individual and giving him the kinds of work and
25 demotions because he came forward asking for help.

1 So it is shocking how badly we are structured today.

2 This panel has a lot of really good ideas that they
3 will submit to us in writing. If you have any other follow-
4 ups, please.

5 Senator Sullivan: I will just mention one thing. I
6 think the risk factor issue is really important, and I track
7 every one of the suicides in Alaska. But my first
8 experience with all of this was horrible, right. I was a
9 Marine recon officer. I had a young Alaska Native marine
10 who was -- we were a reserve unit. He called me because he
11 broke up with his girlfriend. He was very distraught. And
12 I said, "Hey, I am going to see you in 4 days. Do not
13 worry. I will take care of it. You are going to be fine.
14 You are going to be with your brothers." He did not have 4
15 days.

16 So those indicators -- and I did not know that, right.
17 So those indicators that you can give to commanders I think
18 would be really helpful. And by the way, a lot of it,
19 especially with the young ones -- in Alaska I review every
20 case -- a lot of it is, you know, we do not look at, oh
21 well, you broke up with your girlfriend, or you are having
22 problems with your spouse. That is a big issue, a big
23 issue.

24 Senator Gillibrand: Especially for young
25 servicemembers far away from family. They have no support

1 systems. If their commander berates them or demeans them,
2 that is as good as your father berating you or demeaning
3 you. It is so undermining. And for the commanders not to
4 be trained to know the basic things that you did not know --
5 no one trained you on this -- it is not fair for the
6 military because they do not have the tools they need to
7 protect these servicemembers.

8 And I think the stigmatization of asking for help has
9 to be addressed, and I think you are right to start early.
10 Start it in even for the service academies, even for
11 enlisted, just start a process that is better.

12 Senator Hawley?

13 Senator Hawley: I just wanted to piggyback on that.
14 Since it sounds like Senator Gillibrand has you writing
15 recommendations, I want to suggest one more thing to add to
16 that, and it is on the commander training piece. I just
17 wonder, so anecdotally -- and this is pure anecdote, so this
18 is why I would like your expertise on this -- anecdotally,
19 as someone who has taught -- I used to be a professor, and I
20 have worked with young people, young men in particular, that
21 I taught -- what my anecdotal experience has been is that
22 young men, in particular, if you say to them, you know,
23 "Will you see a counselor?" Oh, no. Big stigma. "A mental
24 health professional?" Oh, no, no, no, no. "A doctor?" No,
25 no, no.

1 "Will you get mentored?" Oh yeah, sure. Mentoring,
2 yes. "Leadership training?" Oh, absolutely. Leadership
3 training, yes, absolutely.

4 So I am just wondering, my question to you is, when we
5 think about the commanders, is there something we could do
6 or we could help give them training where they recognize
7 these signs, they can intervene, and they know how to say
8 that, listen, we can be the first line here, and it is not
9 about triggering all the different stigmas but it is about
10 us recognizing that this guy or this gal is in crisis, and
11 we can approach them as the leader and help them, nudge
12 them, help them get the help that they need.

13 You know, is there something we can do in the training
14 component for our commanders that can help that, where we
15 avoid some of those stigmas that for a lot of folks I think
16 are tripwires, where they just check out, like, no, I am not
17 going to do that.

18 Senator Gillibrand: It is almost like it is resiliency
19 training. And it was interesting. Mr. Ford said that we
20 should be looking at mental health as a readiness issue. So
21 if you saying we want everyone to be ready, it is a
22 readiness issue and it is a resiliency training issue. And
23 giving more access to this analysis, the commanders and to
24 the servicemembers and veterans themselves, I think is
25 necessary.

1 Just even the awareness, Dr. Doraiswamy, when you have
2 a handheld app, and you can even self-diagnose, like go
3 through a program that the DoD can develop to say, "Oh, my
4 God, I have got so many risk factors. I need some
5 resiliency training." You know, some kind of like you need
6 resiliency training, and that is not a negative thing to
7 sign up for immediately. Something as simple as that, where
8 you are not seeing a shrink, you are not getting medicated,
9 but you are doing something positive that is supported.

10 Because Dr. Carter's son -- you were not here, but he
11 self-medicated. He was trying to manage his PTSD, trying to
12 manage his anxiety, because that is what servicemembers do.
13 They try to fix it themselves. They do not want to go to
14 help. And he was punished for that. So that is the problem
15 I see in all your testimonies.

16 Please submit the letters. We are here to work hard to
17 lift up these stories and this advice in a very productive
18 way.

19 Thank you. Meeting adjourned.

20 [Whereupon, at 12:13 p.m., the subcommittee was
21 adjourned.]

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