Chairwoman Gillibrand, Ranking Member Tillis, and distinguished subcommittee members, thank you for this opportunity to testify.

I am Dr. Beth Zimmer Carter; I come to you with a unique perspective. I am a Family Physician, retired Army Reserve LTC with command experience, and proud mother of Special Forces Army Ranger Christopher Carter, who died by suicide at age 22.

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

Just months before the end of his Army commitment, Chris was self-medicating with marijuana, legal in his state, to control anxiety and insomnia after medical and mental health treatments failed. He self-admitted this to his new command, who later stated to me, they "felt the need to make an example of Chris," as he was in a leadership position, and many others in the unit were also using marijuana. He was demoted, sacrificed a month's pay, made to do humiliating work, confined to the compound, and they initiated "other-than honorable" discharge proceedings. Chris was already anxious, dealing with PTSD symptoms, and now humiliated and devastated. He attempted suicide for the first time.

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

The morning of his death, I knew Chris was severely struggling while on duty, and I attempted to contact his superiors to notify them and request their assistance. Even though I am a retired Army commander, I was told "the command speaks to soldiers, not moms." Chris proved his suicide sincerity that afternoon on Feb 12, 2015. We buried him on his 23rd birthday.

There were multiple opportunities for the military to recognize the risks and invoke alternate, life-saving approaches, as Chris had:

- Several blast concussive exposures, known to cause Traumatic Brain Injury.
- Been diagnosed with multiple high-risk mental health conditions.
- Felt trapped and hopeless having to re-enlist another year in a toxic environment.
- Humiliation, financial consequences, and legal ramifications due to help-seeking self-acknowledgement of his marijuana use.
- Survivor-guilt after losing his buddy and teammates.
- Recent exposure to the suicide of someone he identified.

Instead, many of the military's actions are known to increase suicidal risks.

Commanders need to:

- Encourage, Support and Reward self-help. Those that stigmatize, isolate, and punish should be held accountable.
- Require mandatory group or personal mental health intervention after a traumatic event, especially one with personnel loss.
- Embed mental health providers in units, to normalize mental health and ease of access, just as with physical health medics and sick bays.
- Communicate to distant families how to enlist support when concerned.

Military Medicine should:

- Get up-stream in prevention. Require mandatory annual mental check-ups just like physical check-ups.
- Better recognize symptoms and use evidence-based treatments for PTSD and suicide care.
- Improve substance abuse treatment options.
- Expedite the Medical Board Process, to a 30-day maximum wait.

Military Institutions must:

- Destigmatize, normalize, and improve access to and use of mental health care.
- Avoid compromising careers for those seeking help.
- Ensure eligible service members are referred to the Warrior Care Programs.
- Continue investigating TBI blast exposure risks and improve prevention, identification, and care.
- Advance Tricare coverage of evidence-based care methods.

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

I am grateful to organizations like the Tragedy Assistance Program for Survivors, the world leader in assisting those who have lost a military loved one. TAPS has been instrumental in support of me and the tens of thousands of military suicide loss survivors.

I appreciate the opportunity to share Chris's story. He was an extraordinary young man with a bright future and will be forever loved and missed. Thank you for considering these insights and recommendations to reduce the preventable devastation caused by a death from suicide.

I look forward to answering any questions you have.