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**UPDATE ON MILITARY SUICIDE  
PREVENTION PROGRAMS**

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HEARING

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES  
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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HEARING HELD

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## **UPDATE ON MILITARY SUICIDE PREVENTION PROGRAMS**

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HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ARMED SERVICES,  
SUBCOMMITTEE ON MILITARY PERSONNEL,  
*Washington, DC, Thursday, March 21, 2013.*

The subcommittee met, pursuant to call, at 10:02 a.m., in room 2118, Rayburn House Office Building, Hon. Joe Wilson (chairman of the subcommittee) presiding.

### **OPENING STATEMENT OF HON. JOE WILSON, A REPRESENTATIVE FROM SOUTH CAROLINA, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL**

Mr. WILSON. I would like to welcome everyone to a meeting of the Military Personnel Subcommittee on the very important issue of military suicide prevention programs. Today the subcommittee meets to hear testimony on the efforts by the Department of Defense and the military services to prevent suicide by service members, military families, and civilian employees.

I want to preface my statement by recognizing the tremendous work the Department of Defense and the service leadership has done to respond to the disturbing trend of suicide in our Armed Forces. This has not been an easy task and I thank you for your hard work.

Suicide by members of our Armed Forces is particularly distressing to me because I consider military service an opportunity for a person to achieve their highest ability of fulfilling life. I also consider military service as a family, where we want the best for each other and we care about each other.

I want service members to know they are talented people who are important and appreciated by the American people. They can overcome challenges.

Suicide is a difficult topic to discuss. Last year 350 service members took their own lives. Each one of them is a tragedy.

Every one of them has a deeply personal story. We cannot rest until we have created every opportunity to change such an awful statistic.

Suicide is a multifaceted phenomenon that is not unique to the military. Unfortunately, in addition to the hardships of military service, our service members are subject to the same pressures that challenge the rest of society. They are exposed to the same stressors that may lead to suicide by their civilian counterparts.

I am deeply concerned about the uncertainty of sequestration and the coming budget challenges, how that will affect our service members and their families. Each of the military services in the

Department of Defense has adopted strategies to reduce suicide by our troops.

I would like to hear from our witnesses whether those strategies are working. How do you determine whether your programs incorporate the latest research and information on suicide prevention?

I am also interested to know how Congress can further help and support your efforts. Lastly, I am interested in learning how our civilian experts are tackling the problems across the Nation and how private organizations, like Hidden Wounds of Columbia, are assisting and making a difference.

With that, I want to welcome our witnesses and I look forward to your testimony.

Before I introduce our panel, let me offer Congresswoman Susan Davis from San Diego an opportunity as ranking member to make her opening remarks

[The prepared statement of Mr. Wilson can be found in the Appendix on page 37.]

**STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL**

Mrs. DAVIS. Thank you, Mr. Chairman.

And welcome to all of you. Thank you so much for being here and sharing your expertise with us.

I am pleased that the subcommittee is continuing its attention on suicides in the military. It has been nearly a year and a half since our last hearing, and during this time we have only seen increased numbers of service members taking their own lives. And behind each statistic we know there are families with shattered lives.

While Congress has pushed forward a number of initiatives to support the Services and the Department of Defense in their efforts to develop policies and programs to reduce and prevent suicides in the force, we know that these numbers continue to grow.

And yet, we also know that military service members are not alone. Over 38,000 individuals die by suicide every year.

In 2010, suicide was the 10th leading cause of death in the United States and the fourth leading cause of death for adults between the ages of 18 and 65. While suicide among young individuals from 15 to 25 years continues to be a concern, the rate of suicide among older Americans is even higher.

It is important that we share what we learn in the military and what is learned by others in our country if we are to be successful in addressing this societal issue. The establishment of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces in the Duncan Hunter National Defense Authorization Act of Fiscal Year 2009 was a start, only a start.

The task force made 76 recommendations, and I am interested in where the Department and the Services are in implementing these recommendations. Have we walked back all the cases that we are aware of and understanding the dynamics involved in all of those?

Have we completed all of these recommendations? And if so, what metrics are being used to track success? What other efforts can be undertaken to address suicide in the military?

I welcome all of you, our witnesses, and look forward to hearing from you about what has been done, what is being done, and where do we go from here in our efforts.

Thank you, Mr. Chairman.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 38.]

Mr. WILSON. Thank you, Mrs. Davis.

I ask unanimous consent to include into the record a statement from Congressman Rush Holt of New Jersey.

[The prepared statement of Mr. Holt can be found in the Appendix on page 39.]

Mr. WILSON. Without objection, so ordered.

We are joined today by an outstanding panel. Given the size of our panel and the desire to give each witness the opportunity to present his or her testimony and each member an opportunity to question the witnesses, I would respectfully remind the witnesses to summarize, to the greatest extent possible, the high points of your written testimony in 3 minutes. I assure you that your written comments and statements will be made part of the record.

Let me welcome our panel: Jacqueline Garrick, Acting Director, Defense Suicide Prevention Office; Lieutenant General Howard B. Bromberg, U.S. Army, Deputy Chief of Staff, G-1, U.S. Army; Vice Admiral Scott R. Van Buskirk, Director, Military Personnel, Plans and Policy, U.S. Navy; Lieutenant General Darrell D. Jones, Deputy Chief of Staff for Manpower and Personnel, U.S. Air Force; Brigadier General Robert F. Hedelund, Director, Marine and Family Programs, U.S. Marine Corps.

And, General, thank you for being here today. This is your first appearance before this committee.

Jerry Reed, Ph.D., Vice President and Director, Center for the Study and Prevention of Injury, Violence and Suicide, the Suicide Prevention Resource Center.

We will proceed, beginning with Ms. Garrick, with opening statements, and it is imminent that we will be having votes. We will, at a prudent time, suspend and then return.

And, Ms. Garrick.

**STATEMENT OF JACQUELINE GARRICK, ACTING DIRECTOR,  
DEFENSE SUICIDE PREVENTION OFFICE**

Ms. GARRICK. Thank you, sir. Of concern for DOD [Department of Defense] is the rate of suicide among its forces, which rose in the past decade from 10.3 to 18.3 per 100,000.

While we saw leveling in 2010 and 2011, the suicide rate for 2012 is expected to increase. DOD has closely tracked every suicide and attempt published in the DODSER [Department of Defense Suicide Event Report] since 2008.

Therefore, we know the majority of our suicides were completed by Caucasian males below 29, enlisted, and high-school educated. In some cases, relationship, legal or financial issues were present.

Service members primarily used firearms and died at home. They did not communicate their intent, nor did they have known behav-

ioral health histories. Less than half had deployed and few were involved in combat.

Nonfatal suicide attempters were similar to those who died. However, those used primarily drugs and had at least one documented behavioral health disorder.

A DOD task force report made 76 recommendations, with the first establishing the Defense Suicide Prevention Office to oversee all strategic development, implementation, standardization, and evaluation of DOD's suicide and resilience activities.

NDAA 13 [National Defense Authorization Act for Fiscal Year 2013] codified this office, which enhances its authority to implement the remainder of the legislation.

A general officer steering committee established priority groups on data, stigma, lethal means, investigations, research, and evaluations, and the Department has made significant strides.

The Defense Suicide Prevention Program Directive will set policy and assign responsibilities. DOD and V.A. [U.S. Department of Veterans Affairs], along with CDC [Centers for Disease Control and Prevention], created a suicide repository going back to 1979, so that now the DOD can affirm military service for the CDC, enhancing its ability to track Guard and Reserve and service member deaths overseas. This will enhance our research, longitudinal studies, and population health surveillance.

DSPO [Defense Suicide Prevention Office] program evaluation approach tracks requirements, funding, and will unite efficiency measures with effectiveness for continuous process improvement reporting on shortfalls and duplications. We are evaluating training to develop core competencies for peer, command, clinical, and pastoral requirements.

A critical aspect of preventing suicide is eliminating stigma that prevents service members or families from seeking help. DOD and V.A. are implementing President Obama's executive order and have a 12-month help-seeking "Stand By Them" campaign to encourage service members, veterans, and their families to contact the military crisis line by phone or online.

We are expanding it in Europe and we are expanding it to Japan and Korea. It is at larger bases in Afghanistan, and where it is not available we have trained medics to initiate a peer support call line, similar to the Guard's Vets4Warriors program.

Since service members often believe that seeking care is career-ending, training is key. In reality, denials and revocations involving mental health are less than 1 percent. Therefore, service members must understand that seeking help is a sign of strength and it does not jeopardize their clearances.

Postvention has implications for prevention and reducing suicide contagion. A postvention guide was published for Reserve Component commanders, and we do a debriefing with TAPS [Tragedy Assistance Program for Survivors] on factors leading up to a service member's death, as reported by the families. And this dialogue builds a frame of reference that the DODSER alone does not provide.

DOD is clarifying the NDAA 13, which authorizes mental health professionals and commanders to inquire about privately owned firearms, ammunition, and other weapons, and we have developed



a family safety curriculum with Yellow Ribbon and the Uniformed Services University, and have distributed over 75,000 gun locks.

Since we know suicide and attempts are associated with prescriptions, DOD started a drug take-back study, allowing beneficiaries to return unused medications in compliance with DEA [Drug Enforcement Agency] rules.

We continue to improve access to quality of care, with behavioral health providers being embedded at the unit level, and we will continue to evaluate that.

DOD has developed a research plan and created teams to translate findings from studies into policies and practices. We have responded to the NDAA 12 by creating a community action team, partnering with nonprofits, universities, and others to assess practices and share lessons learned in family and peer support.

We have expanded Partners in Care, a chaplain program in which faith-based organizations provide support to the Guard and Reserve. And we are exploring therapeutic sentencing techniques for military justice proceedings, as used in Veterans Treatment Courts.

We have worked with the Action Alliance on the National Suicide Prevention Strategy, and we have partnered with the Department of Veterans Affairs on the Veterans Crisis Line, making sure that material is at pre-separation counseling and is incorporated into transition briefings.

So in closing, DOD fervently believes that every one life lost to suicide is one too many and prevention is everybody's responsibility. No stone is being left unturned, and this is a complex issue. The challenges are great. However, this fight will take enormous collective action and the implementation of proven and effective initiatives.

DOD remains optimistic that it will find better solutions that will save more lives.

Thank you, sir.

[The prepared statement of Ms. Garrick can be found in the Appendix on page 41.]

Mr. WILSON. And thank you, Ms. Garrick.

And, General Bromberg, we will proceed. And the moment you get through, the buzzers indicate it is a vote, and so we will then suspend.

**STATEMENT OF LTG HOWARD B. BROMBERG, USA, DEPUTY  
CHIEF OF STAFF, G-1, U.S. ARMY**

General BROMBERG. Yes, sir.

General Wilson, Ranking Member Davis, distinguished members of the subcommittee, on behalf of our Army, thank you for continued strong support and demonstrated commitment to our soldiers, civilians, and families.

As you know, our Nation has been at war for nearly 12 years. Our soldiers, families, and civilians remain the strength of our Nation and have demonstrated unprecedented strength, performance, and resilience. And while physical injuries may be easier to see, there are many invisible wounds, such as depression, anxiety, post-traumatic stress, that also take a significant toll on our service members.

Army leaders at all levels are committed to eliminating the negative stigma associated with seeking help; building physical, emotional, and psychological resilience in our soldiers and families and civilians; and ensuring that anyone who may be struggling gets the help he or she needs.

Tragically, though, the Army has had 324 potential suicides during 2012, the highest annual total on record. Of those, 183 deaths occurred within the Active Component and Reserve Component on Active Duty. The Reserve Component not on Active Duty, a total of 141, is the second highest on record.

While most Army suicides continue to be among junior enlisted soldiers, the number of suicides by noncommissioned officers has increased each of the last 3 years. And almost one-third of our Army suicides have no deployment history and almost 18 percent have never been mobilized from the Reserve Component.

By far, most Army suicides are in the 21- to 30-year-old age range, and that trend has held since 2010.

And, as already mentioned, suicide is not solely a military problem. It is a rising national issue. And while it is difficult, we must use extreme caution when directly comparing the Army population with the general population.

The 2010 national suicide rate is slightly higher than the Army Active Duty rate for 2010 and 2011. This very general comparison strongly supports the idea that suicidal behavior is an urgent national problem that affects all Americans across all dimensions of society, including those who have chosen to serve the Nation by serving in the Army.

And we believe we have an historic opportunity to understand the lessons of the last 12 years and make our force even stronger. And the Army is now moving forward with our Ready and Resilient Campaign plan. This campaign is focused on making resilience a part of our culture and integrates and synchronizes multiple efforts and programs designed to improve the readiness and the strength and resilience of the Army team.

I assure the members of this committee there is no greater priority for myself and other senior leaders of the United States Army than the safety and well-being of our soldiers.

Suicide does remain a complex issue. It is a hard enemy, both for the Army and the Nation. The loss of any life is tragic, and it is imperative that we make a holistic approach to addressing this complex challenge.

Mr. Chairman, Representative Davis, members of the committee, thank you and I look forward to your questions.

[The prepared statement of General Bromberg can be found in the Appendix on page 55.]

Mr. WILSON. General, thank you very much.

And we will suspend and we will begin immediately with Admiral Van Buskirk.

Thank you.

[Recess.]

Mr. WILSON. The Subcommittee on Military Personnel update on military suicide prevention programs shall resume.

And, Vice Admiral Van Buskirk.

**STATEMENT OF VADM SCOTT R. VAN BUSKIRK, USN, DEPUTY  
CHIEF OF NAVAL OPERATIONS, MANPOWER, PERSONNEL,  
TRAINING, AND EDUCATION, U.S. NAVY**

Admiral VAN BUSKIRK. Chairman Wilson, Ranking Member Davis, distinguished members of the committee, thank you for holding this hearing and affording the Navy the opportunity to provide an update on our suicide prevention and resiliency programs.

Sadly, last year the Navy experienced 65 suicides in our Active and Reserve forces, an increase of six over the previous year. We have already suffered the loss of 13 shipmates this year.

We clearly have more to do. Suicide prevention remains a top priority of the Navy leadership, and we remain committed to doing everything possible to save lives.

We continue to vigilantly monitor the health of the force and investigate every suicide and all suicide-related behavior. We take what we learn from our investigations and adapt our education, programs, and prevention strategies.

Operational Stress Control is a centerpiece of our strategy. It is the way we inculcate our new accessions, the way we deliver our training to the fleet and to our leaders. It is a method we use to increase the awareness and strengthen our resilience.

Our Operational Stress Control Program provides an integrated structure of health promotion. It focuses on building resilience, addressing problems early, and promoting a healthy and supportive command climate. We continue to evaluate the response to this critical asset.

Our Navy leaders recognize that they are the key to destigmatizing help-seeking behaviors. The unity of effort at the deckplates is where we strengthen our sailors.

The deckplates is where we identify and mitigate the signs of stress and help our sailors cope and acquire necessary treatment for stress injuries. By teaching sailors better problem-solving skills and coping mechanism for stress we will make our force a much more resilient one. We will continue to do everything possible to support sailors so that they know their lives are valued and are truly worth living.

Thank you, and I look forward to your questions.

[The prepared statement of Admiral Van Buskirk can be found in the Appendix on page 67.]

Mr. WILSON. Thank you very much, Admiral.

General Jones.

**STATEMENT OF LT GEN DARRELL D. JONES, USAF, DEPUTY  
CHIEF OF STAFF FOR MANPOWER AND PERSONNEL, U.S. AIR  
FORCE**

General JONES. Chairman Wilson, Congresswoman Davis, and distinguished members of the committee, thank you for allowing me to testify before you today on behalf of the Chief of Staff of the United States Air Force and all airmen stationed around the world.

Air Force leaders at all levels are committed to suicide prevention through our wingman culture. Suicide prevention is not the purview of the personnel or the medical community. It belongs to commanders and leaders at all level. This is the overarching premise on which the Community Action Information Board was

built and the cornerstone of the Air Force Suicide Prevention Program. Evidence shows this is the necessary framework for effective intervention across the force.

Suicide prevention is a contact sport. It starts with leadership involvement, from the chief of staff to the newest first-line supervisor.

In a wingman culture, airmen look out for their fellow airmen. We teach them to identify risk factors and warning signs for suicide and to take appropriate action once these indicators are identified.

We realize we must continue to reevaluate and enhance our prevention efforts. And, with this in mind, we have taken on several initiatives across the Air Force.

We require front-line supervisor training for our most at-risk career fields and one-on-one training for this program. We are also increasing our mental health provider staff by 335 people of additional trained professionals through fiscal year 2016. And we are revising our Air Force Guide to Managing Suicidal Behavior, which has proven to be an effective clinical tool over the past 10 years.

Within the Air Force, we have not experienced a link between suicides and deployment. The most significant risk factors for suicide in the Air Force continue to be problematic relationships, legal or administrative issues, work-related problems, or a combination of these factors.

We continue to research how we can better identify those at risk to achieve the earliest possible intervention. One such study explores how social media impacts their relationships, help-seeking behavior, and emotional well-being. We are also conducting several research projects examining the role of life events and social stressors in the suicides of our military members.

We continue to collaborate with the Defense Suicide Prevention Office, our sister services, and the Department of Veterans Affairs. Our goal is to leverage our internal resources, combining our experiences and best practices to improve suicide prevention across the force.

We need every airman as we face the difficult challenges ahead. All leaders are responsible for promoting our wingman culture and removing any barriers to a healthy force.

Thank you for your attention to our efforts and for your support in these endeavors to keep all of our airmen healthy and ready. I look forward to answering your questions.

[The prepared statement of General Jones can be found in the Appendix on page 79.]

Mr. WILSON. Thank you very much, General Jones.

And we now proceed to General Hedelund

**STATEMENT OF BGEN ROBERT F. HEDELUND, USMC, DIRECTOR, MARINE AND FAMILY PROGRAMS, U.S. MARINE CORPS**

General HEDELUND. Chairman Wilson, Ranking Member Davis, and distinguished members of the committee, it is my privilege to appear before you today and I would like to thank you for allowing me to testify on behalf of Lieutenant General Milstead.

Like our Commandant, we both are engaged and committed to tackling the complex problem of suicide amongst our marines. It is an all-hands effort to us.

As our Commandant has said, one suicide is one too many. Each suicide has far-reaching impact on families, friends, and fellow marines.

Regardless of the total number, every single suicide is a profound tragedy. Whether we have one or many, we will expend whatever effort is required to gain ground and get ahead of this problem.

As we all know, discovering, and ultimately understanding, what leads one to suicide is elusive. It is very difficult to identify one trend or factor as a key to unlocking the secret to suicide for our population.

However, through our data, tracking, and research, we have found that the primary stressors and risk factors associated with marine suicides and attempts are legal and disciplinary problems, relationship problems, behavioral health diagnoses, financial problems, and substance abuse, or a combination thereof.

Regardless, we are committed to exploring every potential solution, using every resource we have available, and making the right investments toward saving marine lives. We deeply believe that preventing suicide requires engaged leaders who are alert to those at risk and take action to help marines before they reach crisis.

We take care of our own. Thus, we are committed to breaking the stigma that may still exist in pockets around our Corps for those who seek help. We never leave a marine behind on the battlefield and we won't leave a marine behind at home.

We thank you for bringing attention to this national problem, and I look forward to your questions.

Thank you.

[The prepared statement of General Hedelund can be found in the Appendix on page 88.]

Mr. WILSON. Thank you, General Hedelund.

And we now will conclude testimony with Dr. Jerry Reed

**STATEMENT OF DR. JERRY REED, PH.D., MSW, VICE PRESIDENT AND DIRECTOR, CENTER FOR THE STUDY AND PREVENTION OF INJURY, VIOLENCE AND SUICIDE, SUICIDE PREVENTION RESOURCE CENTER**

Mr. REED. Good morning, Chairman Wilson, Ranking Member Davis, and members of the subcommittee.

My name is Jerry Reed and I serve as the director of the national Suicide Prevention Resource Center and as co-director of the Injury Control Research Center for Suicide Prevention.

Suicide is not just a challenge for the defense or veteran communities. It is an American challenge that calls us all to action. Every suicide is a tragedy.

In the United States, suicide is the 10th leading cause of death, claiming more than 38,000 lives in 2010. By comparison, homicide was the 16th leading cause of death, claiming more than 16,000 lives, or fewer than half the deaths than by suicide.

There is no single cause for suicide, no single solution, and no single agency, department, or person can fight this battle alone. We all have a role to play.

While suicide touches all ages across the lifespan, in the general population it is the third leading cause of death for those 15 to 24 years old and the second leading cause of death for those 25 to 34 years old. Suicide rates generally increase with age.

A few similarities between the military and the general population are: more men die by suicide than women, firearms are used in both populations and the outcome is often lethal, and substance use is often a factor in both attempts and completions.

Intuitively, we would expect the military to have lower rates because service members are screened for mental illness and drug abuse on entry into Active Duty, they are healthier than the general population, they are fully employed and fully insured, they are routinely screened for drug use, and they have access to mental health care. Yet, rates in the military have been rising over the past 10 years and this is cause for concern.

What we don't know is why rates are rising and what can be done to reverse this trend. We need to more fully understand the role of combat, deployment, and exposure to traumatic events on suicide risk. We also need to explore why rates are higher among junior enlisted personnel, some of whom have not been exposed to combat, and to better understand the process of help-seeking in our military.

From what we know nationally, some of what has been shown to yield positive results include: following a comprehensive approach, combining several initiatives that target different behaviors, populations and settings. Examples of this that have been or are being pursued in DOD are the Air Force Suicide Prevention Program or the No Preventable Soldier Deaths Campaign at Fort Bliss.

We know that no one program or intervention by itself will suffice. We need to ensure a cohesive approach is taken.

The National Registry for Evidence-Based Programs and the Best Practices Registry include over 100 programs, materials, and practices that science and experience show can prevent suicidal behaviors and reduce risk.

Following a public health approach, we need to look at the data, develop a comprehensive strategy, implement interventions, measure their effects, and evaluate outcomes.

In my closing comments, I would like to offer the subcommittee a few recommendations to consider as we move forward: Follow a battle plan that is comprehensive and incorporates both public health and mental health perspectives. We will not simply treat ourselves out of this challenge.

Our current battle plan is the recently released National Strategy for Suicide Prevention. It is a comprehensive document and guides our national effort.

We also should take steps to successfully integrate DOD and the V.A. activities where possible, and efforts with those going on with the Action Alliance for Suicide Prevention, chaired by former Senator Gordon Smith and Secretary of the Army John McHugh.

This public-private partnership, launched in 2010 by Secretaries Gates and Sebelius, holds great promise for suicide prevention. The alliance has set a goal to save 20,000 lives over 5 years, and we are serious about advancing steps that will move us in this direction.

We should explore ways to ensure that those at risk for suicide do not have access to lethal means, ensure seamless care for those transitioning from Active service to veteran status and from Active service to inactive Guard or Reserve status, and ensure service members know how and where to receive help. And we should also build upon success stories and implement, evaluate, and most importantly, scale up when we see initiatives that are making a difference.

When we implement a program that works, we need to ensure it is sustained over time. And we need to think from both an individual perspective, focused on the service member in need, and from a systems perspective, ensuring that every door a service member enters is the right door and that there is continuity in the care provided between systems.

Finally, we need to change the way we talk about suicide by including stories of hope and resilience through public awareness campaigns, such as DOD's Real Warriors and V.A.'s Make the Connection.

It is important to remember that suicide prevention is a relatively new field of study. And as we have observed from working on other public health issues, the effects of prevention require us to be patient, deliberate, and most importantly, to stay the course.

Thank you for the opportunity to join you this morning. We need to approach this battle with the collective attitude of one team with one fight. It is important to remember that our military comes from the general community and will someday return to the general community.

The more we can do together, the better for those we wish to serve. By working together I am confident that we can and will save lives.

Thank you.

[The prepared statement of Dr. Reed can be found in the Appendix on page 98.]

Mr. WILSON. Thank you very much, Dr. Reed.

And we now will proceed to each member of the subcommittee asking questions for 5 minutes. The time will be determined by Jeanette James, our professional staff personnel. And she herself is a retired Army nurse, and she has been so helpful being a resource to this subcommittee and to the committee at large.

As we begin, from Ms. Garrick and for our service personnel who are here, as a 31-year veteran of the Reserves and Guard myself, as the proud dad of three members of the Army National Guard, I really appreciate Guard service and Reserve service, and we have really relied on the Guard and Reserve as never before, successfully, with overseas operations. But when our Guard members return they don't have the 24/7 support of military facilities; equally, they have the stress of military, but also civilian stress.

Beginning with Ms. Garrick, what programs are there that could and do apply to Guard members?

Ms. GARRICK. We have several programs that we are looking at with the Guard. The one I mentioned, the Partners in Care project, leverages the faith-based communities and is a chaplain program specifically, so that is very helpful in terms of providing some very specific boots on the ground.

And then, of course, our Yellow Ribbon Reintegration Programs are very important, very vital to the pre-, during, and post-deployment phases of the Guard and Reserve deployments. We also have a postvention guide that we have worked on for Reserve component commanders, if there is—had been a death in their unit, that they have the tools and the techniques that they need to be able to respond to a suicide in the unit.

We are doing a Safe at Home program, specifically, that would roll out under Yellow Ribbon. We have distributed about 75,000 gun locks; most of those have been through the Guard. And I think our Vets4Warriors, the call center that utilizes a peer support model, has been very helpful.

So those are some of the programs that I have seen that I think have been working really well with the Guard and Reserve.

Mr. WILSON. Thank you.

General Bromberg.

General BROMBERG. Yes, sir. All our programs in the Army, we are mirroring those at the—trying to mirror those at the State and local level through both the United States Army Reserve command and also through the National Guard. The increased capacity for behavioral health touch points and services available to our Guards, or it has already mentioned the Vet4Warriors peer lines is very good.

Additionally, the United States Army Reserve has reached out to the employer network as well, to link up returning veterans with employers to solve that challenge, which I think is very key. Because we have seen, as I looked at eight recent suicides in the National Guard across the Nation were all linked—one of the causes was—we think was linked to unemployment. So how can we employ that employer network back?

Additionally, Health Promotion & Risk Reduction Councils that we do on the Active side, we are mirroring those at the State and local level also with additional capacity, so they can look inside their units.

And as you know, sir, the challenge of connecting to a guardsman who is not seen every day by a leadership or a chain of command is something we have asked the Guard and Reserve to get after as well.

But, again, a complete mirroring of our programs.

Mr. WILSON. Thank you.

Admiral Van Buskirk.

Admiral VAN BUSKIRK. Yes, sir. In addition to all of our operational stress control programs, which are available to our reservists, we specifically have a Navy and Marine Force Reserve Psychological Health Outreach Program that specifically targets our Reserve Components, both in the Navy and the Marines.

These are 55 specific individuals that we embed with our reservists and that are part of a team that have the behavioral health specialists with them to meet the needs of those personnel who may need to seek their professional help, and also for those people to be able to recognize where help is needed.

In addition to that, we have our Returning Warriors Program, where our—all of our people who are returning—mobilized who are returning back to the States from the deployment go through re-



turning warrior workshops, where additionally we have health professionals embedded to help our people cope—not just our personnel, but their families as well, because it isn't just about the individuals, it is about the families being able to cope with the stress that our personnel have endured.

Mr. WILSON. Thank you.

And, General Jones.

General JONES. Sir, I echo the challenges that we have with Guard and Reserve members as they come home and disperse back into the community. But we are trying to mirror many of the same programs we have found success with on the Active Duty side. The Community Action Information Board in the Guard and the Reserves followed suit, establishing a wing director of psychological health to help monitor these programs and just check on how our airmen are doing when they get back home.

The Guard and Reserve, over the last few years in the—on the Guard side of the house since 2007, have averaged about 16½ suicides a year. On the Reserve side it was somewhat less, about 7½. But it is positive to report that on the Reserve side, the numbers significantly dropped between 2011 and 2012. On the Guard side, we saw a slight spike in 2012, but since 2013, so far this year we have had zero suicides in the Guard or the Reserve, which we are very excited about that. And we know that is just a temporary trend but we want to see how long we can keep that going to help our airmen.

Mr. WILSON. Very encouraging.

Concluding with General Hedelund

General HEDELUND. Yes, sir, thank you.

Many of the relationships that have already been mentioned, the Marine Corps maintains with its Reserve community as well. And I think that in this current environment where we are deploying fewer Reserve units in full, but we continue to deploy Reserves as individuals; we have to ensure that we are making that transition to services for them in a more individual way.

We, too, take advantage of the Yellow Ribbon Program, of course, and we have a Reserve Component that is investing in additional behavioral health specialists to put in key places around the country to address needs in the Reserve community.

But every directive, MARADMIN [Marine Administrative Message], or initiative that goes forward, you will see at the bottom of it, “this applies to the total force.” So every requirement, all the training, education, et cetera, that Active Duty marines are required to fulfill, those commanders and marines that are in the Reserve force are also required to fulfill. So the same support that we give to our Active Duty we provide to our reservists, although delivery sometimes varies.

Mr. WILSON. Well, thank you all. And as part of the military family I particularly want to thank you.

And we now proceed to Congresswoman Susan Davis, the ranking member.

Mrs. DAVIS. Thank you. Thank you, Mr. Chairman.

We all know that there are a multitude of programs that have been in existence for some time and are relatively new. I wonder if you could talk more about how we are evaluating them.

This is difficult because you can't necessarily evaluate a non-event either. If in fact we have people who are not moving to suicide as a result of programs, which we hope is what exactly is happening, but we know in many cases it is not.

Could you talk more about that and about the tools that are being used? And how are really knowing that they are evaluating what we need to know?

Ms. GARRICK. Yes, ma'am. As you recall, the task force report made some recommendations about doing some program evaluation, so that is one of the priority areas that we are concentrating on.

So we have developed what we call a capacity analysis program evaluation approach, where we have taken actually the national strategy, the task force recommendations, the NDAA 12 and 13. So we have outlined all the strategies and then we have looked at the programs and we have started to line up—and we work very closely with the Services; they are providing us with the data and the inputs on what their programs are, what they look like, so that we can start beginning to flesh out what are the programs, what strategic objective are they supporting, and then what are some of the costs that bounce up against those programs.

And then when we look at the strategy we can see, so where are the gaps and overlaps?

Mrs. DAVIS. Ms. Garrick, do you have a sense of a timeline, because we have been with this for a while? Obviously, you can gather data for a pretty long time and we don't—you don't always know what is going to happen a few years down the line.

I am just wondering at what point we will have a comfort level that, in fact, there are some programs that actually aren't doing what we would like them to do and that we are able to shift some of those resources or, you know, activities that are different and that are making a difference.

Ms. GARRICK. Correct. So we started this process of just beginning—pulling the inventory together about 4 or 5 months ago, and we have made quite a bit of progress in what that inventory is, and we have developed sort of a rough order of magnitude on what have we covered down on. And I am hoping by the end of this fiscal year, all things considered, that we will actually be able to start reporting out on what we are seeing in terms of some gaps and overlaps.

And we couple that with an effort we have with the Department of Veterans Affairs on developing a surveillance database. That is where we have taken the DOD data from DMDC [Defense Manpower Data Center], the V.A. data, and the CDC data and we put surveillance data together so we can start looking at the—what do we know about suicides, what are some of the risk factors, how can we do better longitudinal studies, how can we do better population health surveillance like Mr. Reed described.

So marrying up some of those initiatives—again, it is a big-picture perspective.

Mrs. DAVIS. Yes. It sounds like that in some ways we have identified some age groups, and also the fact that a firearm has been used in many of the cases. Is it clear that there are more firearms used in military or not?

I thought, Dr. Reed, you suggested that that is not necessarily—

Mr. REED [continuing]. Population is about 50 percent of the completed suicides in the civilian population are completed with a firearm; in the military I think it is closer to 60 percent.

Mrs. DAVIS. Sixty percent, okay. I thought that I had heard that it was more than that.

Would that be considered a metric, then? I mean, if we think about metrics and what we are looking for, what—how do you describe that for the general public?

General BROMBERG. Ma'am, if I could add—

Mrs. DAVIS. General Bromberg.

General BROMBERG [continuing]. One of the things that we have studied with our Ready and Resilient Campaign plan, one of our major lines of effort is getting exactly at what you are talking about. So, we have already peeled out like 122 programs to start delving into them.

One of the areas we are looking heavily into right now is does resiliency training or other events like—with our Strong Bonds campaigns and training that deals with reducing stressors in relationships—does that training have a direct effect? So can I take the Strong Bonds training and see if I have a decrease in domestic abuse or relationship issues. And we are starting to gather that data now over this course of the year.

Additionally, what we are looking at with the resiliency training, ma'am, is for those soldiers that have had resiliency training, is there a reduce in gestures, attempts, and ideations. We have one unit we have already looked at, and over the last 18 months we are starting to see a turn.

Mrs. DAVIS. May I just really quickly turn to General Hedelund for a second?

At Pendleton I believe they are doing a program and they have had—actually, they haven't had the suicides in this particular unit. It is a pilot. Are you aware of that?

General HEDELUND. I would have to check and get you more information on that, ma'am.

[The information referred to can be found in the Appendix on page 111.]

Mrs. DAVIS. All right.

General HEDELUND. But I would like to echo that it is an area where we do need to get in and make sure that we have got the evidence-based approach going.

Mrs. DAVIS. Thank you.

General HEDELUND. Thank you.

Mr. WILSON. Thank you, Mrs. Davis.

And we now proceed by order of appearance to Congressman Austin Scott, of Georgia.

Mr. SCOTT. Thank you, Mr. Chairman.

And thank you all for being here. It is certainly an issue that I think is a big concern not only to the members of the committee and the military, but to Americans in general.

And I guess two quick questions I have, and then to get to one more specific.

Ms. Garrick, are there any differences among the trends in the different branches? And is there a correlation behind the men and women who are attempting suicide and the V.A. backlog?

Ms. GARRICK. I think overall and in general what we see with—among all the Services are, the big driving forces are these young white males, junior enlisted, with relationship, financial, and legal issues. And I think that is why a lot of the programs I think speak to targeting that. That is why the resilience piece is so important is to help these young people adjust to the military.

We have seen about the same amount with deployments versus nondeployments, combat, noncombat. So we know that there are other driving forces and factors that come into play.

So we look at those populations, we look at the differences between some of those issues and try to target programs that are very specific. The Services have all blended programs that meet their unique needs as—in their unique environments, whether it is aboard a ship, or in theater in Afghanistan. We have seen some programs that we have done there, as well. I mean, I got to spend some time with the Combat Operational Stress Control Team in Kandahar and did some training with them very specific on peer support and crisis-line work.

So we are trying to be very specific in what we are targeting. And then, in terms of the DES [Disability Evaluation System] issue, I don't know that we see a higher number of suicides among those going through a disability process, although we do know that pain and pain management can be a risk for those who have died by suicide. So there is some correlations there.

Mr. SCOTT. Thank you for that. I would be interested, as time permits—I know you have a lot of programs—to know, essentially, what percentage of our men and women that do commit this are caught up in a V.A. backlog.

[The information referred to can be found in the Appendix on page 111.]

Ms. GARRICK. Yes.

Mr. SCOTT. Because that can lead to a tremendous amount of additional stress, as well as the financial conditions that caused the problems.

And so, Dr. Reed, I think I will focus my next question to you, as the doctor. And one of the issues that is brought up again and again is the stigma that is affiliated with the need for assistance and even seeking treatment. That makes it hard for people sometimes to actually reach out to others. I know that we are training people on the warning signs and the seriousness of the issues, which, I think, is wonderful.

And I guess my question is going to get back to the use of a specific therapy with regard to animals, whether it be dogs or some other type of domestic animal that the person is able to establish a friendship with.

But I want to focus on that area, specifically on equestrian facilities. I have got one in my area, Hopes and Dreams Riding Facility. It is in Quitman.

They have a lot of men and women in. They seem to have had a tremendous amount of success with regard to working with people.

And my question is, is there ongoing research with regard to that particular therapy? What are the successes there? And how do we, if it is working—because it does appear to be working from what I see, and again, what I see—how do we get more people involved in those treatment methods that, quite honestly, are at very little cost to us?

Mr. REED. When we were asked by Congress to set up the National Suicide Prevention Resource Center back in 2002 one of the things we were asked to do specifically was to create a Best Practices Registry to begin to serve as a clearinghouse for that which is being done that works.

Today, as I mentioned in my testimony, there are over 100 programs that are listed in the registry. What we need to see happen—I have been to some of the equestrian programs myself; I was out in a tribal community and saw just the benefits of that program for people who might have a difficult time connecting in other ways.

And I think what we have to accept with suicide prevention is, as I mentioned, it is a relatively new field—there is not one solution. It is not necessarily a therapy session in a therapist's office, but it could be an alternative therapy. It could be approaching a connectedness issue through animals or through other kinds of ways to engage a person.

Because part of the challenge is people who struggle with thoughts of suicide don't feel connected to the larger community. And if we can enhance that connectedness through programs such as you have mentioned, and then encourage the program developer to submit that program to the Best Practices Registry for review and hopeful inclusion, we then make it a whole lot more able to be disseminated to the Nation at large to be able to replicate that program if it has got evidence behind it that shows effectiveness.

Mr. SCOTT. Well, thank you for that answer, Dr. Reed. And I guess the one thing that I would, you know—the review process and the other things, I think, if we could expedite them I think that would be a big help.

Thank you, gentlemen, for being here, and ma'am.

Mr. WILSON. Thank you, Congressman Scott.

Now we proceed to Congresswoman Niki Tsongas, of Massachusetts.

Ms. TSONGAS. Thank you, Mr. Chairman.

And thank you all for being here. I commend the work that you all have done, the really focused effort you are bringing to this. And, you know, we all hope going forward we are going to see great progress on this because it is an issue of such deep concern to all of us here, as well as those across the country who hear about the great increase in the numbers of suicides.

But I am concerned that in our current budgetary constraints, in particular sequestration, that this could really undermine all your good efforts and exacerbate the—this particular epidemic. My concern is two-pronged: one, because the strained resources will inevitably force our men and women in uniform to take on more responsibility than ever—in other words, all the pressures of the workplace.

You have looked at, sort of, the legal issues, I mean, that they tend to have relationship issues, financial issues, legal issues—but just the demands of the workplace. We have heard about the multiple deployments, but in reality there are more suicides taking place in people who are not deployed. So is there something in the workplace itself and the demands of the workplace that are exacerbating and causing increased stress?

As one of our witnesses at a recent Oversight and Investigations Subcommittee hearing on the QDR [Quadrennial Defense Review] noted, they said, “You can’t, in reality, do more with less.” And as we have less, you are asking often very young people to do quite a bit more.

Second, I am also worried that the budgetary environment could potentially impede all your prevention efforts from being researched, because a lot of research is certainly going on or fully implemented. So I would welcome all of your comments on just, you know, the stresses in the workplace, how the various cuts coming about one way or the other may, in fact, exacerbate those stresses, and whether or not you see any kind of correlation or are concerned at all as we have to continue to make these cuts. And then second of all, are you worried that it will also have an impact on your—all the other efforts you have put in place?

Ms. GARRICK. Well, ma’am, clearly yes. If we furlough our civilian workforce it means that the military will be picking up some of that workload, so there will be that stress. That stress is ongoing already. We are starting to figure out how we are going to manage that as best we can but it is definitely a concern for everybody across the spectrum, across the Department.

There are some recognition that the workplace stress is certainly a piece of what happens in the nondeployed environment, that we have been at war for 10 years. There is an operational tempo that we are all very conscientious about and that leadership needs to be able to train and mentor junior officers and bring people on board in such a way that helps facilitate a resiliency and mentor them through their careers. And that doesn’t always happen when you have the high operational tempo that we have right now.

So I think your points are well taken and are definitely issues that we are all grappling with and challenges that we will have to face and overcome as we move forward through sequestration, continuing resolutions. I mean, I know you have had many of our senior leaders here discussing those very issues, and clearly, I think there will be ripple effects throughout the Department if sequestration actually goes into effect.

General BROMBERG. Ma’am, with respect to the budget, we are all concerned. But as far as behavioral health and support goes, that is one of our primary areas that we will do everything we can not to furlough in the behavioral health department. And we are going to ask for those exceptions not to do that, to keep that workforce steady so we don’t lose that progress.

With respect to the overall workplace stressors, I think the relationship stressors and those other things you have heard about, alcohol abuse and other things, are just as important as the stress in the workplace. And so working through our Resiliency Campaign, as we continue to train master resilience trainers to teach

people how to deal with the adversities is really key to what we have to do during this time period. And that is one of our major focuses.

Ms. TSONGAS. So the adversities of the workplace as well as the adversities of that which you confront outside the workplace.

General BROMBERG. Disappointments in your family relationships, disappointments if you get in trouble with the law. How do you work your way through that and not get into what they call the “spiral of negative thinking,” the spiral of going down, down, down—how you can help pull yourself out along—and having the leadership engaged with that.

The master resiliency trainers are starting to take effect as put those across all our formations to include families and civilians.

Ms. TSONGAS. Quickly. I have a few more seconds.

Admiral VAN BUSKIRK. Yes, ma’am.

Just, I was in Norfolk 2 days ago doing all-hands calls, one for about 1,200 people, one for about 500—and men and women in uniform, both in the Navy and the Marine Corps. To answer your question, yes. The pressure of the budgetary atmosphere that we are in, the stress, it was significant in terms of the uncertainty that our people are feeling that is being added to the already environment where OPTEMPO [Operations Tempo], PERSTEMPO [Personnel Tempo] are part of the norm in terms of what they are dealing with on a daily basis.

So we have added to that uncertainty with sequestration and the continuing resolution debate that we have been having here and the uncertainty that goes with that.

But from a program standpoint, we remain committed to our programs and we are working to maintain those fully functional. There will be some areas that have more strain than others, but for the behavior health programs that we have, to—keep those fully functional, and we have made those a priority.

Ms. TSONGAS. Thank you.

I think I have run out of time, so thank you, though.

Mr. WILSON. Thank you, Ms. Tsongas.

We now proceed to Congresswoman Kristi Noem of South Dakota Mrs. NOEM. Thank you, Mr. Chairman.

And thank all the witnesses for being here.

This is a tough issue for any family that has lost someone that has taken their own life. And I have a constituent back in South Dakota that is dealing with this, a loss of a son. And, you know, it is a grief that no parent should have to go through.

So I want to thank you for all your work in this area, but obviously we have a long ways to go.

Some of my questions—and, frankly, I have some concerns, and I will direct them at Lieutenant General Bromberg because this young man served in the Army, but after a soldier reaches out for help, what exactly happens at that point?

General BROMBERG. Yes, ma’am.

If the soldier reaches out for help, depends how he reaches out for help. Does he go to a chaplain, does he go to a peer, or does he go to behavioral health? So there are multiple pathways, what we call multiple touch points.

If you start with the unit, training the unit on ask, care, and escort training that teaches the peers to say—ask questions, care about the individual, and escort them to behavioral health. And if they are in the behavioral health network, of course, they go into seeing the behavioral health specialist, and they are treated as they are needed to repair them and get them back to their full capacity. If they go to a chaplain, they can still be referred to that way.

So there are several pathways that the soldier can go down.

Mrs. NOEM. Well, what can happen if the soldier is in counseling then, yet they are soon to be deployed. How is that balanced with their mission that they have in front of them?

General BROMBERG. There are many avenues. For example, if they are in counseling there is a decision made is if the soldier should even deploy. And any soldier that is put on any type of medication, the psychotropic medication, we automatically don't deploy them for at least 90 days to see the effects of the medication.

If the soldier can deal with a mild medication and still deploy, that is a chain of command and a medical decision to make. But there is a 90-day period right there.

Mrs. NOEM. So if they are deployed then they are under the supervision of their commanding officer?

General BROMBERG. And the medical facilities that are forward—

Mrs. NOEM. Medical facility would be—I have that information—

General BROMBERG. Yes, ma'am.

That is tracked in his medical record and it should go forward. I am sure we are not absolutely 100 percent perfect and we have had problems over the past 12 years, but we have improved that to include putting behavioral health forward. So we have behavioral health teams with our forward-deployed organization, which is a step we are doing to standardize that across the Army out through 2016. Because putting behavioral health with the units at the point of action is very key. We have learned that over these last several years.

Mrs. NOEM. You know, I understand that after a suicide occurs that there is an after-action review that it happens with the family. Is there contact with the family during this review?

General BROMBERG. Yes, ma'am. The first is the unit does an after-action review as well as we do after-action reviews all the way up to the Department level. In fact, we meet monthly; the Vice Chief of Staff of the Army hosts a suicide review group with all senior commanders where we look at general trends and cases. And there is also information provided to the family.

Mrs. NOEM. But during that review is the family contacted? I mean, that is the concern that I have with this individual situation is this family was not contacted during that investigation whatsoever.

They were certainly given the advantage of having an after-action review, but I would think if they were really going to understand what happened in that individual situation that there would have to be some kind of communication with the family during the investigation.



General BROMBERG. Yes, ma'am. If you like I can get that follow-on information. We can, you know, dig into the details of this case.

Each one is different. We will normally finish our investigation first. But I will be happy to take that on.

[The information referred to can be found in the Appendix on page 111.]

Mrs. NOEM. Yes, I would really appreciate that, because I think that is a key missing link. And what I am concerned about is that while we are very action-oriented in our military in our national defense, that I don't want us to approach these situations such as checking the box, that we have completed what we feel are requirements, that we need to have the adaptability, the flexibility to care about the individual to take the action that is necessary, because these are crisis situations and just checking the box isn't going to get us the kind of results that we really need and deserve for our service men and women.

Thank you.

I yield back, Mr. Chairman.

Mr. WILSON. Thank you very much, Mrs. Noem.

And we now proceed to Dr. Brad Wenstrup of Ohio

Dr. WENSTRUP. Thank you, Mr. Chairman.

And I applaud all the work that you are doing. I have done some temporary duty at Fort Lewis dealing with suicide prevention. I am familiar with the difficulties in trying to assess and try to prevent and then to try to treat. And I know that your assignment is difficult.

Of course, we are always looking for numbers; we are always looking to try and figure out where are the common trends, and you have identified some of them already, such as legal, financial, and domestic problems.

I know you compare with the civilian numbers, but do we compare, say, 30 and under, of the civilian population? As you mentioned, so many within the military are 29 or younger, so I was curious if we compared in that way and what kind of results you have seen there. Is it pretty similar to the general population?

Ms. GARRICK. Yes, sir. I think Dr. Reed addressed some of that as well. We see a lot of similarities between ourselves and suicide in the civilian population. It is pretty much a mirroring demographic, with young white males with these types of issues and problems. I think there are some studies they have done with college students that look very similar to our population.

Dr. WENSTRUP. So we can't really conclude that this trend within the military is military specific, that that may not be the issue; it may be more societal rather than just military, right, Dr. Reed?

Mr. REED. Great point. And I think that is one thing we really have to tease out. The rate of suicides for 18- to 25-year-olds in the general population is high. It is the third leading cause of death.

So the question really is, what percent of the suicides that are happening in the military in the same demographic are similar, in terms of their cause, to the general population, or perhaps unique to the experience of being in the military?

When you look at another group, the same age group—the college-age student—this population has half the suicide rate of their peers that don't attend college. So what is it that is protecting col-

lege-age 18- to 25-year-olds that is not protecting the general population, or perhaps some of those that are in the military?

These are questions we really have to look at, because it may not be a military-specific explanation for the 18- to 25-year-old suicide rate. It may be more of the fact that these are young people whose brains are still developing. Problem solving skills, coping skills, impulsivity are factors that affect all 18- to 25-year-olds. And maybe we need to look from that perspective as well as we try to address the problem.

Dr. WENSTRUP. Thank you. And so it seems, as often is the case with military research, it tends to benefit the entire country, and I think that this will be a case of that.

The preventive side is often very difficult, obviously. I look at like the ACE [Ask, Care, Escort] program with the Army.

Is there any way of measuring how many saves we have had?

General BROMBERG. Sir, we are just starting to do that now. Earlier example, we looked at one infantry division where they have done now 24 months of resiliency training, and we were tracking the gestures, attempts, and ideations, and to see how many peer-to-peer interventions there were.

And the initial results are—is that while the gestures have remained generally about the same, the number of peer-to-peer interventions has increased dramatically, and therefore the number of cases having to go to behavioral health have really reduced. But we are in the really early stages of doing that and we are trying to link that training to outcome.

Admiral VAN BUSKIRK. I think I would like—just like to add on to that, and that is, sir, that we can't exclusively look at just suicides and suicide-related behavior. I think one of the good things that is happening as we have all investing in our behavioral health specialists and embedding those people in our units. We look at all of the other things that are related to stress and see how that is being managed. Are incidents of alcohol abuse going down? Domestic abuse was mentioned earlier.

So there are these other areas that are also related to stress, to where we see the benefits of when we get the professionals in there, we reduce the stigma. When it is a total leadership, down to the deckplate level, we see success in these areas and start to see the needles move, I think, in terms of the other behaviors that might be associated with stress, which might be indicators of a potential suicide-related behavior later on or an event.

Dr. WENSTRUP. I appreciate you taking on this difficult challenge and thank you for being here today.

And I yield back my time.

Mr. WILSON. Thank you, Dr. Wenstrup.

And we now proceed to Congressman Chris Gibson, of New York.

Mr. GIBSON. Thank you, Chairman.

And I thank the ranking member, as well, for calling this hearing, and all the panelists for your service commitment to our country.

I am encouraged, actually, by the dialogue here in this hearing, and find particularly interesting some of the responses.

Dr. Reed, the recent one you just gave with my colleague here, looking at the data, trying to understand it, how difficult this is

that we are just not going to be able to point to—we are not going to know, you know, by precise numbers.

But I think the focus on resiliency will come through. And over time I think we will see a very positive impact on this.

I want to also mention that Mr. Scott, he brought up equine, and we have a couple of programs going on in our district in upstate New York with initial very favorable reviews. So I am encouraged by that and we are going to continue to work that.

Former commander, 3 years ago a brigade commander in the 82nd—and, you know, can appreciate firsthand how serious our commanders and sergeant majors, first sergeants, are taking this issue and all the emphasis that is put in in a period of enormous stress coming through over a decade of war, the budget situation, the drawdown. All of these pressures, exogenous and impacting. And yet we have a leadership very focused on making a positive difference. Greatly appreciate it.

Ms. Garrick, like you, my wife, Mary Jo, is a licensed clinical social worker. She is part of a congressional spouse's group trying to make a difference on this very issue, and they are partnered with the American Foundation for Suicide Prevention. And, you know, I think they are doing important work.

I went to an event recently in Albany where General Graham and his wife Carol were there. I just can't say enough positive about this event. It was well attended. It was focused on education, on warning signs, actions that could be taken.

So to follow up with the Chairman, you know, having firsthand experience in terms of the Active Component and seeing how engaged we are, my question really is a followup on the Reserve Component and veterans side of this, because as concerning as the data is for our service men and women, we know the veterans' situation is worse.

And I think you are already making a positive impact on the work that you are doing in the DOD. And so, you know, coming away from this event last week, I thought that the American Foundation for Suicide Prevention is really engaged and making a difference on this. And so I am interested to know what partnerships we have with the DOD and what is your review of that and your intentions going forward?

Ms. GARRICK. Yes, we have established a community action team approach, as described by, actually it was Admiral Mullen when he wrote the "Sea of Goodwill." So we took that concept and we have started to have these community action roundtable discussions where we bring in from the community organizations like the Tragedy Assistance Program for Survivors, the suicide association you have just mentioned. Dr. Reed and I talk quite a bit and I work very closely with the Department of Veterans Affairs.

Our last roundtable we held we had several university participation—Harvard, UCLA, the universities in North Carolina and South Carolina were both on the phone, Penn State. So we had some really great university dialogue on looking at peer support and curriculum for peer counselors.

So we are doing a lot of these kinds of outreach efforts. And my partnership with the Department of Veterans Affairs truly does allow us to leverage looking at building a joint data repository

across the Department with HHS [Department of Health and Human Services], the CDC data as well. And I think a really important step forward is that the DOD will now confirm for CDC Guard Reserve deaths, so that will really help us understand the reach into the States and what that looks like at the local level.

So those kinds of partnerships, they may—it may take us a while, but those things are certainly the steps that I see that we needed to take and I think are going to be very helpful in moving us forward and understanding this from a perspective that Dr. Reed described.

Mr. GIBSON. Well, I appreciate that comment. And just to put a finer point on the Albany area, it is about 3 hours or so from Fort Drum, and about 2 hours from West Point. But the population—about 15 percent of the population, veterans. So this is why this event was so critically important, because they were educating the social workers and some of the volunteers who are at the V.A.—the Stratton V.A.—and also support some of the Active Duty and the National Guard that are in the Albany area, whether it be on recruiting, ROTC, or the 42nd Infantry Division right there in New York.

So I am going to be working with the committee and see if there is maybe more we can do on this partnership, but I appreciate everything that everyone is doing.

Thank you, and I yield back.

Mr. WILSON. And thank you, Mr. Gibson. And thank you for your family's commitment and service.

We now proceed to Congresswoman Carol Shea-Porter, of New Hampshire.

Ms. SHEA-PORTER. Thank you very much, Mr. Chairman.

And thank you all for being here and the great work that you are doing.

I have to say, it is frustrating. I wish that we had one name across the military spectrum. I am reading about all these various programs, and through the years while I have had the privilege of serving here there have been different titles—all, you know, working to serve this purpose and try to help enlisted men and women and officers as well. But the complexity of just the titles and the program has to throw a lot of the intended recipients.

So my first question is, how many people are you aware of, no matter how hard you try for your outreach, how many victims or their families have said they didn't know where to turn?

Ms. Garrick.

Ms. GARRICK. Yes, I don't know that I have an exact number of how many, but I have certainly heard that as well. And that is why, again, part of what we have done, and all of the Services in their statements noted that we have tried to craft one message for moving forward, and that is if you need help, get it. Treatment works.

And when we work with the military crisis line we have an "It's Your Call" campaign, and then this year we launched the "Stand By Them" campaign, which is a V.A.-DOD single-message, single point of contact, 1-800 number. And if you type—if you call the number it is the same number as the SAMHSA [Substance Abuse and Mental Health Services Administration] suicide hotline num-

ber so that regardless of whether you press one or don't press one you are getting funneled into the same help with the same protocols in place, so that our service members and their families are using the same services that veterans and their families have available to them so that there is that pull-through.

And that is why it is so important that at transition we are going to be able to provide them that information, as well. So as they move forward, the message never changes. It is the "It's Your Call," the "Stand By Them" campaign, and the same 1-800 number.

Ms. SHEA-PORTER. But do we keep any statistics? Is the question asked: Did you know where to turn? Did you know this service was available? Because my interaction with service men and women and veterans, and certainly we know this from the Vietnam era for all the outreach, you know, that somehow or another there was still a curtain there—were not aware of it. And I know that our V.A. in Manchester, New Hampshire, has been reaching out and going to where veterans actually are, trying to draw them into the system so they can have access to needed benefits.

So there is still some kind of a curtain there, and is there any way that we are measuring how effective we are? Are we asking, did you know where to turn? Did the family know once they were aware things weren't right? Because I think that is an important part, to make sure that we are actually reaching them.

Ms. GARRICK. Yes, I think going back to the previous question from Congressman Gibson, that is why these community action teams and that approach is so important. Because we can't do this alone, we really do need our community members involved and engaged so that that message is getting out there, that our veterans service organizations know how to facilitate a rescue, they know how to call the 800 number, how to go online, how to do the texting, the chatting, so that all that is out there.

We just did do a study with the Guard and Reserve, actually, on suicide prevention and resilience. We asked support professionals and commanders, so what resources are you aware of? What do you use? What do you like? What don't you like? So that we could get a better understanding of that exact issue.

Ms. SHEA-PORTER. But again, you know, does it actually arrive through the individual's curtain and do they know that? And so I have a very simple suggestion. I thought, everybody has to go to the grocery store. You know, we don't have to go look for resources to help ourselves or our family members. Maybe we know to do that; maybe we don't. But everybody has to go to the grocery store.

Can we put the number on grocery bags? Can we ask various companies and all of the great corporations and small family businesses to put this telephone number on grocery bags to—because there is still some kind of problem there where they are just not all aware of the resources there.

So for all the great work you are doing, if there are individuals that are not tied into VSOs [Veterans Service Organizations], if they are not tied into various organizations, if they think in their minds that it is better not to be connected to the military or to the Veterans Administration for whatever reason, how do we still reach those who have not reached out and we have not noticed yet?

Ms. GARRICK. No, and I think that is a great suggestion.

Ms. SHEA-PORTER. So I yield back.

Ms. GARRICK. We have had some conversation about doing that with the commissaries.

Ms. SHEA-PORTER. Right, so I—but past the commissaries, because a lot of them will not be using commissaries. I think this is going to call for the effort, and it has already been developed for a long time, I know, but continuing to make sure that our business community and our nonprofits as well as those who are in the military and veterans community can work together to put this out there.

Because these programs are there, they are wonderful, but some people still do not access them.

So thank you, and I yield back.

Mr. WILSON. Thank you, Ms. Shea-Porter.

We now proceed to Dr. Joe Heck, of Nevada.

Dr. HECK. Thank you, Mr. Chairman.

Thank you all for what you are doing and for being here. I am sorry that I missed your testimony. I had another hearing to attend, but I did read through your written statements prior to today.

First, I want to thank Ms. Garrick for bringing up the TAPS program and forging a community partnership with them, not just for the Services that they provide to the family members but for looking at the information that they glean from the family members during their debriefings and how that may help us identify future risk. I was just at their anniversary dinner a couple nights ago, so an incredible program and I am glad that you are involved with them.

I approach the issue, I think, a little bit differently, as a military health care provider and as a brigade commander who over the last 2 years has had one successful and two threatened suicides within my command. So it is a real issue for me that hits home.

You know, when the Army launched its health promotion, risk reduction, and suicide prevention campaign in 2009 and it stood up the task force, the Army Reserve participated and came up with four pillars that they were going to concentrate their efforts on, and I want to talk about two of them. One was reducing the stigma associated with asking for help, which has been addressed somewhat here today, and the second was providing resources to geographically dispersed personnel.

I tell you, fortunately, for the two threatened suicides that we had, it was fortunate that those individuals were located within the community where the unit was based. Again, you know, being geographically dispersed in the Reserves can mean a lot, and in my brigade I have got soldiers that are 3 hours or more away from the unit.

But these individuals made statements to their first-line leaders. Their first-line leaders then utilized the ACE mnemonics and went out and asked, took them and escorted them to care. And both of them were then enrolled in behavioral counseling services, and I truly believe that that program saved those two soldiers' lives.

Unfortunately, the completed suicide, although having taken place in the same town as where the unit was located, had no previously seen indicators.

And actually, his first-line leader and he were friends and they happened to be out that night together. And then 2 hours later, after they departed company, the first-line leader was called and told that the person he was just with had successfully committed suicide.

So the issue I bring up about stigma is, as we try to put more and more of this responsibility on first-line leaders, especially in the Reserves, we are looking at 25-, 26-year-old E-5s, and I can tell you that in the successful case, that first-line leader is still beating himself up over the fact that not only was he a friend but he was his first-line leader, and he feels like he failed in recognizing what happened.

And I can tell you that as we talk—about seeing in the written statement the stigma reduction campaign that is being developed, I mean, but stigma reduction was identified in 2009. I identified it when I returned from my deployment in 2008, because you knew that if you checked the box on your post-deployment health risk assessment that you had seen a dead body or anything like that you were not going to be released. You were going to spend another 2 to 3 days going through additional counseling, and obviously everybody is waiting to get home to their families and so they knew not to check the box—not because they didn't want to ask for care but they knew it was going to delay their ability to get back to their families.

So why is it taking until—why are we still developing a stigma reduction campaign when this had been identified well before 5, 6 years ago?

General BROMBERG. Yes, sir. I just think over all—and I understand the frustration and the challenges—think this is a cultural change. I think it is not that we are developing a campaign or failing to recognize it. I think as I talk to young men and women, and the numbers are getting better as far as people that think stigma is improving, but not as fast as we would like.

This is a huge cultural change for us, whether your background or how you were raised all the way through your background in the military. And I think it is the engaged leadership and the evasive leadership, and then success stories of where you can seek help and not be penalized for that help.

There is just a recent data I looked at this week, we have seen very slight improvement this last year, but great improvement over 4 or 5 years—about 20 percent improvement is in stigma reduction. We are just going to have to stay at it and keep leadership engaged.

Dr. HECK. And I just have a couple seconds remaining. I just want to bring up the issue about help to the geographically dispersed.

It seems like a lot of the concentration has been on getting them access to care, but again, if they are remote from their unit, we have got to identify them. Who are they going to identify themselves to?

And have we done anything with, you know, our—you know, units within the same compo [component], whether National Guard units, sister service units, Active Duty installations, the V.A., so that if somebody calls their unit and they are 3 hours away, and

they say, “I am having a problem,” that we can get them plugged in with somebody in a uniform who they are going to be able to relate to much easier than somebody showing up in civilian clothes on their doorstep. Have we looked at trying to branch out across Services and compos?

General BROMBERG. Yes, sir, we are working at it diligently right now, and I will provide you some more additional information on the specifics of how we are getting after that.

[The information referred to can be found in the Appendix on page 111.]

Dr. HECK. I appreciate it.

Thank you, Mr. Chair, for—and the ranking member for holding this very important hearing, and I yield back.

Mr. WILSON. And thank you, Dr. Heck.

And indeed, this is an important hearing and it is obvious the commitment of everyone here. And while we have this opportunity, we will proceed with additional questions.

And, Dr. Reed, in particular, the Center for Disease Control has indicated suicide is the third leading cause of death among 15- to 24-year-olds, and is the second leading cause of death between 25- to 34-year-olds. And you have already actually brought up something interesting, and that is there is a differential between college-age—young people who are attending college, not attending college, the suicide rate. Are there practices within the civilian community that could be adopted to the military?

Mr. REED. Yes, sir. One of the things that happened in 2005 was after the tragic death of Garrett Smith, the son of Senator Gordon and Sharon Smith, the Congress passed the Garrett Lee Smith Memorial Act. It has been in place since 2005. It is really the first Federal appropriation that has been authorized and funded to fund States, tribes, and territories, as well as college campuses, to really aggressively look at early intervention and prevention in suicide prevention amongst this age group.

These cohorts have been funded since 2005. It is still active today, and we gather the cross-site evaluation that is providing SAMHSA some very valuable information in terms of what seems to be working. And each grantee has been required to assess their own performance, and those performances each year are shared with others who are trying to do the same thing.

So this is a perfect example of where, working with Ms. Garrick, we can share some of what we are learning in the civilian community that may have relative value to what is happening in the military community as well, especially for those younger military members who may not have taken their life or thought about taking their life as a result of a combat experience, but may be more of a developmental issue with regards to their place and age.

Mr. WILSON. Well, thank you for providing that.

And, Ms. Garrick, I, too, am—was very appreciative of TAPS. I know firsthand the Yellow Ribbon Campaign. I want to thank you.

We proceed to Mrs. Davis

Mrs. DAVIS. Thank you, Mr. Chairman. I appreciate just a second round quickly to try and mention a few issues that are out there, I think, that we talk about.



One of them is a guilt factor, that, in fact, people came home, someone came home and felt that their buddies did not. And I don't know to what extent you find that that is a large factor that is being addressed or you think maybe is not getting the attention that it deserves.

I think the other issue is just the loss of hope, which we know is probably more than any other thing that people can express or that family members can express about a loved one, that they didn't see that coming perhaps, but that was a big factor. People have talked about the issue of contagion.

And I think, Dr. Reed, you mentioned it is how we speak about suicide that makes a difference.

I am recalling, Mr. Chairman, that one of the first hearings that we had here where we had a father talk about his son, and of course, it was very emotional, and trying to understand, essentially, the question of, how come nobody—how come we didn't know, and what services were out there?

So I don't know to what extent you want to address those, but those are all issues.

But the one that I think you can maybe, you know, get your head around a little bit is the factor that at least 10 percent, as we know, in the service have perhaps access to guns at a greater level than in the general population. And the fact that we have the literature indicating that restricting access to means—firearms, of course—is an effective strategy for preventing suicides.

Now, in the military, are we using and thinking about that and the preventive strategies that are required, knowing that our service members have access, of course, and perhaps are not getting to help because, you know, they—it is just too—in some ways it may be too easy. Can anybody like to talk about that?

Ms. GARRICK. Sure. First of all, the NDAA 13 just gave us some really good clarifying language on who can, when can you ask about personally owned firearms, ammunition, and other weapons, and so we are working on a guidance for that so that we can get that information out to the Services and make sure that everybody, that the clinicians as well as the commanders, are tracking that on what you can do. So, I think, that was an important step for us.

And I do want to go back and just sort of comment on what you said about trauma, hope, and contagion, because this is clearly not just a mental health issue. Suicide is a behavior and it is a—and I think that is why it is so important that we have chaplains involved in this process as well as commanders and mental health providers. This really will take a community response within the military community and outside of the military community to address some of those key points.

And I think the research we need to do—and I just met with General Patton the other day, who heads our Sexual Assault Program office [Sexual Assault Prevention and Response Office], I think marrying up, so what are the different issues? What are the areas of concern? And how can we learn more about trauma and the—its implications, and hope and resilience and its implications? I think those are all very key factors.

And then the means restriction is certainly important. I think the Services can certainly tell you more about what they are doing in that regard.

Mrs. DAVIS. And if there is anything more that Congress could or should be doing to help. In addition, obviously, we talked about the—just the resource issue, in terms of assistance.

I think just one other thing to add—I know my time is running out—is just, how do we determine the quality of care that is being provided, as well? I mean, I don't doubt that we have the bulk of our caregivers who are providing that quality care, but we also sometimes talk to people that don't go additionally because they don't help them out.

General BROMBERG. Yes, ma'am, it is to protect the weapons—on our installations, of course, that is no issue. Commanders have the authority to get in what I call almost that invasive leadership, asking those questions to withdraw those weapons. And the NDAA did help us significantly by opening up the aperture for those that live off-post or off the installation so we can ask the right questions to try to retrieve those weapons.

The commands are going after that very aggressively. So the weapons piece, I think, is absolutely essential.

As far as the quality of care, I think, it is the positive, continuous dialogue in reaching out to those individuals to find out what else they need, because it may not be just behavioral health. It may be some other type of relationship issue or financial issue. Where can we provide that additional support?

General JONES. Ma'am, in the Air Force, we have had—rather than going after looking at who carries and has access to weapons we look at career fields. Three of our most at-risk career fields are security forces, aircraft maintenance, and intelligence. Obviously, security forces would have access to weapons.

We target those career fields with special first-line supervisor training, must be done one-on-one, must be done in small groups. And we found a lot of success with that.

The other thing we are trying to do is make our health care providers more accessible without applying the stigma. Eighty-three percent of all of our primary care clinics have mental health providers embedded in the clinic, so if you go in to see one physician he can take you next door to talk to a mental health care provider without having to take you down the hall to the mental health care clinic.

And I think that really gets at some of the stigma. And I think the stigma is really the metric that shows us that we are making some headway here. Ninety percent of everybody in the 2012 Air Force climate assessment survey said they believe leadership was interested in suicide prevention and felt that was a great thing.

And also in the 2012 survey, 84 percent of the people said they knew who to talk to. They would talk to their coworkers, they would talk to their supervisors and their branch chiefs—not for mental health care but for the first contact to tell someone that they had trouble—ma'am, much to your question of where they would take them. And that leads to the ACE care, where you ask the person—do they have an issue, you care for them, you escort them over to a real professional.

And in that same survey, 95 percent of the people in the Air Force said—and this was Active Guard and Reserve—said the leadership was genuine. Ninety-five percent said the family, friends, and coworkers would support them if they had mental health issues and sought help. And 83 percent said that they would feel comfortable talking about suicide to their coworkers and to professionals. And we think that is a big plus in our numbers.

Mrs. DAVIS. Big improvement. Thank you.

Thank you, Mr. Chairman.

Mr. WILSON. Thank you, Mrs. Davis.

And as we conclude, I want to thank all of you for your genuine, very thoughtful compassion toward our service members, military families, and veterans.

At this time we shall be adjourned. Thank you.

[Whereupon, at 12:15 p.m., the subcommittee was adjourned.]



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**A P P E N D I X**

MARCH 21, 2013

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**PREPARED STATEMENTS SUBMITTED FOR THE RECORD**

MARCH 21, 2013

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**Statement of Hon. Joe Wilson**  
**Chairman, House Subcommittee on Military Personnel**  
**Hearing on**  
**Update on Military Suicide Prevention Programs**  
**March 21, 2013**

Today the subcommittee meets to hear testimony on the efforts by the Department of Defense and the military services to prevent suicide by service members, family members, and civilian employees.

I want to preface my statement by recognizing the tremendous work the Department of Defense and the service leadership has done to respond to the disturbing trend of suicide in our Armed Forces. This has not been an easy task and I thank you for your hard work. Suicide by members of our Armed Forces is particularly distressing to me because I consider military service an opportunity. I want service members to know they are talented people who are important and appreciated by the American people. They can overcome challenges.

Suicide is a difficult topic to discuss. Last year 350 service members took their own lives. Every one of them is a tragedy; every one of them has a deeply personal story. We cannot rest until we have created every opportunity to change such an awful statistic.

Suicide is a multifaceted phenomenon that is not unique to the military. Unfortunately, in addition to the hardships of military service, our service members are subject to the same pressures that plague the rest of society today. They are exposed to the same stressors that may lead to suicide by their civilian counterparts. I am deeply concerned about how the uncertainty of sequestration and the coming budget challenges will affect our service members and their families.

Each of the military services and the Department of Defense has adopted strategies to reduce suicide by our troops. I would like to hear from our witnesses whether those strategies are working. How do you determine whether your programs incorporate the latest research and information on suicide prevention? I am also interested to know how Congress can further help and support your efforts. Lastly, I am interested in learning how our civilian experts are tackling this problem across the Nation and how private organizations like Hidden Wounds of Columbia, South Carolina, are assisting.

**Statement of Hon. Susan A. Davis**  
**Ranking Member, House Subcommittee on Military**  
**Personnel**  
**Hearing on**  
**Update on Military Suicide Prevention Programs**  
**March 21, 2013**

I am pleased that the subcommittee is continuing its attention on suicides in the military. It has been nearly a year and a half since our last hearing on military suicides, and during this time, we have only seen increased numbers of service members taking their own lives. While Congress has pushed forward a number of initiatives to support the Services and the Department of Defense in their efforts to develop policies and programs to reduce and prevent suicides in the force, sadly these numbers continue to grow.

Yet, military service members are not alone. Over 38,000 individuals die by suicide every year. In 2010, suicide was the 10th leading cause of death in the United States, and the fourth leading cause of death for adults between the ages of 18 and 65. While suicide among young individuals, 15–25 years old, continues to be a concern, the rate of suicide among older Americans is even higher. It is important that we share what we learn in the military and what is learned by others if our country is to be successful in addressing this societal issue.

The establishment of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces in the Duncan Hunter National Defense Authorization Act of Fiscal Year 2009 was a start. The task force made 76 recommendations and I am interested in where the Department and the Services are in implementing these recommendations. Have they all been completed, and if so, what metrics are being used to track success? What other efforts can be undertaken to address suicide in the military?

I welcome our witnesses, and look forward to hearing from them on what has been done, what is being done, and where do we go from here in our efforts.

Statement for the Record  
Rep. Rush Holt  
Hearing on Military Suicide Prevention  
Before the  
Subcommittee on Military Personnel  
House Committee on Armed Services  
March 21, 2013

Chairman Wilson, Ranking Member Davis, members of the subcommittee—thank you for the opportunity to offer my views on a topic of great concern to us all: the suicide epidemic among our servicemembers and veterans.

Once again, our nation is on track this year to suffer more military and veteran casualties from suicides than from enemy action. This has happened repeatedly over the last few years, and the trend has continued despite a clear recognition of the problem by successive Secretaries of Defense and by Secretary of Veterans Affairs Eric Shinseki.

As a House member who has taken a leading role in searching for solutions to this ongoing human tragedy, one thing has become clear to me: there are effective programs around the country that can help save lives, but the Pentagon and the VA are not putting a priority on funding and publicizing those programs—despite explicit Congressional direction that they do so.

Over the last two years and with the bipartisan support for my amendments by the House Committee on Appropriations, Congress has increased funding for suicide prevention and outreach programs in both departments by \$80 million. I've emphasized the need for both the Pentagon and the VA to increase their outreach focus via direct television ad buys and social media engagement. Instead, both departments continue to drag their feet on implementing the kinds of programs that we have pushed them to do over the last several years. Ads on city buses—one of the major VA initiatives over the last year or so—will only reach a tiny fraction of the audience compared to a TV ad buy during the Super Bowl. My frustration is compounded by the knowledge that there are truly effective local and state programs that, if properly funded and supported, have the capacity to have a national impact.

Indeed, one of the most successful suicide prevention and counseling programs in America, Vets4Warriors, is operated in my home state of New Jersey. It started in 2005 as Vet2Vet, a New Jersey-only program focused on our state's National Guard and Reserve members. Its success was so great—no servicemember who used the program took his or her life—that the 2010 DoD Task Force on the Prevention of Suicide by Members of the Armed Forces recommended that Vet2Vet should be examined as a potential national model. The key reason the program works so well is that every person who takes a call from a servicemember or veteran is also a former servicemember.

This peer-to-peer connection is vital in building the trust necessary to get a soldier or veteran with a problem to open up about their experiences, fears, needs and hopes.

In December 2011, the National Guard Bureau decided that the expanded Vet2Vet program, now rechristened Vets4Warriors to denote its national character, should be the program of record for Guard personnel nationwide who were seeking counseling services. That was the right decision, and it put the Guard Bureau well out in front of the rest of DoD in showing a real commitment to working with and funding local or state programs with proven track records of success. Unfortunately, you can't find a link to Vets4Warriors on the NGB homepage. The NGB also hasn't established a Twitter feed for Vets4Warriors, or a Facebook presence, or any other dedicated social media presence for the program. That lack of action is in direct contravention of the intent that I had when I argued on the House floor for more funds for programs like Vets4Warriors. And it certainly isn't for lack of money.

I'm glad the House Committee on Armed Services is holding an oversight hearing on this general topic this week. Why the NGB has failed to take these steps is something requiring further oversight by the Armed Services and Appropriations committees in both chambers, but so does the entire DoD and VA approach to outreach to at-risk veterans. The Iraq War veteran who inspired my efforts to end the military suicide epidemic, the late Sgt. Coleman Bean of East Brunswick, New Jersey, took his own life while waiting for the VA to schedule his counseling appointment. If they are serious about reducing suicides among our nation's warriors, Secretaries Hagel and Shinseki will move heaven and earth to make sure that programs like Vets4Warriors receive the funding and authority they need to reach—and save—America's finest.

STATEMENT  
OF  
JACQUELINE GARRICK, LCSW-C  
ACTING DIRECTOR OF THE DEFENSE SUICIDE PREVENTION OFFICE  
BEFORE THE  
SUBCOMMITTEE ON MILITARY PERSONNEL  
OF THE  
HOUSE ARMED SERVICES COMMITTEE  
CONCERNING  
UPDATE ON MILITARY SUICIDE PREVENTION  
ON  
MARCH 6, 2013

Mr. Chairman and members of the Committee, thank you for the opportunity to present information on the accomplishments of the Department of Defense's (DoD) Suicide Prevention Program.

Suicide ranks as the tenth leading cause of death in the United States (U.S.), according to the Centers for Disease Control and Prevention (CDC).<sup>1,2</sup> Over the past decade, the national suicide rate has gradually increased for the general U.S. population.<sup>3</sup> For 2010, the U.S. suicide rate for males, ages 17-60 was 25.1 per 100,000, which rose from 21.8 per 100,000 in 2001. For comparative purposes, this adjusted rate best matches the U.S. Armed Forces population. The suicide rate among the U.S. Armed Forces also rose in the past decade, going from 10.3 suicides per 100,000 Service members in 2001<sup>4</sup> to 18.3 suicides per 100,000 Service members in 2009.<sup>5</sup> While essentially level in 2010<sup>6</sup> and 2011<sup>7</sup>, the suicide rate for 2012 is expected to increase once death investigations have been completed and a final manner of death determination is issued.<sup>8</sup>

The Department has closely monitored and examined suicides since 2008 and suicide attempts since 2010 amongst its Service members. The DoD collects this data in the DoD Suicide Event Report (DoDSER), which standardizes suicide surveillance efforts across the Services (Air Force, Army, Marine Corps, and Navy) to support the DoD's suicide prevention mission.<sup>9</sup> The DoDSER collects crucial data, such as demographic information, cause and

<sup>1</sup> This is the ranking as of 2011, the most recent year (2010) for which CDC has data. Suicide was also the 10th leading cause of death for 2010, 2009, and 2008.

<sup>2</sup> Hoyert, D. L., & Xu, Jiaquan. (2012, October 10). Deaths: Preliminary Data for 2011. *National Vital Statistics Reports*, 61(6), 1-51.

<sup>3</sup> Centers for Disease Control and Prevention (CDC). (2012, May 11). National suicide statistics at a glance: Trends in suicide rates among persons ages 10 years and older, by sex, United States, 1991-2009. Retrieved from <http://www.cdc.gov/ViolencePrevention/suicide/statistics/trends01.html>

<sup>4</sup> 160 confirmed suicides

<sup>5</sup> 310 confirmed suicides

<sup>6</sup> 298 confirmed suicides, 17.8 per 100,000

<sup>7</sup> 301 confirmed suicides, 17.5 per 100,000

<sup>8</sup> As of March 1, 2013, the CY 2012 YTD numbers are: 350 suicides, 291 are confirmed and 59 are pending

<sup>9</sup> <https://t2health.org/programs/dodser>

manner of death or attempts, substance abuse and psychological health history, and deployment and combat experiences. It incorporates associated factors, such as marital status, rank, and educational levels. A comprehensive report summarizing DoDSER data is published annually.

According to the most recently published DoDSER Calendar Year 2011 Annual Report, the Department knows that the majority of military suicides were completed by enlisted Caucasian males, age 29 and below, with a high school education. In some cases, legal or financial issues were present and many had experienced a failed intimate relationship. Service members primarily used firearms to complete a suicide and died at home. The majority of Service members did not communicate their intent for self-harm nor did they have a known history of behavioral health problems. Less than half of those who died by suicide had deployed,<sup>10</sup> and a small number were involved with direct combat.

Service members involved in non-fatal suicide attempts were most often high-school educated, junior enlisted Caucasian males under the age of 25. Slightly more than half had a failed intimate relationship. The majority used drugs in their suicide attempt, which most frequently occurred in their own residence. The majority did not communicate their intent for self-harm, but, in contrast to those who died by suicide, most had at least one documented behavioral health disorder. Less than half of those who attempted suicide had a history of deployment,<sup>11</sup> and a small number had experienced direct combat.

With suicide on the rise in the military, the Department established the Task Force on the Prevention of Suicide by Members of the Armed Forces in response to Section 733 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2009. The Task Force issued a report in August 2010 that provided 76 recommendations for how the Department could more

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<sup>10</sup> Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), or Operation New Dawn (OND)

<sup>11</sup> OEF, OIF, OND

effectively prevent suicide. First among its recommendations was the establishment of a centralized suicide prevention office that would uncover best practices and help identify and reduce inefficiencies and gaps across the Services.

DSPO began operations in November 2011, as a component of the Office of the Under Secretary of Defense for Personnel and Readiness. DSPO oversees all strategic development, implementation, standardization, and evaluation of DoD suicide and resilience programs, policies, and surveillance activities. The Office works very closely with the Army, Navy, Air Force, Marine Corps, Coast Guard, and National Guard Bureau through the Suicide Prevention General Officer Steering Committee (SPGOSC), which directs the implementation plan for the Task Force recommendations, and the Suicide Prevention and Risk Reduction Committee, which coordinates on action items and shares best practices to support Service members and their families. NDAA FY13 codified this office, which enhances the authority by which DSPO operates.

To fulfill the Task Force recommendations that the Department accepted for action, DSPO immediately developed a strategy to work with the Services and other key partners that is informed by the DoDSER data. The Department's strategy accounts for other key research findings and recommendations—such as President Obama's Executive Order on Mental Health, the National Strategy for Suicide Prevention, congressional mandates, the RAND Corporation study,<sup>12</sup> and DoD and Veterans Affairs (VA) joint Integrated Mental Health Strategy (IMHS), which includes action items for preventing suicide and enhancing resilience among Service members and their families.

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<sup>12</sup> The RAND Corp. groups behind "The War Within" are the RAND Center for Military Health Policy Research and the Forces and Resources Policy Center of the RAND National Defense Research Institute.



To execute these actions and recommendations, the SPGOSC established nine priority groups. These focus on issuing suicide prevention policy, increasing data fidelity, reducing stigma, containing access to lethal means, standardizing death investigations, developing a research strategy, and evaluating programs, trainings and quality of care.

DSPO and the Services have made significant strides in the nine priority areas. Specifically, the Department is responding to the NDAA FY13 by issuing the first DoD-wide comprehensive suicide prevention policy. DSPO developed the DoD Directive 6490.rr, "Defense Suicide Prevention Program," which is anticipated to be released in 2013. Once published, the policy will determine applicability, standardize definitions, establish standards, and assign responsibilities for the Defense Suicide Prevention Program. For example, it will (1) require leaders to foster a command climate that encourages DoD personnel to seek help and build resilience; (2) mandate that the Department provides continuity to quality behavioral healthcare during times of transition; (3) require a sustainable Service-wide suicide prevention education and training program; (4) establish methods for standardized mortality data collection; and (5) requires each Service to staff, fund and maintain a Department level Suicide Prevention Program Manager.

To enhance the fidelity of suicide data, DSPO is coordinating and developing a process to improve DoDSER and other surveillance data, to analyze data, and translate findings into policy updates and program strategy. To create a joint Suicide Data Repository, DSPO is working with our VA partners to jointly purchase Service member and Veteran mortality data from the CDC National Death Index (NDI) going back to 1979,<sup>13</sup> which will facilitate comparative trending over time, improve analytical capabilities, and allow for a richer data set for mining mortality of

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<sup>13</sup> The first year for which NDI data is available.

all who have served. In addition, DoD will affirm military service for the CDC, thereby enhancing its capabilities to track National Guard and Reserve deaths and Service members who die overseas. This mortality data will enhance research projects for longitudinal studies and population health surveillance activities. The Department also is reviewing and evaluating the non-criminal death investigations currently conducted to determine if the processes can be modified and enhanced to include more suicide-related information.

The 2010 Task Force noted<sup>14</sup> that there were nearly 900 suicide prevention activities across the Department and found that while the Department had attempted to evaluate its programs, there were inconsistencies, redundancies, and gaps in its approach. Recognizing that there are challenges with measuring prevention since outcomes of the counterfactual—that which did not happen—are difficult to capture and connecting programs to reduced mortality or morbidity are not easy conclusions to draw, DSPO responded by developing a comprehensive capacity analysis of suicide prevention programs and resources through an automated resource management tool that tracks requirements and funding across the Future Year Defense Plan. DSPO plans to unite these efficiency measures with effectiveness and engage in continuous process improvements reporting that will have pecuniary implications for decision makers. The objective of this approach is to be able to identify suicide prevention and resilience programs that align to strategic goals and areas where there are shortfalls or duplication of effort. This will result in potential savings by eliminating duplicative programs and generate fiscal efficacy by using those savings to cover identified gaps, or fund new evidence-based initiatives that leverages efforts to translate research. Eventually, the plan is to be able to case manage Service members at risk and track the changes in their wellness to the referral resources utilized.

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<sup>14</sup> DoD Task Force on the Prevention of Suicide by Members of the Armed Forces, “The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives,” August 2010.

To meet a similar goal, DSPO is conducting a comprehensive training evaluation to develop an overarching training strategy by the end of fiscal year 2013 that provides a framework of core competencies for the Services to implement training in a way that meets their individual and sub-population needs, such as at the peer, command, clinical, or pastoral level.

A significant achievement for the Department has been its annual suicide prevention conference partnership with VA, which is an Integrated Mental Health Strategy requirement. In June 2012, the conference was attended by over 1,100 participants; primarily mental health providers and peer counselors who were able to receive the latest research information and emerging best practices. The importance of this conference was underscored by the appearance of not only the Secretary of Defense, but the Secretaries of VA and Health and Human Services (HHS); together addressing the public health response needed to curtail suicide in the U.S.

The Department is tackling one of the most critical aspects of preventing suicide: eliminating the stigma that prevents some Service members or their families from seeking help when they have behavioral health and other problems. The Department is working to implement the Executive Order on *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families* issued by President Obama on August 31, 2012. To accomplish these requirements, the DoD and VA are leading a 12-month, help-seeking campaign to encourage Service members, Veterans, and their families to contact responders at the Veterans/Military Crisis Line by phone<sup>15</sup> or online<sup>16</sup> when they are in crisis. The DoD and VA created “It’s Your Call” messaging for Service members and “Stand By Them” materials to involve family and friends. DoD and VA are also collaborating to develop several Public Service Announcements (PSAs) that encourage Service members and their friends and families to

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<sup>15</sup> 1-800-273-8255, press 1

<sup>16</sup> [www.militarycrisisline.com](http://www.militarycrisisline.com)

contact the Veterans/Military Crisis Line. For instance, in December 2012, a Military Crisis Line PSA aired on the White House's Joining Forces Website,<sup>17</sup> encouraging help-seeking over the holidays. VA and DoD are also launching a PSA nationwide in March 2013 that urges families and friends to stand by Service members and Veterans and to get them help in their time of need.

In cooperation with the Services and VA, DSPO has worked to ensure that the Military Crisis Line is available in Europe, and we are in the process of extending that capability in Japan and Korea. The Military Crisis Line is available at larger bases in Afghanistan, but where it is not available, such as on many forward operating bases, DSPO worked with Task Force 14 Medical to establish a confidential peer support crisis hotline that utilizes local cell phone services. General Allen signed off on this hotline just before the holidays, and we trained a Combat Operational Stress Control team of medics to answer the lines using a similar protocol that the National Guard uses with the successful Vets4Warriors peer support call center.

In addition, the Department is focused on training and educating a wide variety of Service members and DoD civilian employees on how to cultivate a ready and resilient force. To foster this "Total Force Fitness," DSPO works closely with the office of the Joint Chiefs of Staff and the Services to present this model. To ensure that best practices in suicide prevention are widely instilled, DSPO hosted numerous educational sessions geared to a vast range of audiences including, senior military leaders, wounded warrior Recovery Care Coordinators, public affairs officers, and civilian supervisors.

Through these trainings, DSPO is increasing awareness among Service members and health providers about mental health exclusions related to their security clearances and the Standard Form 86 (SF-86), "Questionnaire for National Security Positions." Service members describe seeking behavioral healthcare as the "last resort" due to fear of negative career impacts,

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<sup>17</sup> <http://www.whitehouse.gov/blog/2012/12/11/taking-care-our-military-families-holiday-season>

which include adverse determinations of personal security clearances. Although the vast majority of behavioral problems would not disqualify Service members from obtaining or maintaining their security clearances, they often believe that seeking care is career-ending. In reality, the percentage of all security clearance denials and revocations for cases involving mental health issues is very small-less than 1 percent.<sup>18</sup> To this end, we are working to ensure Service members understand that seeking help is a sign of strength and, when they proactively reach out for assistance, it does not jeopardize their security clearances.

Postvention, the response in the wake of a suicide, also has implications for prevention and reducing suicide contagion. A DoD Reserve Component stakeholder group identified the need for a Postvention Guide,<sup>19</sup> so one was created and published for Reserve Component Commanders. It gives them guidance on survivor support, memorial services, and community involvement in the wake of a unit member's suicide. The survivor perspective is informative in understanding the impacts of policies and practices. To further its surveillance efforts, DSPO engages in a monthly postvention debrief with the Tragedy Assistance Program for Survivors (TAPS) Suicide Program Director to review factors leading up to a Service member's death as reported by the families referred to TAPS by the Services for peer support. This dialogue builds a frame of reference that the DoDSER data alone does not provide.

In light of the fact that firearms are the main means for completed suicides, the Department established a working group to define policies that will contain at-risk Service members' access to both military and privately-owned weapons. As part of this effort, the Department is also providing clarifying guidance on Section 1057 of the NDAA FY13, which authorizes mental health professionals and commanding officers to inquire about plans to acquire

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<sup>18</sup> Defense Personnel Security Research Center, June 2011.

<sup>19</sup> Department of Defense. "Reserve Component Suicide Postvention Plan: A Toolkit for Commanders." May 2012.

or possess privately-owned firearms, ammunition, and other weapons. Further efforts to promote safety involve a partnership with the Yellow Ribbon Reintegration Program and the Uniformed Services University of the Health Sciences to develop curriculum for a family home safety planning class that incorporates the use of gun locks. The Department has distributed over 70,000 gun locks across the Services and National Guard as a part of this effort.

Since suicides and suicide attempts were also associated with prescription drugs according to DoDSER data, the Department contracted a feasibility study to determine how to best implement a drug take-back program aiming to reduce drug-induced suicides and attempts by allowing recipients of pharmaceuticals to return unused medications to the pharmacy in compliance with Drug Enforcement Agency rules.

The Department continues to increase Service members' access to and quality of behavioral health care by expanding the practice of embedding behavioral health providers in operational units. These providers have a positive impact on mission readiness and safety. Behavioral teams are made up of several mental health providers who train, deploy and reside with their units. As integral members of the unit, the providers build a bridge between Service member and mental health professional, leading to early identification and intervention for those unit members who need their help.

Through its program evaluation approach, DSPO will be able to monitor appropriate access to care. Furthermore, DSPO is examining ways to more effectively identify and track risk and protective factors within the force to identify Service members whose wellness is at risk. DSPO is building a capability to identify active and Reserve components experiencing stressors that could impact their individual resilience, and then help to ensure that they receive outreach and/or care from an effective resource.

The Department is developing a unified, strategic, and comprehensive DoD plan for research in military suicide prevention and consults with the Military Suicide Research Consortium. This also includes working with the RAND Corporation to examine whether current research efforts map to the Department's strategic needs and congressional mandates for suicide prevention. This study will be completed by June 2013, and a plan that incorporates research goals for the National Suicide Prevention Strategy will be drafted by July 2013. DSPO established a team dedicated to translating knowledge accrued from evaluations, research and studies into clinical and non-clinical practices or policies that benefits leaders and support personnel. Moreover, the Department conducted the first systematic assessment of the Reserve Components' use of and satisfaction with suicide prevention and resiliency resources, which allowed it to obtain information about program oversight practices and command climate elements that influence planning and implementation of initiatives.

The Department is responding to Section 533 of the NDAA FY12, which accents the importance of collaborating with both public and private partners in several ways. First, DSPO created a Community Action Team approach, as described by the Office of the Joint Chiefs of Staff, that links Department experts with non-profit organizations, universities, and other entities in order to assess best practices in suicide prevention and share lessons learned in areas such as family and peer support education. Secondly, working with the Substance Abuse and Mental Health Services Administration, DSPO expanded Partners in Care, a chaplain program in which faith-based organizations provide services and support to members of the National Guard and their families. Next, through the DoD Joint Service Committee on Military Justice, DSPO is exploring the feasibility of developing policies that would recommend using therapeutic sentencing techniques developed by Veterans Treatment Courts in military justice proceedings

for Service members diagnosed with behavioral health problems. Finally, the Department has worked closely with the National Action Alliance, a group created by HHS Secretary Kathleen Sebelius and former Defense Secretary Robert Gates. The Honorable John McHugh, Secretary of the Army, is the public sector executive committee co-chair of the National Action Alliance, and the Department had several other key players who reviewed and provided recommendations for the National Strategy on Suicide Prevention (NSSP), which was issued in September 2012. The NSSP focuses on reducing suicide over the next 10 years, and DSPO has incorporated these strategic goals into its program evaluation approach.

Also in response to Section 533 of the NDAA FY12, the Department is taking steps to ensure the availability of suicide prevention resources or Veterans Crisis Line materials to Service members and their dependents during pre-separation counseling from the armed forces and at the VA benefits briefing during the Transition Assistance Program.

In closing, everyone in the Department fervently believes that even one life lost to suicide is one too many and prevention is everyone's responsibility. The Department has launched a vast array of initiatives in collaboration with the Services, and other Departments and agencies to most effectively prevent suicide in the military. The Department will continue to address the urgent need to standardize and enhance suicide prevention and resiliency activities and to disseminate all lessons learned and best practices across the armed forces. This issue is complex, and the challenges are great. However, while this fight will take enormous collective action—and the implementation of proven and effective initiatives—the Department remains optimistic that it will find better solutions that will save more lives.

Again thank you for allowing my testimony.



**Jacqueline Garrick, LCSW-C, BCETS**  
**Acting Director,**  
**Defense Suicide Prevention Office**  
**Department of Defense**

Jacqueline Garrick has been named the Acting Director for the Defense Suicide Prevention Office (DSPO) under Readiness. Since November 2011, she has lead the charge to create a Defense Suicide Prevention Program that includes drafting policies, standardizing data collection and reporting, evaluating programs, reducing stigma, building resilience, and increasing help seeking behavior through partnerships and outreach efforts to Service members and their families.

In 2009, she was appointed to the Department of Defense first as the Principal Director and was briefly the Acting Deputy Under Secretary of Defense for the Wounded Warrior Care and Transition Policy (WWCTP) Office and then assigned to be the Special Assistant in Reserve Affairs to oversee Resiliency, Readiness and Suicide Prevention. She has had responsibility for Recovery Care, Transition Assistance, Disability Evaluation and Suicide Prevention activities across the Department.

Prior to that, she served the House Committee on Veterans' Affairs as a Professional Staff Member to assist the Disability Assistance and Memorial Affairs Subcommittee hold hearings and draft legislation on such issues as stressor evaluations, benefits outreach, and information technology. She was a Senior Policy Analyst for the Veterans' Disability Benefits Commission from 2005 to 2007 and supported the Commission in its efforts to evaluate all benefits programs available for disabled veterans, supervised research and legal assistants, and contributed to its Final Report.

Ms. Garrick was the Deputy Director for Health Care at The American Legion for six years. She developed and implemented its policies on veterans' healthcare issues, gave congressional testimony, ran outreach initiatives, and was a media spokesperson. She supervised the Gulf War Task Force and the National Field Service, which visited all VA facilities. She led task force visits to over 50 VA facilities exploring issues, such as patient care, budget, and research compliance.

In 1992, she accepted a commission as a United States Army captain, and served as a social work officer at Walter Reed Army Medical Center. During that time, she managed programs for soldiers who had served in the Gulf War, Somalia, Bosnia, and Haiti and counseled soldiers, retirees, and their families on a myriad of issues and assisted with transition.

Upon completion of her BSW and MSW from Temple University in Philadelphia PA, she returned to her native New York to become the Program Director for the Vietnam Veterans Resource Center. During her tenure, Ms. Garrick provided

individual, group, and family therapy to Vietnam veterans and their dependents. In addition, she ran a program for incarcerated veterans. Ms. Garrick consulted for Vietnam Seminars and Consulting in 1991, and developed a program for former Soviet Union military members who served in Afghanistan. She created a self-help guide for Russian veterans, and traveled extensively throughout the Soviet Union marketing these techniques and educating veterans about Posttraumatic Stress Disorder (PTSD).

Ms. Garrick is involved with many professional and civic organizations, and was the editor of *Trauma Lines* for six years. After September 11, she was a disaster mental health counselor at the Pentagon Family Assistance Center. She also ran her own consulting practice for four years, the FARgroup, and provided policy analysis, strategic planning, fundraising, program development and evaluation support to nonprofit, private and government entities. She has presented on PTSD throughout the United States, Germany, Great Britain, Turkey, Russia, the Ukraine, Israel, and the Netherlands. Her books; *You Can Too: A Mind, Body, Spirit Connection for Weight Loss* and *Trauma Treatment Techniques: Innovative Trends* were both published in 2005.

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RECORD VERSION

STATEMENT BY

LIEUTENANT GENERAL HOWARD B. BROMBERG  
DEPUTY CHIEF OF STAFF, G-1  
UNITED STATES ARMY

BEFORE THE HOUSE ARMED SERVICES COMMITTEE  
SUBCOMMITTEE ON MILITARY PERSONNEL

FIRST SESSION, 113<sup>TH</sup> CONGRESS

ON MILITARY SUICIDE PREVENTION

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**STATEMENT BY  
LTG HOWARD B. BROMBERG  
DEPUTY CHIEF OF STAFF, G1  
UNITED STATES ARMY**

**Introduction**

Chairman Wilson, Ranking Member Davis, and Distinguished Members of this Committee – Thank you for the opportunity to appear before you on behalf of America's Army.

The United States Army remains engaged in the longest period of combat operations in our Nation's history. Our Soldiers, Army Civilians and Families remain the strength of our Nation and have demonstrated unprecedented strength, performance and resilience over the past 12 years. While physical injuries may be easier to see, "invisible wounds" such as depression, anxiety and post traumatic stress take a significant toll on our service members. Army leaders at all levels are committed to eliminating the negative stigma associated with seeking help; building physical, emotional and psychological resilience in our Soldiers, Army Civilians and Families; and ensuring that anyone who may be struggling gets the help he or she needs.

**Strategic Overview**

The Army had 324 potential suicides during 2012 – the highest annual total on record. Of those, 183 deaths occurred within the Active Component and Reserve Component on Active Duty. This total exceeds the previous high of 148 in 2009. The Reserve Component (ARNG/USAR) not on Active Duty total of 141 is the second highest on record, exceeded only by the 2010 total of 166. While most Army suicides continue to be among junior enlisted Soldiers, the number of suicides by Non-Commissioned Officers has increased over each of the last three years. Of note, during this same three-year period, 2010-2012, we have seen a decrease among Asian/Pacific Islanders and Native Americans. By far, most Army suicides were in the 21-30 age range, a trend that held each year from 2010 to 2012.

The observed attributes of the Army's suicide profile describe Soldiers across all components; however, it is important to remember that while Soldiers in all components share some common challenges, Army National Guard (ARNG) and United States Army Reserve (USAR) Soldiers may face unique and disparate stressors. Army Leadership recognizes that suicide prevention is even more challenging with these individuals who may not be "full-time" Soldiers. Soldiers in the ARNG and USAR may be more acutely affected by unemployment issues and other negative effects of current economic conditions than their Active Component counterparts. Financial stress borne by many ARNG and USAR Soldiers is the same as those in the civilian community

As requirements in Afghanistan and Iraq began to decrease, starting with troop withdrawal from Iraq in 2009 (completed in 2011), we have seen an aggregated increase in the number of suicides in Service Members who have not deployed. However, we have also seen an increase in suicide numbers of Soldiers who have deployed one or more times from year to year from CY 2009 through CY 2012.

Suicide is not solely a military problem – it is a rising National issue. Comparison between the National suicide rate and Army suicide rate should be done with caution. There are differences between the two populations, which make direct correlations problematic (e.g. gender ratio, age range, etc.). The demographically-adjusted 2010 U.S. national suicide rate for males between 17- 60 is 25.1 per 100,000, based on the latest crude rate published by the Centers for Disease Control (CDC). This rate is slightly higher than the Army Active Duty rate for 2010 and 2011, which was 22.2 per 100,000 and 22.1 per 100,000, respectively. These very general comparisons strongly support the notion that suicidal behavior is an urgent national problem that affects all Americans across all dimensions of society, including those who have chosen to serve in an Army uniform.

With all things considered, and with what we know about the U.S. national suicide rate, the approach towards the suicide challenge should continue to be coordinated and multifaceted. The Army is confident that through our continued emphasis in the

services, programs, policies, and training that support our Army Family, we will overcome this threat to our Force.

The Army continues to institute a multi-disciplinary, holistic approach to health promotion, risk reduction, and suicide prevention. This approach is reflected in the various senior leader forums that are conducted throughout the Army: the Army Vice Chief of Staff-led Suicide Senior Review Group; the Health Promotion Risk Reduction Council; and the Community Health Promotion Councils at posts, camps, and stations.

Key elements of the Army's approach are:

- Prompt access by Soldiers to quality behavioral health care;
- Multi-points screening and documentation of mild Traumatic Brain Injuries/Post Traumatic Stress Disorders;
- Improved leader and Soldier awareness of high-risk behavior and intervention programs; and
- Increased emphasis on programs that support Total Force (Soldiers, Army Civilians and Family members) readiness and resilience.

### **Changing Culture**

The Army had traditionally perpetuated a culture in which asking for help was seen as weakness. This culture is now changing and must continue to change.

Although the Army is overcoming most of the stigma related barriers, stigma remains a challenge within the Force. A comprehensive Stigma Reduction Campaign Plan is being developed to identify and eliminate institutional and cultural barriers and promote seeking help for invisible wounds. The campaign will highlight Army, DoD, VA and national stigma reduction initiatives and target: Education and Outreach; Policies and Procedures; and Evaluation and Measurement. At the core of this initiative will be a robust communications campaign with effective messaging to promote help seeking for a myriad of invisible wounds.

We have experienced a degree of reduction in Soldiers' negative perception toward seeking help for behavioral health issues. Results from the Sample Survey of Military Personnel (SSMP) from 1999 to fall 2012, revealed that the percentage of officers and enlisted Soldiers who felt seeking behavioral health counseling / care would harm their career dropped significantly, from 81% to 54% for officers and from 69% to 52% for enlisted Soldiers. While many factors may influence this occurrence, we believe that two key efforts contributed to this change: co-locating behavioral health care with primary care and expanded use and promotion of confidential services (Military Crisis Line; on-line self-assessment programs for substance abuse; and confidential treatment programs). The Army has also increased access to, and availability of, Behavioral Health Care services. This has contributed to an overall increase in the number of Behavioral Health encounters from 991,655 in FY07 to 1,961,850 in FY12, a 97.8% increase.

We continue to employ a multi-tiered approach to increase awareness regarding suicide prevention and behavioral health services. Included are public service announcements using celebrities and Army leaders; advocacy and outreach messages and programs through numerous non-governmental organizations; and educational videos such as our "Soldier to Shoulder" series. Additionally, the Army continues to promote the use of confidential support programs such as Military OneSource and the Army's Confidential Alcohol Treatment and Education Pilot (CATEP) which bolster our efforts to ultimately mitigate stigma associated with seeking behavioral health care from among our ranks.

#### **Suicide Prevention Awareness Training**

Suicide Prevention Awareness Training continues to be updated based on trends and lessons learned from the Vice Chief of Staff of the Army-led Suicide Senior Review Group meetings each month and assessments conducted during installation visits.

During the 2012 Suicide Prevention Stand Down, commanders across the Army led their personnel in team-building activities and conducted suicide prevention and

resilience training to promote the buddy system and sharpen intervention skills and knowledge.

Programs such as Embedded Behavioral Health, a multidisciplinary, community based program that provides behavioral health care to Soldiers in close proximity to their units and in coordination with their unit leaders is a leading example in how the Army is redesigning behavioral health services. Embedded Behavioral Health is being established for all operational units in the active Army. Program evaluation determined that Embedded Behavioral Health resulted in statistically significant reductions in: 1) inpatient psych admissions 2) off-post referrals, 3) high risk behaviors and 4) number of non-deployables.

Additionally, Embedded Behavioral Health has higher acceptability and satisfaction rates by both Soldiers and supported leaders than conventional systems. These results directly contributed to the decision to expand the program in support of all operational active Army units and an example in how the Army is aligning behind evidenced based programs in establishing a network of complementary behavioral health services in support of Soldiers and Families.

Among other efforts, the Army is enhancing behavioral health care through: Tele-Behavioral Health, Patient Centered Medical Home and School Behavioral Health focused on reaching Soldiers and beneficiaries wherever they are located in order to improve access and reduce stigma.

#### **Ready and Resilient Campaign**

For us to continue to improve, and increase capability and performance, we must continue to build resilience in our total force. We have a historic opportunity to understand the lessons of the last 12 years and make our strong force stronger. Thus on February 4, 2013, the Secretary of the Army issued a Directive requiring the Army to move forward with its Ready and Resilient Campaign (R2C) plan. The R2C will address the challenges that stress the Force, and integrate and synchronize the multiple efforts



and programs designed to improve the readiness and resilience of Soldiers (Active, Reserve and National Guard), Army Civilians and their Families.

The R2C is focused on making resilience a part of our culture, using the Comprehensive Soldier and Family Fitness (CSF2) program and other supporting programs to accomplish that objective. The campaign also recognizes the value of the Army Profession Campaign. R2C, like many of our suicide prevention programs, targets Soldiers; however, every opportunity is taken to expand available programs and services to our Army Civilians and Family Members, as appropriate to their needs. Some programs don't elicit immediate change in behavior, but are based on the premise that investment now will help achieve desired results in the future.

#### **Comprehensive Soldier and Family Fitness Program**

Another holistic approach is the Army's Comprehensive Soldier and Family Fitness (CSF2) Program which addresses the precursors to suicide. CSF2's mission is *to increase the physical and psychological health, resilience and enhanced performance of Soldiers, Families and Army Civilians*. Key elements of the CSF2 Program include:

- Training for Soldiers, Family members and Army Civilians by a cadre of NCOs (along with some spouses and Army Community Service personnel) who serve as Master Resilience Trainers (MRT) at their home stations. The Army's goal is to embed MRTs down to the company level.
- A Global Assessment Tool (GAT) which measures an individual's psychological health and level of resilience. The designed to be taken annually and after deployments; it is designed to identify additional training needs to improve resiliency. Taking of the GAT is mandatory for all Soldiers on at least an annual basis; it is available to Family members and Army Civilians on a voluntary basis.
- Comprehensive Resilience Modules – short videos that provide self-development in specific areas identified by individual GAT assessments.

A key element of resilience training is teaching individuals to avoid the catastrophic thinking that leads to an emotional downward spiral, and providing them with skills to identify the positive things in their lives. The Army is focused on Institutional Training -- ensuring that elements of resilience training are taught at all levels -- from basic training to the War College.

The effectiveness of CSF2's holistic approach has been verified by four independent, peer-reviewed technical studies performed between February 2011 and February 2013.

The results include the following findings:

- Soldiers who committed suicide were significantly less resilient (as measured by the GAT) than other Soldiers
- Soldiers who received training conducted by a MRT improved their GAT scores (a measure of their psychological health and resilience) more than Soldiers who did not
- MRT training shows the greatest results for Soldiers 18 to 24 years old
- Developing MRT skills leads to improved Soldier adaptability and optimism, which, in turn, leads to decreased anxiety, depression and PTSD

CSF2 provides tools and skills that stay with Soldiers, Army Civilians and their Families long after leaving the Army. Some future plans include: expanding the number of CSF2 Training Centers at installations throughout CONUS and OCONUS; making resilience training part of Soldier in-processing; and developing a social media-oriented Health and Fitness Platform to provide an interactive online environment.

#### **Army Strong Bonds Program**

One program that has been tremendously beneficial is Army Strong Bonds. The Strong Bonds program has been highly effective in helping Soldiers and Family members develop resilience and readiness by giving them the skills necessary to cope with stress within relationships. Data shows that suicide rates are closely related to relationship issues; therefore, programs that support healthy relationships also potentially reduce

suicides. Strong Bonds training helps reduce relationship-related stress, thereby reducing the number of failed relationships and, potentially, the number of suicides. In support of Army-wide suicide prevention efforts and in response to the Army Vice Chief of Staff's Health of the Force assessment, the Chaplaincy conducted a Strong Bonds "surge" that trained 50,000 Soldiers and their Family members in FY12.

#### **Learning More Through Research - Army STARRS**

In June 2013, the Army will enter its fifth year of the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) partnership with the National Institute of Mental Health (NIMH). This study represents the largest study of mental health, psychological resilience, suicide risk, suicide-related behaviors, and suicide deaths in military personnel ever conducted. The goal is to identify factors that put a Soldier at risk for suicide, and factors that provide resilience, at specific points of Army service and over time. This information will then be used to develop evidence-based, targeted intervention strategies to decrease the frequency of suicides in the Army.

During the initial years of Army STARRS, researchers analyzed information from nearly 40 Army and Department of Defense datasets, spanning more than a billion data records, on all 1.6 million Soldiers who served on active duty from 2004-2009. In addition, the team is collecting data from willing Soldiers in every component of the Force (Active Army and those Army National Guard and Army Reserve Soldiers on active duty) who are in all phases of Army Service (Soldiers in initial entry training, Soldiers before and after deployment, Soldiers in theater, and Soldiers assigned to installations worldwide). Extensive information is collected through surveys and psychological evaluations, blood samples, and through Army and Department of Defense administrative records.

To date approximately 112,000 Soldiers have voluntarily participated in Army STARRS and approximately 52,000 have given blood samples. Researchers will analyze these samples to look at biological risk associated with a history of mental illness and these samples could be used as a baseline for future studies.

The size of these cohorts is unprecedented in military research; this grand scale will help our understanding of suicide risk and protective factors and the development of mental health disorders. The data will compliment other survey and neurocognitive data to give researchers a more complete understanding of risk and resilience.

Preliminary findings include analyses in the areas of deployments, enlistment waivers, unit combat deaths, unit suicides, marriage, private housing, age and education, rank, years of service, military occupational specialties, exposure to traumatic events, head/neck/blast injury, prescription drug abuse, mental health disorders and treatment, and suicide attempts. Researchers are using these findings to develop tools to help identify subsets of Soldiers who may be at elevated risk for suicidal behaviors. Army STARRS is currently working with the Army on analogous approaches to targeting prevention and treatment interventions for Soldiers with particularly elevated suicide risk.

#### **Conclusion**

Any time a Soldier, Army Civilian or Family member chooses to end his or her life, the loss is devastating to Family and friends, fellow Soldiers, and the Army. It is our shared responsibility – the responsibility of our nation's military leaders and Congressional leaders – to ensure the readiness of our military and the well being of our Soldiers. As we continue our mission to reduce the occurrence of suicide, I ask for your support as we continue to build and sustain the resiliency and readiness of our Soldiers, civilians and Families.

We have invested a tremendous amount of resources and deliberate planning to preserve the All-Volunteer force. Simply put, People are the Army. We have a continued responsibility to the courageous men and women who defend our country to take care of them and their Families. We must not break faith with those who dedicate their lives to serving our nation.

I assure the esteemed Members of the committee that there is no greater priority for me and the other senior leaders of the United States Army than the safety and well-being of our Soldiers. I wish to thank all of you for your continued support, which has been vital in sustaining our all-volunteer Army through an unprecedented period of continuous combat operations and will continue to be vital to ensure the future of our Army.

**Lieutenant General Howard B. Bromberg**  
*U.S. Army Deputy Chief of Staff, G-1*



Lieutenant General Howard B. Bromberg became the U.S. Army's 46<sup>th</sup> Deputy Chief of Staff, G-1 on July 21, 2012. He is responsible for developing, managing, and executing manpower and personnel plans, programs, and policies for the total Army. Prior to this assignment, he served as the Deputy Commanding General/Chief of Staff, U.S. Army Forces Command.

Lieutenant General Bromberg hails from California and was commissioned as an Air Defense Artillery officer in the U.S. Army upon graduation from the University of California at Davis in 1977. He holds a bachelor's degree in Agricultural Economics and Management. Throughout his career, Lieutenant General Bromberg has served in Army units in the United States, Germany, Korea and Southwest Asia. He has commanded at every level in the air defense community from platoon to installation.

Lieutenant General Bromberg's command assignments include Commanding General, Fort Bliss, Texas; Commanding General, 32d Army Air Missile Defense Command, Fort Bliss, Texas, while serving in Operation ENDURING FREEDOM, Operation IRAQI FREEDOM, Saudi Arabia, Kuwait and Iraq; Commander 11th Air Defense Artillery Brigade, Third Army; Commander 1st Battalion, 43d Air Defense Artillery, Eighth Army, Republic of Korea; Commander, A Battery, 6th Battalion, 52d Air Defense Artillery, Germany.

Lieutenant General Bromberg's principal staff assignments include Chief of Staff, U.S. Strategic Command, Offutt Air Force Base, Nebraska; Deputy Director, Force Protection/Director, Joint Theater Air and Missile Defense Organization, J-8, The Joint Staff, Washington, DC; Director of Enlisted Personnel Management Directorate, U.S. Army Human Resources Command, Alexandria, VA.; Operations Officer (S-3)/Executive Officer (XO), 2d Battalion, 43d Air Defense Artillery, Germany and Operation DESERT SHIELD/STORM, Saudi Arabia; Operations Officer, Defense Branch, J-3, The Joint Staff, Washington DC; Chief, HAWK Operational Readiness Evaluation Team, 32d Army Air Missile Defense Command, Germany; and Platoon Leader, D Battery, 6th Battalion, 52d Air Defense Artillery, Germany.

Lieutenant General Bromberg's decorations and awards include the Distinguished Service Medal (with two Oak Leaf Clusters), Defense Superior Service Medal (with Oak Leaf Cluster), the Legion of Merit (with three Oak Leaf Clusters), Bronze Star, Purple Heart, Defense Meritorious Service Medal, Meritorious Service Medal (with three Oak Leaf Clusters), Army Commendation Medal (with two Oak Leaf Clusters), Joint Service Achievement Medal, Army Achievement Medal (with Oak Leaf Cluster), Parachutist Badge, Joint Chiefs of Staff Identification Badge and the Army Staff Identification Badge.

Lieutenant General Bromberg is married. He and his wife have two daughters.

**NOT FOR PUBLICATION  
UNTIL RELEASED BY THE  
HOUSE ARMED SERVICES  
COMMITTEE**

**STATEMENT OF  
VICE ADMIRAL SCOTT R. VAN BUSKIRK, U.S. NAVY  
CHIEF OF NAVAL PERSONNEL  
AND  
DEPUTY CHIEF OF NAVAL OPERATIONS  
(MANPOWER, PERSONNEL, TRAINING AND EDUCATION)  
BEFORE THE  
SUBCOMMITTEE ON MILITARY PERSONNEL  
OF THE  
HOUSE ARMED SERVICES COMMITTEE  
ON  
UPDATE ON SUICIDE PREVENTION**

**MARCH 6, 2013**

**NOT FOR PUBLICATION  
UNTIL RELEASED BY THE  
HOUSE ARMED SERVICES  
COMMITTEE**

Chairman Wilson, Ranking Member Davis, and distinguished members of the Committee, thank you for holding this important hearing and for affording me the opportunity to offer an update on Navy's Suicide Prevention and Resiliency Programs.

The loss of a single shipmate to suicide is a tragedy that affects many; it takes away a life, shatters a family, and hurts unit cohesion and morale. We have been working closely with the Office of the Secretary of Defense and the other Services in their broader efforts of implementing the President's Military Mental Health Executive Order. As part of these efforts all of our programs are being internally reviewed and vetted to ensure we provide access to servicemembers and their families to best quality services and care. Only when we work together will we be able to make a difference. We remain resolute in our efforts as we focus on the root causes and contributing factors that lead to suicide-related behaviors and suicides, and creating an environment in which Sailors are comfortable coming forward when they feel they may harm themselves, or when they know of a shipmate contemplating harm or showing symptoms of excessive stress that may lead to suicidal thoughts or acts.

We continue to vigilantly monitor the health of the force and investigate every suicide and suicide related behavior. The suicide prevention team examines each case for pertinent information about the circumstances leading to the behavior and action that might inform our prevention program. Lessons learned from these case examinations are applied towards training improvement. Our observations continue to support that:



- Demographic distribution of suicides largely mirrors the demographics of the Navy as a whole. (Typically a male in pay grades E4 to E6 who completes the act of suicide with a firearm.)
- Suicides typically occur at a time in which Sailors are experiencing increased work responsibilities and family demands.
- Recent deployment experiences may contribute to suicide in some instances, although, overall, deployment history alone does not appear to increase suicide risk.
- Sailors who complete suicide tend to have experienced stress factors across multiple aspects of their lives, including relationship, legal, financial problems, or mental health issues.

While stressors may contribute to suicide risk, resiliency is strengthened through leadership and peer support, strong family bonds, support services, and a sense of purpose. Suicide prevention training requires leader-focused action and responsibilities to promote resilience and well being in Sailors, which is where Navy's efforts remain focused.

#### **Suicide Prevention – All Hands, All of the Time**

Suicide prevention is an “all-hands – all of the time” effort, involving Sailors, family members, peers, and leadership. We have adopted a comprehensive, tailored approach to resilience-building, suicide prevention training, intervention, research, and analysis. This includes a solid foundation of unit-level suicide prevention coordinators, mental health providers, installation first responders skilled in handling behavioral emergencies, and increased family awareness of suicide risk, warning signs, and support resources.

Command awareness and intervention remain a critical component of our suicide prevention strategy. Leadership provides Sailors with a clear sense of mission and purpose while creating an environment of trust and unit cohesion in which Sailors and families can thrive in the face of multiple demands and stressors. We remain vigilant about known risk factors such as: the effects of work related stress, financial concerns, legal problems, relationship issues and their impact on the physical health and psychological well-being of Sailors. Identifying such issues, we must intervene and offer assistance. Current efforts are focused on:

- Education and Awareness
- Prevention and Intervention
- Sailor Care and Crisis Response

#### **Education and Awareness**

One of the keys to successful suicide prevention in the Navy is robust education and awareness aimed at improving knowledge and understanding throughout the Navy. Our Operational Stress Control (OSC) training program provides an integrated structure of health promotion, family support, and prevention information, and focuses on building resilience, addressing problems early, and promoting a healthy and supportive command climate.

OSC offers Sailors a lexicon by which to self-identify stress reactions, and encourages them to seek help before the situation escalates to an unmanageable state. Engaged leadership promotes awareness of the stress continuum and underlines the importance of mind and body fitness to support Navy's tenets of *Warfighting First, Operate Forward and Be Ready*. Every

uniformed member, from our newest recruit to the Chief of Naval Operations, receives basic OSC and Suicide Prevention training. Institutionalized across the fleet and embedded in various career milestone courses, more than 32 advanced OSC modules are tailored to the career milestones of the Sailor and incorporate tangible skills to strengthen resilience and mitigate stress.

Recognizing the importance of a leadership-driven effort in de-stigmatizing help-seeking behaviors, leaders receive additional specialized training in five core areas of responsibility:

- (1) Strengthen Sailors, families, and units;
- (2) Identify signs of stress response;
- (3) Mitigate the effects of stress;
- (4) Treat (and support treatment of) stress injuries, and
- (5) Reintegrate the Sailor into the unit and/or society following suicide-related behaviors

or other interventions.

Confronted with increased tempo of operations (OPTEMPO) and stress placed on Sailors, we launched four Mobile Training Teams (MTTs) in support of OSC training, based in our two largest fleet concentration areas, Norfolk and San Diego. These MTTs provide world-wide, on-demand interactive training to Navy commands, both afloat and ashore, which offers a more personal and relevant method of delivery that meets the needs of our Sailors in varied operational environments. There is a significant demand for these services and we will continue to evaluate the location and number of teams available, providing additional teams when and where necessary.

**Prevention and Intervention**

We appreciate Congress including in the National Defense Authorization Act for Fiscal Year 2013, language that authorizes health care professionals and for commanding officers to inquire about personal firearms when there are reasonable grounds to believe a Sailor may be at risk for suicide or causing harm to others. Engaging with Sailors on a personal level is the foundation of effective prevention and intervention. Empowering shipmates, leaders, family, and community members to recognize early signs of risk and to take actions that address such concerns at the earliest possible point is a fundamental tenet of suicide prevention. We are acutely cognizant that recognition of stress-related behaviors must be followed by effective action. Mobilizing the network of shipmates to help fellow shipmates in distress is a critical protective factor against suicide.

Our prevention and intervention strategy promotes training Sailors to Ask, Care and Treat (ACT). This brings a command-level focus to the issue of suicide and the importance of breaking down barriers and reducing stigma, thereby promoting a more resilient force. Behavioral Quick Polls reflect that over 90 percent of our force knows to *ASK* a shipmate what is bothering him/her and then to *CARE* about the Sailor, engage in conversation and then to escort the Sailor to *TREATMENT*. All hands receive stress first-aid intervention training to ensure they are able to recognize a shipmate in trouble, break the code of silence and intervene, and connect the shipmate to the right leader or caregiver for support. When integrated with our OSC curriculum, Sailors are taught to look beyond stereotypical warning signs, recognize changes in behavior and initiate helpful actions to save lives, reduce further injury, and promote personal growth.

This deck plate level focus is reinforced by providing every commanding officer with a Suicide Prevention and Response Toolkit containing a wealth of resources, checklists and tools including intervention strategies and information to address known suicide risk factors, and assessments for key command Sailor readiness programs (e.g., Physical Fitness, Navy Alcohol and Drug Abuse Prevention, Sexual Assault Prevention, Operational Stress Control). Each toolkit includes post-intervention guidance for leaders and addresses required actions when a command experiences suicide-related behavior or a suicide.

Sailors increasingly recognize the importance and courage needed to seek help when distress becomes overwhelming. A 2010 Behavioral Health Quick Poll reflects that the majority of Sailors are confident in their ability to effectively respond to a Sailor who talks about suicide and the ability of their commands to support Sailors seeking help for suicidal thoughts or actions. Our Navy web sites include the message, “Life is Worth Living” and a link to the Military Crisis Line. reinforcing a coordinated and systematic year-round communications strategy that includes leadership messaging, internal media, and educational materials to raise awareness about suicide risk and provides ready access to resources. In 2012, over 1,900 Sailors requested and received command assistance for reported suicidal ideations. Others have sought help from chaplains, family services or medical professionals. It is clear leadership plays a critical role in creating an environment that promotes resilience, encourages use of resources to address potential problems before thoughts of self-harm occur, and actively supports reintegration into the unit following intervention or treatment.

Navy’s suicide prevention program focuses on Sailors as well as the families who support them. We provide resiliency support for Navy families struggling to cope with the challenges of long separations, disruption to family routine, anxiety over the safety of the deployed parent, and

the well-being of the parent caring for the family at home. Fleet and Family Support Centers (FFSCs) provide comprehensive family and deployment support, life skills training, counseling, and transition support.

Project FOCUS (Families Overcoming Under Stress), initiated by the Navy Bureau of Medicine and Surgery (BUMED) in 2008, provides state-of-the-art family resiliency services to military children and families at over 20 Navy installations and online for those in remote locations. FOCUS promotes a culture of prevention and reduction of stigma through a family-centered array of programs, such as community briefings, education workshops, individual and family consultations, and resiliency training. This approach teaches Sailors and their families to understand their emotional reactions, communicate more clearly, solve problems more effectively, and set and achieve goals throughout the deployment cycle. FOCUS has been recognized by the Executive Office of the President and the Office of the First Lady as a model for prevention/intervention of psychological health services for military families. More than 300,000 Service members, families, providers and community members have participated in FOCUS.

Our efforts are not limited to our Active component, in addition to leveraging all of the mental health programs, Reserve component (RC) Sailors and their families receive specific support through the Navy Reserve Psychological Health Outreach program. Psychological health outreach team coordinators and members, located at the five regional reserve commands, provide RC Sailors psychological health assessments, education, and referrals to mental health specialists. This program has facilitated successful reintegration of countless citizen/warriors mobilized in support of national defense requirements.

The increased attention on suicide prevention and behavioral challenges faced by today's force has motivated Sailors to step up and care for each other. The Coalition of Sailors Against Destructive Decisions (CSADD), a grassroots peer-mentoring program led by, and for, young Sailors, continues to grow with over 200 chapters Navy-wide. CSADD focuses on empowering junior Sailors with the tools and resources to promote good decision-making processes, bystander intervention and leadership development, while reinforcing a culture of shipmates-helping-shipmates. CSADD promotes awareness and discussion among peers across a range of areas, including suicide prevention, financial management, and responsible use of alcohol, personal safety, and domestic violence. CSADD initiatives include the "Stop and Think Campaign," which highlights the potential consequences of poor decisions, an active *Facebook* page on which Sailors can ask questions, access information and training materials, share lessons learned, and access a semi-annual newsletter which highlights best practices across the Navy.

#### **Sailor Care and Crisis Response**

While most Navy suicide prevention activities focus on resilience-building and early intervention, we must also be prepared to intervene at any stage of a crisis. It is not enough to know what to do. We must also know how to do it. Every Navy command is required to maintain a crisis response plan to ensure individuals understand how to quickly and effectively get help to someone in distress, and to ensure the safety of someone at acute risk, until they can receive professional care.

To better support deployed Sailors, we created the Navy Mobile Care Team (MCT). This team, which consists of mental health clinicians, research psychologists, and enlisted psychiatry technicians, has been continuously deployed to Afghanistan since its inception in 2009. The

team routinely travels across all regions of Afghanistan providing behavioral health surveillance using the Navy Behavioral Health Needs Assessment Survey (BHNAS), individual, unit, and command consultations, and combat and operational stress control training (including psychological first aid) to Sailors serving in the combat zone. The MCT mission is to provide preventative mental health services and immediate unit level feedback and consultation to Sailors and unit leaders, frequently engaging Sailors in close proximity to their units after critical stressful events with the expectation of returning them to duty. It routinely links Sailors in the combat zone with mental health providers as a means of reducing stigma associated with seeking care.

In addition to the Mobile Care Team, the Medical Home Port Program is a team-based model focused on optimizing the relationship between patients, providers and the broader healthcare team. Mental health providers are embedded within Medical Home Ports to facilitate regular assessment and early mental health intervention. This model enables Sailors to be treated in settings in which they feel most comfortable and reduces the stigma associated with the care they receive. Additionally, improving early detection and intervention in the primary care setting reduces the demand for time-intensive intervention in mental health specialty clinics.

When a suicide occurs, timely and compassionate resources and assistance are the first step to mitigating the effects on those impacted by the tragedy. Navy formalized a memorandum of understanding with the renowned Tragedy Assistance Program for Survivors (TAPS), enabling them to offer their unique support services directly to Navy families during the long grief and recovery process following a suicide loss. Additionally, Navy Special Psychiatric Rapid Intervention Teams (SPRINT) are on call 24 hours-a-day, seven days-a-week, for circumstances requiring a higher level of support, and local chaplains and Fleet and Family



Support Centers regularly provide command consultation, assistance in arranging memorial and funeral services, and grief counseling.

Investigations into completed Navy suicides indicate that when contemplating suicide a Sailor may come in contact with key personnel, such as legal professionals, first responders, and chaplains, who have the opportunity to intervene. We implemented targeted training to ensure these individuals are prepared to identify risk factors and respond appropriately. Specialized training for officers of the Judge Advocate General Corps (JAGC) and agents of the Naval Criminal Investigative Service (NCIS) has proven critical in recognizing and intervening when suicide ideations and gestures are made. We are creating new training products specifically for installation emergency first responders, such as Emergency Medical Services (EMS), dispatch, and security personnel, which covers safety, de-escalation, and response coordination for behavioral health emergencies and suicide risk situations.

### **Conclusion**

We ask an incredible amount of our Sailors and their families. In return, we are inherently responsible for providing them with the level of support and care commensurate with their personal sacrifices. On behalf of all the men and women of the United States Navy and their families, thank you for your commitment to this critical issue and for your continued support of our Sailors and their families.

## United States Navy Biography

10/11/2011 - Present

### Vice Admiral Scott R. Van Buskirk

Vice Adm. Van Buskirk, a native of Petaluma, Calif., graduated from the United States Naval Academy in 1979. He assumed duties as the Navy's 56th Chief of Naval Personnel on Oct. 11, 2011. Serving concurrently as the Deputy Chief of Naval Operations (Manpower, Personnel, Training and Education) (N1), he is responsible for the planning and programming of all manpower, personnel, training and education resources for the U.S. Navy. He manages an annual operating budget of \$29 billion and leads over 20,000 employees engaged in the recruiting, personnel management, training and development of Navy personnel. His responsibilities include overseeing Navy Recruiting Command, Navy Personnel Command, and Naval Education and Training Command.



Ashore, he received his master's degree at the Naval Postgraduate School and served tours in the Navy Office of Legislative Affairs; Submarine Force U.S. Pacific Fleet; Bureau of Naval Personnel; and, Submarine Force U.S. Atlantic Fleet.

At sea, he served on board USS *Seawolf* (SSN 575), USS *Salt Lake City* (SSN 716), USS *Tunny* (SSN 682), and USS *Georgia* (SSBN 729) GOLD, and commanded the USS *Pasadena* (SSN 752) and Submarine Development Squadron 12.

As a flag officer, he has served as commander, Task Force Total Force; deputy to the Deputy Chief of Staff, Strategic Effects (MNF-Iraq); commander, Carrier Strike Group Nine; assistant deputy, Chief of Naval Operations for Operations, Plans and Strategy (N3/N5B); deputy commander and chief of staff, U.S. Pacific Fleet; and, most recently, as the 47th commander of the United States 7th Fleet, forward deployed in Yokosuka, Japan.

He is entitled to wear the Distinguished Service Medal, Defense Superior Service Medal, Legion of Merit (seven awards), and other various personal, unit and service awards.

*Updated: 18 November 2011*

DEPARTMENT OF THE AIR FORCE  
PRESENTATION TO THE SUBCOMMITTEE ON MILITARY PERSONNEL  
COMMITTEE ON ARMED SERVICES  
UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: SUICIDE PREVENTION

STATEMENT OF: LIEUTENANT GENERAL DARRELL D. JONES  
DEPUTY CHIEF OF STAFF MANPOWER, PERSONNEL  
AND SERVICES UNITED STATES AIR FORCE

MARCH 6, 2013

NOT FOR PUBLICATION UNTIL RELEASED  
BY THE COMMITTEE ON ARMED SERVICES  
UNITED STATES HOUSE OF REPRESENTATIVES

**Air Force Suicide Prevention**

Suicide prevention remains a top priority of Air Force leadership, and we remain committed to doing everything possible to save lives. The Air Force Suicide Prevention Program (AFSPP), launched in 1996 and fully implemented by 1997, emphasizes leadership involvement and a community approach to reducing deaths from suicide. The program is an integrated network of policy and education that focuses on reducing suicide through the early identification and treatment of those at risk. It uses leaders as role models and agents of change, establishes expectations for Airman behavior regarding awareness of suicide risk, develops population skills and knowledge, and analyzes every suicide. The program represents the Air Force's fundamental shift from viewing suicide and mental illness solely as medical problems and instead seeing them as larger service-wide community problems. The program was designed with 11 overlapping elements that resulted in enhancing the capacity of the Air Force to recognize and respond to Airmen in distress on multiple levels. These 11 elements can be grouped into the three broad categories of Leadership and Community, Education and Protections for Those Under Investigation.

**Lessons Learned**

In 2004 and 2010 the Air Force joined with researchers from the University of Rochester to evaluate the effectiveness of the Air Force program in reducing suicides. The results of these efforts concluded that the program works best with a sustained focus on measured execution of all 11 Elements. Also in 2010, the Air Force program managers conducted a comprehensive gap analysis and identified areas for enhancement. Some of these improvements included publishing guidance and communication to leaders, chaplains, and public affairs on the topics of suicide prevention and post suicide response. The Air Force began updating its guidance by rewriting and publishing our Suicide Prevention Instruction, establishing tiered training requirements, and codifying DoD Suicide Event Report (or DoDSER) requirements. We identified our career fields at highest risk for suicide and tailored training specifically for them, to include requiring a frontline supervisor training course. We developed the Airman's Guide to Assisting Personnel in Distress, and the Community Action Information Board (CAIB) directed all units

to complete an annual end-of-year self-assessment checklist to ensure full implementation of the 11 Elements of our program.

**Recent Initiatives**

The Air Force is committed to strengthening and improving its program. Some recent suicide prevention initiatives include conducting live training for all installation suicide prevention program managers and hosting an Air Force-wide suicide prevention focus group to gather feedback on the perceptions of the program from our Airmen in the field. We queried their knowledge of the program and asked them to recommend improvements. A summary of these suggestions was briefed to senior leadership at the Air Force CAIB and those recommendations are currently being evaluated for implementation. Our required annual training was revised to increase emphasis on early help-seeking and leadership involvement with an interactive training module that emphasizes the Ask, Care, Escort model, which focuses Airmen on how to serve as good Wingmen, and specifically how to identify distress signals from fellow Airmen who may be at risk for suicide, and how to take appropriate action. Units have the option of completing this training on-line or via small group discussions. A 20-minute annual key skills frontline supervisor refresher training module is in development to sustain leadership skills in the prevention of suicides in our highest risk career fields. The Air Force Guide to Managing Suicidal Behavior, a clinical guide for mental health providers for assessing, managing, and treating suicidal ideation, is currently under revision.

**Recent Research Efforts**

The Air Force is fortunate to have a long history of research partnerships with DoD and non-DoD experts to expand our knowledge of suicide and suicide prevention. Current research with RAND Project Air Force is seeking to understand how Airmen use social media, to include the impact of social media use on relationships, help seeking, and emotional well-being. Research with the University of Rochester is examining the role of life events and social stressors factors in the suicides of specific clusters of personnel. The Air Force Research Lab and the University of Rochester are studying the relationships between personal well-being and suicide risk.

**Active Duty, Guard, and Reserve Trend**

Last year 51 active duty Airmen took their lives, a rate of 15.3 per 100,000. Although this is consistent with the upward trend in Air Force suicide rates since 2007 and is reflective of similar increases found in U.S. civilian rates during this same time period, we find this trend extremely disturbing as each member of our Air Force Total Force team is highly valued. Deployment does not seem to be a risk factor for suicide in the Air Force. The stressors most frequently experienced by Airmen prior to a suicide include relationship problems, legal/administrative issues, work-related issues or a combination of these factors. The Air Reserve Component had a total of 25 suicides in 2012, consistent with the rate of incidence in 2011 and 2010. Unfortunately, the Air National Guard trended slightly upward in 2012, while the Reserve was down. The Guard and Reserve also report similar risk factors for suicide as the Active Component.

**National Perspective on Suicide**

The AFSPP is actively engaged with the Defense Suicide Prevention Office (DSPO) in helping shape suicide prevention efforts across the Department of Defense through the Suicide Prevention and Risk Reduction Committee, the General Officer Steering Committee on Suicide Prevention, and other working groups and committees. The Air Force significantly contributes to 5 DSPO working groups, with significant impact on strategic messaging and stigma reduction. The Air Force also partners with DSPO and other services in promoting the "Military Crisis Line" component of the Veterans Crisis Line to assure Airmen have access to immediate confidential services as close as their phone.

The AFSPP continues to contribute to the body of scientific literature and to the study of suicide and suicide prevention. The 2012 National Strategy on Suicide Prevention states: "...the experience of the U.S. Air Force Suicide Prevention Program has shown that leadership, policy practices, and accountability can combine to produce very impressive successes. These findings should be shared and adapted for use in different settings." The Air Force is very committed to our ground-breaking program to prevent suicides and will continue to apply all the best practices science has to offer.

**Post-Traumatic Stress Disorder**

Although Post-Traumatic Stress Disorder (PTSD), has not proven to be contributing factor for recent suicide incidents or trends in the Air Force, newly diagnosed cases are rising on a yearly basis. However, we are encouraged that our overall rate of PTSD remains below 0.5 percent, and our retention rate for Airmen diagnosed with PTSD remains at 74 percent. We believe the best way to reduce mental health stigma is to treat and retain Airmen who seek care. Retaining the majority of Airmen with a PTSD diagnosis is concrete evidence that we are meeting that goal.

Our Airmen continue to be screened for PTSD symptoms via Pre- and Post-Deployment Health Assessments at various points throughout the deployment cycle. All Airmen receive education and training on how to recognize symptoms of PTSD and how to access the right resources. Because of the nature of their work, we know that our Explosive Ordnance Disposal (EOD), Security Forces, Medical, and Transportation career fields are at highest risk for developing PTSD. In 2010, the Air Force established the Deployment Transition Center at Ramstein AB, Germany, to provide an effective reintegration program for members of these occupational fields as they return home from a high risk deployment. To date, more than 5,000 Airmen have passed through the Center and research has shown solid evidence that the program helps Airmen by decreasing symptoms of Post-Traumatic Stress Disorder along with problematic alcohol use and relationship difficulties.

Another way the Air Force supports the growing needs of our Airmen in uniquely stressed career fields is by dedicating Mental Health and Primary Care staff to select EOD units and assigning Mental Health providers to support several Remotely Piloted Aircraft and Intelligence units. In addition, mental health clinicians known as Behavioral Health Optimization providers have been placed in 82 percent of our Primary Care clinics, with a goal of staffing 100 percent of clinics by the end of 2013. This allows the delivery of less formal and less stigmatizing care within Primary Care clinics, helping provide “the right care at the right time in the right place.”

We are also dedicated to providing adequate mental health provider staffing and training. In response to the 2010 National Defense Authorization Act, Section 714, mental health active duty

authorizations will increase 25 percent by 2016 to support the psychological needs of all Airmen. We thank the Committee for your efforts to help us meet our critical staffing needs. Our mental health providers are trained in evidence-based treatments, to include Prolonged Exposure and Cognitive Processing Therapy. This training is delivered in internships and residency programs for trainees and to all providers following completion of training. Finally, the Air Force continues to collaborate with the Departments of Defense and Veterans Affairs in advancing research on prevention and treatment of combat related injuries, including PTSD.

**Conclusion**

On behalf of Air Force leadership, I pledge to you that we will continue to seek the answers to why suicides occur and how we can intervene to prevent them. We need every Airman on the team as we face the difficult challenges of the future. We will continue to work closely with our Army, Navy, DoD and VA colleagues to find the best practices and to share them effectively. Thank you for your tremendous support in this endeavor.





## BIOGRAPHY

UNITED STATES AIR FORCE

### LIEUTENANT GENERAL DARRELL D. JONES

Lt. Gen. Darrell D. Jones is the Deputy Chief of Staff for Manpower, Personnel and Services, Headquarters U.S. Air Force, Washington, D.C. General Jones serves as the senior Air Force officer responsible for comprehensive plans and policies covering all life cycles of military and civilian personnel management, which includes military and civilian end strength management, education and training, compensation, resource allocation, and the worldwide USAF services program.

General Jones entered the Air Force in 1979 as a graduate of Mississippi State University's ROTC Program. He has served in a wide variety of assignments at base level, major command, secretariat, combatant commands and Headquarters U.S. Air Force. He has commanded a squadron, group, two wings and a direct reporting unit. The general also led the Headquarters U.S. Air Force Deputy Chief of Staff for Personnel's Issues Team, served as Director of Personnel for Pacific Air Forces, and was Director of Manpower and Personnel, Headquarters U.S. Central Command.



Prior to his current assignment, the general was the Commander, Air Force District of Washington, and Commander of the Air Force Forces for Joint Forces Headquarters-National Capital Region, Andrews Air Force Base, Md., which provides the single Air Force voice and component to the Joint Forces Headquarters-National Capital Region, as well as organizes, trains and equips combat forces for the aerospace expeditionary forces, homeland operations, civil support, national special security events and ceremonial events.

#### EDUCATION

- 1979 Bachelor of Science degree, Mississippi State University
- 1984 Master of Arts degree in business administration, Webster University, St. Louis, Mo.
- 1984 Squadron Officer School, Maxwell AFB, Ala.
- 1991 Air Command and Staff College, Maxwell AFB, Ala.

1994 Air War College, Maxwell AFB, Ala.

#### ASSIGNMENTS

1. October 1979 - April 1982, assistant Chief, Quality Force Section; Chief, Customer Assistance Section; Chief, Quality Force Section; and Chief, Personnel Utilization Section, Consolidated Base Personnel Office, Williams AFB, Ariz.
2. April 1982 - August 1984, assistant for Resource Distribution, later, Chief, Assignment Analysis Branch, Deputy Chief of Staff for Personnel, Headquarters Air Training Command, Randolph AFB, Texas
3. August 1984 - August 1985, executive officer to the Deputy Chief of Staff for Personnel, Headquarters Air Training Command, Randolph AFB, Texas
4. August 1985 - August 1986, personnel adviser and board member, Secretary of the Air Force Personnel Council, Air Staff Training Program, Washington, D.C.
5. August 1986 - August 1987, Chief, Consolidated Base Personnel Office, 384th Combat Support Group, McConnell AFB, Kan.
6. August 1987 - September 1988, Director of Personnel, 384th Combat Support Group, McConnell AFB, Kan.
7. September 1988 - June 1990, Commander, 384th Mission Support Squadron, and Chief, Mission Support, 384th Combat Support Group, McConnell AFB, Kan.
8. June 1990 - June 1991, student, Air Command and Staff College, Maxwell AFB, Ala.
9. June 1991 - May 1992, Chief, Entitlements, Compensation and Education, Directorate of Manpower Personnel and Security, Headquarters U.S. European Command, Stuttgart, Germany
10. June 1992 - June 1994, Chief, World War II Commemoration Branch, later, Deputy Chief, World War II Commemoration Division, Directorate of Manpower Personnel and Security, Headquarters U.S. European Command, Stuttgart, Germany
11. July 1994 - June 1995, student, Air War College, Maxwell AFB, Ala.
12. June 1995 - June 1997, Chief, Force Structure Plans and Policies, Directorate of Military Personnel Policy, Deputy Chief of Staff for Personnel, Headquarters U.S. Air Force, Washington, D.C.
13. June 1997 - June 1999, Chief, Personnel Issues Team, Deputy Chief of Staff for Personnel, Headquarters U.S. Air Force, Washington, D.C.
14. June 1999 - May 2001, Commander, 62nd Support Group, McChord AFB, Wash.
15. May 2001 - July 2002, Director of Personnel, Headquarters Pacific Air Forces, Hickam AFB, Hawaii
16. July 2002 - June 2004, Commander, 66th Air Base Wing, Hanscom AFB, Mass.
17. June 2004 - June 2006, Director of Manpower and Personnel, Headquarters U.S. Central Command, MacDill AFB, Fla.
18. June 2006 - January 2008, Commander, 37th Training Wing, Lackland AFB, Texas
19. February 2008 - November 2009, Director of Force Management Policy, Deputy Chief of Staff for Manpower and Personnel, Headquarters U.S. Air Force, Washington, D.C.
20. November 2009 - December 2010, Commander, Air Force District of Washington, Andrews AFB, Md.
21. December 2010 - present, Deputy Chief of Staff, Manpower, Personnel and Services, Headquarters U.S. Air Force, Washington DC

**SUMMARY OF JOINT ASSIGNMENTS**

1. June 1991 - May 1992, Chief, Entitlements, Compensation and Education, Directorate of Manpower Personnel and Security, Headquarters U.S. European Command, Stuttgart, Germany, as a major
2. June 1992 - June 1994, Chief, World War II Commemoration Branch, later, Deputy Chief, World War II Commemoration Division, Directorate of Manpower Personnel and Security, Headquarters U.S. European Command, Stuttgart, Germany, as a major and lieutenant colonel
3. June 2004 - June 2006, Director of Manpower Personnel, Headquarters U.S. Central Command, MacDill AFB, Fla., as a colonel and brigadier general

**MAJOR AWARDS AND DECORATIONS**

Distinguished Service Medal  
Defense Superior Service Medal  
Legion of Merit with two oak leaf clusters  
Defense Meritorious Service Medal  
Meritorious Service Medal with two oak leaf clusters  
Air Force Commendation Medal  
Air Force Recognition Ribbon  
National Defense Service Medal with bronze star  
Global War on Terrorism Expeditionary Medal  
Global War on Terrorism Service Medal

**OTHER ACHIEVEMENTS**

1988 Outstanding Personnel Manager of the Year Award (Base-level Senior Personnel Manager), Strategic Air Command  
1989 Outstanding Personnel Manager of the Year Award (Base-level Senior Personnel Manager), SAC  
1989 Outstanding Personnel Manager of the Year Award (Base-level Senior Personnel Manager), USAF  
2008 General and Mrs. Jerome O'Malley Award

**EFFECTIVE DATES OF PROMOTION**

Second Lieutenant Oct. 28, 1979  
First Lieutenant Oct. 28, 1981  
Captain Oct. 28, 1983  
Major March 1, 1988  
Lieutenant Colonel May 1, 1993  
Colonel March 1, 1999  
Brigadier General March 1, 2006  
Major General July 3, 2009  
Lieutenant General Dec. 14, 2010

(Current as of January 2011)

NOT PUBLIC UNTIL RELEASED BY THE  
HOUSE ARMED SERVICES COMMITTEE

STATEMENT  
OF  
BRIGADIER GENERAL ROBERT F. HEDELUND  
DIRECTOR, MARINE AND FAMILY PROGRAMS DIVISION  
UNITED STATES MARINE CORPS  
BEFORE THE  
SUBCOMMITTEE ON MILITARY PERSONNEL  
OF THE  
HOUSE ARMED SERVICES COMMITTEE  
CONCERNING  
MILITARY SUICIDE PREVENTION  
ON  
MARCH 21, 2013

NOT PUBLIC UNTIL RELEASED BY THE  
HOUSE ARMED SERVICES COMMITTEE

**Introduction**

Chairman Wilson, Ranking Member Davis, and distinguished Members of the Subcommittee, on behalf of your Marine Corps, I would like to thank you for inviting me here today to discuss the issue of military suicide prevention. We are grateful for your continued, active engagement in making lasting improvements to the overall health, well-being, and quality of life for Marines and their families.

One suicide is too many. Each tragic loss to suicide has a far-reaching impact on families, friends and our entire Marine Corps community. Suicide prevention is not a single act but rather a series of actions that support the Marine Corps community health approach to addressing the issues facing Marines and providing support to Marines and family members. Preventing suicide requires vigilance and our concerted effort to harness the strength of engaged leaders. Engaged leaders are alert to those at risk for suicide and take action to help Marines address the stressors in their lives. They help individual Marines optimize their physical, psychological, social, and spiritual needs. Totally fit Marines are fortified and strengthened and better able to withstand the tensions and stressors of life in and out of the Marine Corps. Affirming and restoring the indomitable spirit of Marines is an enduring mission and how we “keep faith with Marines and families.”

Individual suicide cases are uniquely complex and the effects ripple through the family and Marines left behind. Prevention takes a multilevel (unit, family, peer, individual, community, society), multifaceted public health approach (individual/peer suicide prevention, family training, responsible reporting of suicide, stigma reduction of receiving behavioral healthcare treatment, case management). The Marine Corps is committed to consistently and aggressively identifying sources of suicide risk and ways to approach and increase effectiveness

of our training and support efforts. We are working with the Department of Defense in their broader efforts of implementing the President's Military Mental Health Executive Order. As part of these efforts all of our programs are being internally reviewed and vetted to ensure we provide access to servicemembers and their families to best quality services and care. .

At this point, all Marines are taught to recognize the warning signs of suicide, ask if a Marine is thinking of suicide, express genuine care and concern for the Marine, and immediately escort the Marine to help. Further, Marine Corps leaders are taught and make it a priority to know their Marines on a personal level and show genuine compassion and concern for them. Leaders are also taught that they serve as models to show Marines that it takes a strong, committed person to ask for and receive help.

#### **Understanding the Statistics and Risk Factors**

Between 2001 and 2007, the number of suicides in the Marine Corps fluctuated between 23 and 34, but between 2007 and 2009 we saw a disturbing increase. From a recent low point of 25 suicides in 2006, the number increased to 52 in 2009. During Calendar Year 2010 and 2011, 37 and 32 Marines, respectively, died by suicide. For Calendar Year 2012, the number of suicides increased to 48. The Marine Corps is concerned with the increased number of suicides in 2012 and the primary challenge remains teaching Marines to engage help-seeking services early, before problems worsen to the point of suicide. Attempted suicides have increased from 164 attempts in 2009, to 172 in 2010, to 163 in 2011 and to 179 in 2012.

Understanding the risk factors is very complicated. Therefore, identifying one reason for trends in the number of suicides is difficult. However, we consistently track suicides through the Department of Defense Suicide Event Reporting surveillance system and have partnered with

several research agencies to further explore the underlying reasons of suicide. We believe that the increase in suicide attempts may be due to an increase in surveillance and reporting requirements and command interventions where a Marine noticed another Marine in distress and helped them receive support and care.

Marine suicides and attempts resemble our institutional demographics: Caucasian male, 17-25 years old, and between the ranks of Private and Sergeant (E1-E5). Based on our analysis, we know that the primary stressors Marines experience prior to suicides and attempts are relationship problems, legal or disciplinary problems, behavioral health diagnoses, financial problems, and substance abuse.

#### **Suicide Prevention Efforts**

We will not rest in our efforts to prevent suicide. To efficiently manage behavioral health risk, protective factors, and ultimately prevent suicide, the Marine Corps combined all related programs under a new Behavioral Health Branch. The reorganization synchronized program functions such as research, policy, training, prevention, and treatment. The Marine Corps is developing prevention activities to mitigate the risk across behavioral health.

Currently, we are developing a behavioral health integrated training which addresses common risks and protective factors across all behavioral health domains. The training, built on the Institute of Medicine Prevention Continuum, supports universal awareness and selected and indicated training for certain high risk Marines populations. We believe that our universal awareness of suicide within the Corps is effective. Supporting research is ongoing and will inform our continued action to cover all areas of need.

Our *Never Leave a Marine Behind* suicide prevention training series focuses on key learning objectives including seeking help early, before a situation becomes a crisis, and how to help your fellow Marine. Marines are taught to recognize the warning signs for suicide during the *Never Leave a Marine Behind* suicide prevention training. The training requirement reinforces that Marines are alert to those at risk for suicide at all times and take immediate action to help Marines address the hard times or pain in their lives. All Marines are taught the acronym, R.A.C.E. (Recognize; Ask; Care; Escort), method as a simple tool to recognize suicide warning signs, ask one another about suicide, care for each other through listening and support, and escort fellow Marines to help. It is important for all Marines and family members to take an active role in suicide prevention.

Marines are also taught that distress in some individuals can lead to the development of unhealthy behaviors including withdrawal from social support and ineffective problem solving. These behaviors may intensify the risk of suicide. The people who a Marine sees every day (fellow Marines, co-workers, family, friends) are in the best position to recognize changes stemming from distress and to provide support. Marines are taught to know each other at a personal level – to know their behavior patterns and their likes and dislikes so that they can identify even subtle changes. Any substantial or observable change in behavior warrants further discussion with the individual.

The Marine Corps is implementing a Case Management System (CMS). The CMS reaches across multiple programs to provide the most suitable information and analysis, greatly enhancing appropriate treatment planning and assisting with addressing the Marine's needs. The system assists in the identification of at-risk Marines and improves appropriate service delivery as well as aftercare efforts. The CMS better equips the Marine Corps to closely monitor Marines



at risk for suicide to ensure they receive appropriate care. Plans are underway to streamline access to care to highlight community counseling capabilities of improved screening, preventive and treatment services. Community counseling will improve tracking of referrals to specialty care.

The Marine Corps is expanding the Military Family Life Consultant (MFLC) Program. The addition of embedded MFLCs as part of the behavioral health services provided to Marines and their families will be seamlessly woven into the larger support network of command structures, and will enhance unit cohesiveness and health and human services across the Corps. The embedded MFLC Program will provide confidential counseling by licensed clinical providers.

The Marine Corps DSTRESS line, which expanded worldwide in early 2012, provides anonymous, 24/7 counseling services to any Marine, attached Sailor, or family member. The line is staffed by veteran Marines and Fleet Marine Force corpsmen, Marine family members, and civilian counselors specifically trained in Marine culture. The counseling provided gives any Marine, attached Sailor, or family member 'one of their own' to speak with about everyday stress or their heaviest burdens in life.

Operational Stress Control and Readiness (OSCAR) team training builds teams of Mentors (selected unit Marines and leaders), Extenders (unit medical and religious personnel), and Mental Health Professionals who work together to provide a network of support. This model empowers Marines with leadership skills to break associated stigmas and act as sensors for the commander by noticing small changes in behavior and taking action early. This supports the commander in building unit strength, resilience, and readiness as well as keeping Marines in the

fight. Further combat and operational stress control training and education is expanding across the Marine Corps to provide targeted knowledge, skills, and tools to Marines and families.

Additional on-going or new prevention efforts include: the appointment and training of Suicide Prevention Program Officers for each battalion and squadron to essentially serve as the “eyes and ears” of the suicide prevention program for the commanding officer; implementation of the Columbia Suicide Severity Rating Scale to assess and evaluate for suicide; continuing dialogue with Marine Corps Defense Counsel to address an important stressor for Marines – legal issues; force-wide dissemination of reintegration and postvention plans aimed at reintegrating Marines following a suicide-related event and for command postvention plans following a death; and partnering with weapons and field training battalion to gain insights into reducing access to lethal means.

#### **Research and Partnerships**

The complex nature of suicide prevention requires an important balance between immediate action and long-term planning. Research, partnerships, and effective collaboration are necessary to stay abreast of the latest available information within the suicide prevention arena and to explore future program needs. To further our understanding of suicide prevention and to evaluate program effectiveness, the Marine Corps is partnering with federal agencies, academia and private industry.

In October 2011, the American Association of Suicidology (AAS) began a two-year focused study of suicides to better understand suicide risk and protective factors and better inform prevention and surveillance efforts. The AAS study involves investigating a person's death by attempting to reconstruct what the person thought, felt, and did in the days preceding

his or her death. This approach is a gold standard in researching suicides, and involves collecting all available information on the deceased via structured interviews of family members, relatives, friends, and attending health care personnel.

In an effort to improve upon our mandatory *Never Leave a Marine Behind* suicide prevention training series, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury is conducting a study to assess the effectiveness of our prevention training. Additionally, we are collaborating with the National Institute of Mental Health and the Army Study to Assess Risk and Resilience in Service members, the Department of Veterans Affairs/University of California San Diego Marine Resilience Study to continue research of the biological, psychological, and social factors affecting Marine resilience.

Other ongoing or future research efforts focus on: examination of suicide behavior in the Marine Corps and early career variables to better identify those in need of targeted prevention services; development of a new high impact clinical suicide prevention tool utilizing text messages based on the “Caring Letters Project;” and studying the effects of suicide on Marine family members and evaluation of postvention and casualty response.

The Marine Corps is partnering with Navy Medicine to identify and reduce gaps in prevention and treatment. Areas of focus include: (1) Enhanced screening for suicide risk; (2) Management of at-risk personnel, including those with a history of mental health issues and suicide attempt; and (3) Stricter policies for the monitoring of at-risk personnel, including follow-on care. We are also attentive to the mental health of our warriors and are dedicated to ensuring that all Marines and family members who bear the invisible wounds caused by stress receive the best help possible. Our partnership with the Navy will continue to address the needs of Marines and their families in the face of the nationwide shortage of qualified mental health

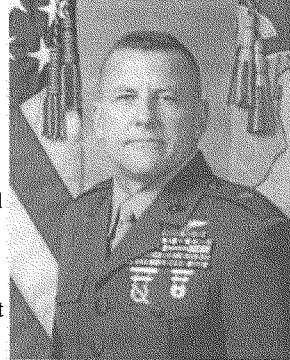
care providers, and are committed as a Corps to making sure every Marine struggling with a stress issue gets the support and treatment they need. Finally, we actively participate as a member of the DoD Suicide Prevention and Risk Reduction Committee (SPARRC), meeting monthly with our DoD and Department of Veterans Affairs partners to join efforts in reducing suicides.

**Conclusion**

Suicides are a loss that we simply cannot accept. The Corps is connected to each of our Marines and the loss is felt throughout the Corps – from the individual Marine in the unit to the Commandant. The Marine Corps is concerned with our number of suicides. Taking care of Marines is fundamental to our ethos and serves as the foundation of our resolve to do whatever it takes to help those in need. We will not rest in our efforts to prevent suicide. Suicide is a complex problem that requires an ‘all-hands’ comprehensive strategy. Our leaders at all levels are personally involved in efforts to address and prevent future tragedies and will remain actively engaged in this fight. We don’t leave a Marine behind on the battlefield and we don’t leave a Marine behind at home.

Thank you again for your concern on this very important issue.

A native of Pompano Beach, Florida, BGen Hedelund received his bachelor's degree from Florida Atlantic University and was commissioned a Second Lieutenant in April 1983. He was designated an unrestricted Naval Aviator in May 1985.



As a CH46E pilot, BGen Hedelund has deployed overseas with HMM-264 (1985-1988), HMM-365 (1991-1994) and HMM-162 (2001-2003). He was a Basic and Advanced Helicopter Flight Instructor at Helicopter Training Squadron 18 at NAS Whiting Field from 1989-1991. BGen Hedelund served as a CH46E Instructor and Assault Support Department Head at Marine Aviation Weapons and Tactics Squadron One (MAWTS-1) in Yuma, AZ.

Command assignments include Commanding Officer, Headquarters Squadron, Marine Aircraft Group 29, MCAS New River in 2000. In 2001, he assumed command of HMM-162. The Golden Eagles deployed with Marine Aircraft Group 29 in support of major offensive combat operations during Operation IRAQI FREEDOM from January to May 2003. BGen Hedelund also served as the Commanding Officer, MAWTS-1 from July 2006 to June 2008. From August 2009 to February 2011 BGen Hedelund was Commanding General, Marine Corps Warfighting Laboratory; serving concurrently as the Vice Chief of Naval Research at the Office of Naval Research (ONR).

BGen Hedelund is a distinguished graduate of The Basic School and Marine Corps Command and Staff College. He attended the Air War College, Montgomery, AL during the 2004 academic year and has also attended the Joint Forces Staff College, Norfolk, VA.

Staff assignments include selection as a member of the Marine Corps Strategic Studies Group serving the Commanding General, Marine Corps Combat Development Command. BGen Hedelund has also served at US Joint Forces Command where he was assigned to the Joint Warfighting Center/J7, responsible for Joint Force Training and Exercise support for US Northern Command. He reported to the Pentagon in July 2008 to serve as Military Assistant and Marine Aide to the Secretary of the Navy and finished his tour there as the Secretary's Senior Military Assistant.

In February 2011, BGen Hedelund assumed duties as Director, Marine and Family Programs Division (MF), M&RA, HQMC in Quantico, VA.

Testimony of Jerry Reed, Ph.D., MSW  
House Armed Services Committee  
Military Personnel Subcommittee  
"Update on Military Suicide Prevention"  
March 6, 2013 Hearing

**Introduction**

Good afternoon Chairman Wilson, Ranking Member Davis, members of the subcommittee. I appreciate this opportunity to testify before you on the topic of suicide prevention. My task today is to present the information on suicide in the general population with an emphasis on the age and demographic groups equivalent to that of junior enlisted personnel who represent the majority of military suicides. I also hope to help the subcommittee better understand if the patterns of suicidal behavior occurring in the military are unique to the service setting or representative of suicide in the general population. I will also share a few recommendations on lessons learned from our work with suicide prevention efforts in the general population.

Since 2008 I have served as the Director of the national Suicide Prevention Resource Center operated by the Education Development Center and funded by the Substance Abuse and Mental Health Services Administration. Our center is the only federally-funded suicide prevention resource center promoting the advancement of the National Strategy for Suicide Prevention, building national capacity, capturing best practices, providing training and technical assistance, and serving as a clearinghouse for suicide prevention. Prior to this position, I directed the Suicide Prevention Action Network USA, worked for a few years on Capitol Hill, served 15 years as a career civil servant managing quality of life programs with the Department of the Army and served four years on active duty in the U.S. Navy. I hold a doctorate in health related sciences from the Virginia Commonwealth University where my dissertation focused on variation among state suicide rates in older adult males. I have worked in the field of suicide prevention for the past sixteen years.

**Understanding the Challenge**

In recent years much attention has been paid to the burden of suicide among Service Members and Veterans. We frequently hear the statistics on the number of Service Members who die by suicide in a given month. These numbers capture our attention and rightfully, mobilize our concern. Rarely a week goes by when there is not an article in a newspaper or a feature story in a major magazine that brings this problem to the attention of the American people. These reports are certainly a call to arms. But the fact is that suicides by Service Members represent less than one percent of suicides in the nation. It is important to note that suicide is not just a defense or veteran problem; it is an American problem that must be addressed by a collective national effort. It is also important to remember that suicide is not just a problem affecting younger people. Just a few weeks ago, the Veterans Administration released the 2012 Suicide Data Report that revealed that a majority of Veteran suicides are among males aged 50 and older and that males between 50-59 years of age are the most frequent callers to the Veteran Crisis line.

The fact that suicide occurs in such numbers among older Veterans reflects a similar reality in the general population.

Suicide claims a tremendous toll on the people of the United States. In 2010, the last year for which national data are available, 38,364 Americans died by suicide. This represents a rate of 12.4 per 100,000. Suicide was the 10<sup>th</sup> leading cause of death in the nation. By comparison, homicide was the 16<sup>th</sup> leading cause of death claiming 16,259 lives in 2010 or 60 percent fewer deaths than suicide. In addition to death by suicide, there are other forms of suicidal behavior which we must acknowledge as we seek to find effective solutions. The 2011 National Survey on Drug Use and Health administered by the Substance Abuse and Mental Health Services Administration reported that 8.5 million adults over the age of 18 had serious thoughts of suicide; 2.4 million made a suicide plan; and 1.1 million made non-fatal suicide attempts. More than 600,000 of these attempts required medical treatment. In short, suicide and suicidal behavior is a national problem, warranting a national solution. The good news is that many suicide deaths are preventable and we can, through our collective action, save lives.

While suicide affects all age groups, suicide among our youngest citizens is a particular concern as these lives are cut far too short before they have had the opportunity to lead long, productive and meaningful lives. In 2010, suicide was the 3<sup>rd</sup> leading cause of death for young people ages 15-24. For those between the ages of 25-34, suicide was the 2<sup>nd</sup> leading cause of death.

Is the suicide problem in the military different than it is for the general population? The recently released National Strategy for Suicide Prevention reported that "The suicide rate for active duty military personnel has historically been significantly lower than the rate for a comparable population of Americans. However, both the numbers and rates of suicide have been increasing over the past decade." Some of the patterns of suicidal behavior in the military and the general population are similar. In both civilian life and the military, men die by suicide at higher rates than women. In 2010, 79 percent of suicides in the United States were males and 95 percent of those who died by suicide in the military were males. Men more often use guns, which generally inflict a fatal wound in an instant. In spite of these similarities, the fact that the military population is screened for mental illnesses and drug abuse on accession, is healthier than the general population, is fully employed and fully insured, is routinely screened for drug use while serving, and has virtually unlimited availability of health and mental health care, we would expect them to have lower suicide rates than the general population. And this was true until the last few years. So clearly something is happening that warrants both study and action.

Young adulthood is a time of transition. Young people are leaving the family environment and entering other settings with different rules, roles, and risks. Young people who choose to enter the military are entering a unique environment, one that offers both challenges and opportunities for suicide prevention. The military offers structure, well-defined roles, a community, housing, and health care. But as the data show, even the military environment does not protect young people from the tragic experience of suicide. While offering important opportunities for connection and support, the military presents unique pressures and demands that might elevate the risk for suicide. These include separation

from family, long work hours, deployments, and exposure to potentially traumatizing events to name a few. But we must not let media reports lead us to the conclusion that suicide in the military results directly from the stresses of combat. The National Strategy for Suicide Prevention also pointed out that “the overwhelming majority of suicides occurred in a nondeployed setting, and more than half of those who died by suicide did not have a history of deployment.” The Department of Defense Suicide Event Report (DoDSER) found that less than 16 percent of those in the military who died by suicide in 2011 had direct combat experience. However, the Army STARRS study showed that combat experienced members had higher rates of suicide than their non-combat experienced peers. Therefore, we need to examine opportunities for prevention, both pre and post deployment that will inform our knowledge of the impact of combat service on suicide in our military. While it may not explain all suicides, it may provide insight to some suicides. Implicit in the social contract we make with the young people who volunteer to protect our nation is that we, the nation, will provide them with the resources to do this job as safely and efficiently as possible. We provide them with the training, arms, and technologies to engage in combat. We provide them with medical care to maintain their readiness and to help them heal when wounded. We should do no less to protect them from the behavioral health dangers they face – regardless of whether these dangers are inherent to their age or particular to the stresses of serving in the armed forces.

#### **The Need for a Comprehensive Approach**

The real question is whether there are steps we can take to effectively reduce the levels of suicidal behavior in our military. Both research and experience show that the answer to this question is “yes.” We may be able to learn from the experience of suicide prevention on the campuses of colleges and universities. While there are obvious differences between service in the military and attendance at university, the age group (18-24) of those participating in each is roughly the same. The suicide rate among college age students is approximately 7.5 deaths per 100,000. This is roughly half the rate of their same-aged peers that do not attend college. College students have access to resources that their non-collegiate peers do not. These resources include access to campus counseling services, prohibitions concerning firearms on campus, reduced access to alcohol and other drugs on campus, a support structure including resident assistants, and the availability of campus support and engagement opportunities such as sororities, fraternities and clubs that encourage student engagement with their peers. College students are also actively in pursuit of a career goal or ambition. These resources may function as protective factors for those attending college. Through the federally-funded Garrett Lee Smith Memorial Act which provides grants to campuses to advance suicide prevention efforts, we hope to learn much about suicide prevention with this age group that could be helpful to inform actions which could be used to prevent suicide in the military.

I also want to acknowledge the military’s own successes in implementing comprehensive and effective suicide prevention efforts. There is no doubt in my mind that much is being done to prevent suicide in the military. The Department of Defense Suicide Event Report (DoDSER) is an excellent capture of important data to use for planning interventions. The U.S. Air Force created a program that resulted in a 33 percent reduction in Airmen suicides along with corresponding reductions to other threats to the



well-being of military personnel. Their approach implemented 11 initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors. Another initiative is occurring at Fort Bliss, Texas, where the command leadership created a comprehensive approach that focused on suicide prevention, risk reduction and resilience that resulted in a reduction of suicide deaths in one year. This approach called the “No Preventable Soldier Deaths” campaign warrants a close look. Let’s hope these results are sustained over time.

The successes of the Air Force and Fort Bliss programs provide testimony to the importance of creating a comprehensive response. Approaches where leadership support from the top, education and training for all who provide support to service members and their families, strengthening connections, promoting resilience and ensuring access to care are the approaches we should take moving forward. Every suicide is a tragedy. Suicide does not have one simple cause. It is not the result of a virus or a bacterium. Suicide is a complex outcome that is influenced by many factors. While individual factors are important, so too are relationships with family, peers, and others as well as influences from the broader social, cultural, economic, and physical environments. Just as there is no single path that will lead to suicide, there is no single solution or program that will solve the issue of suicide. We must create programs and support approaches that respond to the range of risks that impel individuals toward harming themselves and at the same time promote the range of protections that support those who are experiencing a difficult time. At the same time, we need to tailor these comprehensive efforts to the specific environment and culture in which we are trying to prevent suicide. We need to look at both the data on suicide in the military to understand what groups are at risk, and what role if any their military service plays in their suicide risk. I would suggest there is much that the suicide prevention community supporting efforts in the general population can add to this conversation in support of our colleagues in both DoD and VA as they engage in this important work. From my perspective, we must approach this issue with the attitude of “One Team...One Fight” and work side by side to learn from each other on behalf of all those who struggle with suicide. We all want to save lives and prevent suicide. Every life matters and while cultures and environments may differ, solutions may have much more in common than we realize. We should remember that those who serve in our military come from the general population and will return to the general population when their service is complete. The more we can provide seamless and consistent support, informed by practice and research, the more stability we can provide for those at potential risk.

#### **Applying the Evidence**

We don’t need to start an exploration for a comprehensive approach to suicide prevention from scratch. We know a great deal about what works to prevent suicide. In 2005, Mann and two dozen colleagues conducted a systematic review of the evidence for suicide prevention. Their findings emphasized the importance of two strategies that the research has shown will reduce rates of suicide. One is training physicians to recognize and treat depression. The other is restricting access of people at high risk for suicide to lethal methods. While other strategies they reviewed had promise, these two had robust data on outcomes. Our knowledge of effective strategies to prevent suicide does not end with these two

approaches, or the Air Force and Fort Bliss experiences. The National Registry of Evidence-based Programs and Practices includes 13 approaches specific to suicide prevention. The SPRC/AFSP Best Practices Registry includes over 100 programs, materials, and practices that science and experience show can prevent suicidal behaviors and reduce risk. Some of these programs and materials were designed specifically for use with the military and with veterans. We need to make sure that effective programs are implemented where they can do the most good. And we need to continue to study how suicide prevention programs among Service Members and Veterans can be delivered and evaluated to expand the options available in all the settings that can have an impact upon our military, veterans, and their families.

Responding to mental health needs of our young people in the military is an essential part of our collective focus. This focus should include training physicians, behavioral health providers, and counselors on detecting and responding to the warning signs of suicide. We also need to promote a culture in which members of the military are not afraid to seek help because it may subject them to ridicule or interfere with career advancement. Preserving confidentiality would go a long way to changing help-seeking behavior in the military. If service members do not think that their problems will remain confidential, or perceive that their seeking help will have career consequences, they will not seek help. If they are concerned they will be humiliated or singled out in front of their peers in a very public way, many will not seek treatment. And if they do not seek help, their problems will remain untreated. Some may argue that members of the military have a great advantage over civilians in their access to health care, including behavioral health care. Our challenge is to ensure that they seek this access when they are experiencing behavioral health issues associated with suicide. We must also make sure that the health care professionals serving members of the military are trained to effectively treat the behavioral health problems associated with suicidal behaviors. I am pleased to report that a one-day training program offered by the Suicide Prevention Resource Center in training mental health providers the core competencies in suicide risk assessment entitled "Assessing and Management of Suicide Risk," has been utilized by the Navy, Air Force and Marine Corps. To date over 2700 providers have been trained. Nationally, more than 20,000 mental health providers have received the training. Other important partners for suicide prevention found on our military installations are family services centers, financial counseling, legal offices, drug and alcohol services, chaplains, and other social and healthcare services. Programs and services like Military One Source, the 1-800-273-TALK network of crisis centers, and behavioral health providers in the community puts help within reach of Service Members and Veterans and encourages them to seek this help. All those on military installation have a role to play in suicide prevention. We must fully engage them in these efforts just as we are trying to do in the general population. We need to help them learn how to look for signs of stress in those they lead, serve and support, and we must engage commanders, peers, families, support staff, and others in the chain of command to know the signs of distress and ensure those in need are referred for care.

Restricting the access of individuals experiencing an emotional crisis to lethal means is a proven method of preventing suicide. This is especially true of firearms, which often prove fatal when used by an individual to harm him or herself. Reducing access to lethal means may be especially challenging in the

military environment. But it can be done without impairing the ability of the military and individuals in the military to have ready access to the weapons necessary to protect themselves and our country. If we can take steps to minimize access to a lethal mean at the time of crisis, we may introduce enough time for the crisis to subside and help those at risk connect with the support that will put them on a path to recovery.

#### **Planning and Working Together**

Addressing suicide in any sector whether military or civilian, public or private, requires a team effort and a carefully thought out and carefully implemented plan. When we go into war, we have a battle plan. And we have a national plan for preventing suicide. I had the privilege of working with our Surgeon General of the United States, Dr. Regina Benjamin, as a co-lead for the revision of the National Strategy for Suicide Prevention, our nation's battle plan for combating suicide. I also serve on the team that is coordinating implementation of this plan, the Action Alliance for Suicide Prevention, which was launched in 2010 by Secretaries Sebelius and Gates. The Action Alliance is a public-private partnership whose mission is to advance the National Strategy and to catalyze, champion and cultivate action on behalf of suicide prevention in our nation. This partnership is led by our private sector co-chair, Senator Gordon Smith, and our public sector co-chair, Secretary of the Army John McHugh. They are working side-by-side with approximately 45 representatives from the public and private sectors in an effort to save 20,000 lives over five years. This is an unprecedented effort to bring all the players to the table to ensure that we each do our part and mobilize the resources of our respective sectors to reduce suicide in the nation. The Action Alliance includes representatives from public agencies such as the Centers for Disease Control and Prevention, National Institute of Mental Health, Departments of Justice, Defense and Veterans Affairs and the Substance Abuse and Mental Health Service Administration, to name a few. It includes representatives from the private sector, including the media, health care, and the faith community. And it includes representatives from the armed services and agencies that serve Veterans. To fully protect our nation's military personnel and Veterans, it is necessary to bring together the agencies in which they serve, the agencies which serve them, and the communities in which they live, and with everyone at the table, create and implement a comprehensive plan to address the unique factors that put Service Members at risk. We have much to share and much to learn by working more closely together. We are making progress.

#### **Sustaining Our Efforts**

Another important lesson we've learned about suicide prevention is the importance of sustainability. Activities to prevent suicide are only effective inasmuch as they are sustained. Again and again we have seen that when effective programs are implemented, suicide rates go down. But when attentiveness to those programs diminishes, rates once again rise. We see this in other public health problems, too. Sustainability is especially important in the military environment as personnel rotate through commands and new people enter the service as older members retire or leave the service and re-enter civilian life. Fortunately, the military has a framework for sustaining programs. It is a culture informed by regulations and compliance standards, enforced with inspections and a commitment to continuous improvement.

We need to ensure that suicide prevention efforts are knitted together by a cohesive strategy and sustained over time with vigor. It is also important that we require ongoing evaluation to find out what is working, what is not, and to keep evaluating so we sustain improvements over time. It must be maintained as a permanent component of the military's health infrastructure, as well as the Veteran's Administration health services and the other health and behavioral health providers that serve Veterans and their families.

#### **Changing the Conversation**

Finally, we have to change the way we talk about suicide in the military. Changing the conversation does not mean ignoring the problem or pretending it does not exist. But much of the current conversation about suicide in the military tends to ignore the larger context of suicide as a problem in our country. It also tends to ignore the fact that we know a lot about preventing suicide. Our conversation about suicide in the military and in the nation needs to stress how much we do to prevent suicide. We need to highlight success stories, like that of Fort Bliss. While not concealing the very real problem of suicide in the military, and the toll it entails, we need to be careful not to present suicide as more common than it actually is. We don't want to create the impression that suicide is a normal – or even acceptable – response to stress, even the most traumatic stress from combat. We don't want to stereotype our Service Members and Veterans as being damaged permanently from the psychological wounds of war. The truth is that the men and women wearing this nation's military uniforms have shown outstanding resilience in the face of over a decade of war. They have responded to their nation's call, have borne the burden, and are returning to their communities as upstanding citizens. In many cases, they have weathered punishing adversity and kept going. Some have struggled with thoughts of suicide for a time, even for a long time, and most, have survived and are surviving. This in my opinion is a part of the story we must be sharing. They are truly heroes and we need to hear more of their stories. Their stories can be lifesaving for them and for others. They can provide hope and guidance to the soldier, sailor, airman or marine who may feel that a self-inflicted death is the only solution to their problems.

#### **Conclusion/Summary**

I want to thank the Committee for this opportunity to speak on behalf of suicide prevention, as well as on behalf of Service Members and Veterans of the United States Armed Forces, of which I am one. I want to encourage members of the Committee to work with us in suicide prevention, as well as those who serve the military and our Veterans, to continue our collective and collaborative efforts to prevent suicide, in the military, among our Veterans and in the general population as well. I hope I have shown that we have the knowledge and ability to take steps to reduce the toll of this needless tragedy. We have a national strategy that should guide our future efforts. What we need now is the will, the collaboration, and the resources to implement and sustain these efforts, and help protect those who have so generously volunteered to serve and to all the citizens they so graciously defend.

**Jerry Reed, Ph.D., M.S.W.**  
**Vice President and Director**  
**Education Development Center**  
**Center for the Study and Prevention of Injury, Violence and Suicide**  
**Suicide Prevention Resource Center**

Jerry Reed began serving as the Director of the national Suicide Prevention Resource Center in the United States in July 2008. In this role he oversees the federally funded Suicide Prevention Resource Center (SPRC). Through this work he provides state and local officials, grantees, policymakers, interested stakeholders and the general public with assistance in developing, implementing and evaluating programs and strategies to prevent suicide. Additionally, Dr. Reed serves as the Director of the Center for the Study and Prevention of Injury, Violence and Suicide overseeing a staff of 45 and directs the work on multiple projects.

Prior to this appointment, Dr. Reed served for five years as Executive Director of the Suicide Prevention Action Network USA (SPAN USA) a national non-profit created to raise awareness, build political will, and call for action with regard to advancing, implementing and evaluating a national strategy to address suicide. He spent 15 years as a career civil servant working in both Europe and the United States as a civilian with the Department of the Army developing, implementing and managing a variety of quality of life programs including substance abuse prevention and treatment, family advocacy, child and youth development programs, social services and the range of morale, welfare and recreation programs. Selected as a Congressional Fellow in 1996, Dr. Reed worked in the Office of U.S. Senator Harry Reid (NV) serving as senior advisor on health care, mental health, suicide prevention and aging issues.

Dr. Reed speaks nationally and internationally on the topic of suicide prevention. His interests include geriatrics, mental health, suicide prevention, violence prevention and public policy. He serves on the Board of the International Association for Suicide Prevention as Chair of the Council of Organizational Representatives and is a member of the Violence Prevention Alliance Steering Committee operated with the World Health Organization in partnership with international partners.

Dr. Reed received a Ph.D. in Health Related Sciences with an emphasis in Gerontology from the Virginia Commonwealth University in Richmond in 2007. His research topic addressed variation among states in crude rates of older adult male suicide. He also received a Masters of Social Work degree with an emphasis in Aging Administration from the University of Maryland at Baltimore in 1982.

**DISCLOSURE FORM FOR WITNESSES  
CONCERNING FEDERAL CONTRACT AND GRANT INFORMATION**

**INSTRUCTION TO WITNESSES:** Rule 11, clause 2(g)(5), of the Rules of the U.S. House of Representatives for the 113<sup>th</sup> Congress requires nongovernmental witnesses appearing before House committees to include in their written statements a curriculum vitae and a disclosure of the amount and source of any federal contracts or grants (including subcontracts and subgrants) received during the current and two previous fiscal years either by the witness or by an entity represented by the witness. This form is intended to assist witnesses appearing before the House Committee on Armed Services in complying with the House rule. Please note that a copy of these statements, with appropriate redactions to protect the witness's personal privacy (including home address and phone number) will be made publicly available in electronic form not later than one day after the witness's appearance before the committee.

**Witness name:** Jerry Reed, Ph.D., MSW

**Capacity in which appearing:** (check one)

Individual

Representative

**If appearing in a representative capacity, name of the company, association or other entity being represented:**

**FISCAL YEAR 2013**

federal grant(s) / contracts	federal agency	dollar value	subject(s) of contract or grant
Suicide Prevention Resource Center	SAMHSA	\$5,271,000 (prime)	Suicide prevention
Grant for Injury Control Research Centers	CDC / University of Rochester	\$203,343 (sub)	Suicide prevention, injury prevention
Reducing Barriers to Help Seeking for Mental Health Problems	U.S. Army	\$294,819 (prime)	Stigma reduction, discrimination, help seeking behavior

**FISCAL YEAR 2012**

federal grant(s) / contracts	federal agency	dollar value	subject(s) of contract or grant
Suicide Prevention Resource Center	SAMHSA	\$5,471,000	Suicide prevention
Reducing Barriers to Help Seeking for Mental Health Problems	U.S. Army	\$498,790	Stigma reduction, discrimination, help seeking behavior

**FISCAL YEAR 2011**

Federal grant(s)/ contracts	federal agency	dollar value	subject(s) of contract or grant
Suicide Prevention Resource Center	SAMHSA	\$4,471,000	Suicide prevention
Reducing Barriers to Help Seeking for Mental Health Problems	U.S. Army	\$383,973	Stigma reduction, discrimination, help seeking behavior

**Federal Contract Information:** If you or the entity you represent before the Committee on Armed Services has contracts (including subcontracts) with the federal government, please provide the following information:

Number of contracts (including subcontracts) with the federal government:

Current fiscal year (2013): \_\_\_\_\_;  
 Fiscal year 2012: \_\_\_\_\_;  
 Fiscal year 2011: \_\_\_\_\_.

Federal agencies with which federal contracts are held:

Current fiscal year (2013): \_\_\_\_\_;  
 Fiscal year 2012: \_\_\_\_\_;  
 Fiscal year 2011: \_\_\_\_\_.

List of subjects of federal contract(s) (for example, ship construction, aircraft parts manufacturing, software design, force structure consultant, architecture & engineering services, etc.):

Current fiscal year (2013): \_\_\_\_\_;  
 Fiscal year 2012: \_\_\_\_\_;  
 Fiscal year 2011: \_\_\_\_\_.

Aggregate dollar value of federal contracts held:

Current fiscal year (2013): \_\_\_\_\_;  
 Fiscal year 2012: \_\_\_\_\_;  
 Fiscal year 2011: \_\_\_\_\_.

**Federal Grant Information:** If you or the entity you represent before the Committee on Armed Services has grants (including subgrants) with the federal government, please provide the following information:

Number of grants (including subgrants) with the federal government:

Current fiscal year (2013): 3 \_\_\_\_\_ ;  
Fiscal year 2012: 2 \_\_\_\_\_ ;  
Fiscal year 2011: 2 \_\_\_\_\_ .

Federal agencies with which federal grants are held:

Current fiscal year (2013): SAMHSA, CDC, US Army;  
Fiscal year 2012: SAMHSA, US Army;  
Fiscal year 2011: SAMHSA, US Army.

List of subjects of federal grants(s) (for example, materials research, sociological study, software design, etc.):

Current fiscal year (2013): suicide prevention, injury prevention, Stigma reduction, discrimination, help seeking behavior;  
Fiscal year 2012: suicide prevention, Stigma reduction, discrimination, help seeking behavior;  
Fiscal year 2011: suicide prevention, Stigma reduction, discrimination, help seeking behavior.

Aggregate dollar value of federal grants held:

Current fiscal year (2013): \$5,769,162  
Fiscal year 2012: \$5,969,790;  
Fiscal year 2011: \$4,854,973.



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**WITNESS RESPONSES TO QUESTIONS ASKED DURING  
THE HEARING**

MARCH 21, 2013

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**RESPONSE TO QUESTION SUBMITTED BY MRS. DAVIS**

General HEDELUND. Yes, I am aware of the pilot program in mindfulness training. The goal of the program is to provide Marines with another tool to combat stress through the use of meditative techniques. We're expecting the results from the study in the fall of 2013. [See page 15.]

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**RESPONSE TO QUESTION SUBMITTED BY MR. SCOTT**

Ms. GARRICK. Since the VA claims backlog issue falls under the VA, we would have to defer to them for the percentage of those who were waiting for their VA claims.

However, we do know that from the initiation of the Disability Evaluation System (DES) Pilot (November 2007) through November 2012 (the most recent update from Military Departments, there were 156 deaths reported of Service members enrolled in the DES. Of these, 32 determined to be suicide. During the same time period (2007–2012), there were approximately 1700 Service members who died by suicide. Therefore, approximately 1.9 percent (32/1700) of the total Active Duty and Reserve suicides were in the DES process at the time of their death. [See page 16.]

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**RESPONSE TO QUESTION SUBMITTED BY MRS. NOEM**

General BROMBERG. The investigating officer (IO) did not interview the Soldier's Family because he did not feel it was pertinent to addressing the lines of inquiry in Army Directive (AD) 2010–01. He initiated his investigation by looking at the County Sheriff's Department report, which included depositions from the two individuals who had found the Soldier after the incident. He then developed a list of acquaintances and members of the chain of command who knew the Soldier, and after these interviews the IO believed he was able to answer each question of each line of inquiry in AD 2010–01.

The policy states that during an investigation, "any contact or communications with a Family member of the Soldier should be pursued only when absolutely essential to the conduct of the investigation." AD 2010–01 directs the IO to answer a series of questions which largely are focused on the Soldier's interactions with his/her peers, superiors, and subordinates. [See page 21.]

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**RESPONSE TO QUESTION SUBMITTED BY DR. HECK**

General BROMBERG. The unit chain of command represents the center of gravity for the health and care of our Soldiers and Families. The uniqueness of our geographically dispersed population mandates sustained partnerships with local community leaders and resources. Our leadership is committed to health, safety and welfare of all Soldiers and Family members; providing the appropriate linkage to available resources and assistance closest to where they live is a key component of that commitment. Venues such as the Yellow Ribbon Reintegration Program and Strong Bonds facilitate this connection with education and awareness of local networks of community support most appropriate and available to our Soldiers. Other resources like our Fort Family Outreach Center and Army Strong Community Centers assist in virtually bridging the gap with commensurate services inherent to an active duty installation. These resources provide geographically relevant information. We continue to work collaboratively with our sister components in order to capitalize on both inherent capability and capacity to connect our Soldiers and Families with the resources and assistance needed. [See page 28.]



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**QUESTIONS SUBMITTED BY MEMBERS POST HEARING**

MARCH 21, 2013

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## QUESTIONS SUBMITTED BY MS. SHEA-PORTER

Ms. SHEA-PORTER. 1) What steps are the Defense Suicide Prevention Office and the Services taking in terms of support and treatment, to meet the mental health challenges facing spouses and children? There are some innovative National Guard Yellow Ribbon Programs, like that of our own New Hampshire National Guard, that follow and support families as well as Guard members before, during, and after deployment. Are you talking to the States and incorporating the best practices of such programs?

Ms. GARRICK. Yes. The Department of Defense (DOD), through the Defense Suicide Prevention Office, has formed a Community Action Team process comprised of representatives from non-profit organizations, universities and others to discuss suicide prevention best practices. In addition, it has recommended policy changes for military justice and civilian court processing adjudicating Service members who appear in civilian courts under state jurisdiction diagnosed with psychological conditions. DOD has expanded the National Guard Chaplain Partners In Care program, which leverages state community faith-based organizations responding to Service members, Reserve members and their families.

Family members may be able to recognize warning signs and see changes in their Service member's behaviors before anyone else since they interact with them in a less-guarded state. DOD is drafting an Info Guide "Supporting Military Families In Crisis: A Guide to help You Prevent Suicide." It is designed to empower military families by introducing them to the warning signs of suicide, reduce the stigma and uncertainty associated with seeking behavioral health, and provide ways to avail resources, get help, and build family resilience.

Ms. SHEA-PORTER. 2) Do DSPO and the Services have a strategy and the capacity, to provide adequate mental health screening and care for families? If not, how are they partnering with civilian social services and non-profit organizations to fill the support gaps? New Hampshire's National Guard Yellow Ribbon Program, for example, partners with Easter Seals to provide needed support.

Ms. GARRICK. Yellow Ribbon Reintegration Programs (YRRP) and Returning Warrior Workshops are retreats that facilitate family member involvement in the reintegration process. YRRP offers specific pre, during, and 30, 60 and 90 day post deployment sessions that focus on managing the stressors related to deployment and the resources for reintegration.

Military Treatment Facilities and the TRICARE network offer behavioral health care and support to all beneficiaries. The Patient Centered Medical Home—Behavioral Health Team (PCMH—BHT) model is leveraging a primary care behavioral health case management approach and the Psychological Health Council has incorporated suicide prevention and family issues into its scope.

The Services have dedicated military family support centers (MFSC) that help Service members successfully balance and integrate their military and civilian lives. MFSCs provide relocation assistance, financial training, and family education/advocacy services. For National Guard/Reserve members, military and family life counselors (MFLC) are available to provide short-term, non-medical counseling during drill weekends and other events or locations where Service members and their families gather. Family members can also benefit from Military OneSource's 12 (non-medical brief intervention) sessions to resolve marital or family challenges. Section 706 of the 2013 NDAA authorizes the Department to conduct a pilot study on enhancement of mental health in the National Guard by partnering with community agencies. The National Guard Bureau has developed a draft pilot program.

Ms. SHEA-PORTER. 3) Are family member (spouses and children) suicides being tracked by DSPO and/or the Services? If not, why not?

Ms. GARRICK. DOD does not track at the Department level suicide deaths for families of Service members, because DOD has no reliable means to do so. Suicide deaths among spouses or dependents are determined by a civilian authority and not a medical examiner from the Armed Forces Medical Examiner System (AFMES). As a result, DOD must rely on civilian authorities and Service members to report spouse/dependent deaths. DOD has no authority to require civilian health and mortality authorities to forward autopsy findings to DOD. Service members do report

dependents' death for beneficiary purposes, but there are often lags in that information, and manner of death is not always included.

Ms. SHEA-PORTER. 4) What authority will DSPO have to ensure the suicide prevention policies they develop will be implemented by the Services?

Ms. GARRICK. DSPO activities are under the authority of the Secretary of Defense, who exercises authority, direction, and control over the Military Department and Services.

Ms. SHEA-PORTER. 5) What steps are the Defense Suicide Prevention Office and the Services taking in terms of support and treatment, to meet the mental health challenges facing spouses and children? There are some innovative National Guard Yellow Ribbon Programs, like that of our own New Hampshire National Guard, that follow and support families as well as Guard members before, during, and after deployment. Are you talking to the States and incorporating the best practices of such programs?

General BROMBERG. Yes, we are talking to the states to ensure the best practices are being incorporated. Two major barriers in obtaining Behavioral Health (BH) care for Military Children and Families are limited Access to Care and Stigma.

The Army, in an effort to reduce these barriers, established School Behavioral Health Programs (SBH) and Child and Family Assistance Centers (CAFAC), specifically designed using the Public Health and Communities of Practice Models. SBH Programs and CAFACs are currently in varying stages of development and provide services at a limited number of Army Installations. These programs are at risk of being reduced for numerous reasons to include: a critical national shortage of BH Child and Family providers; lack of sustained funding in the current fiscal environment; sustainment of programs and proliferation of new programs supporting the BH needs of Children and Families.

SBH programs currently operate in 46 schools on eight installations (Tripler, Joint Base Lewis-McChord, and Forts Carson, Campbell, Meade, Bliss, Bavaria and Landstuhl, Germany). SBH programs, by design, support resiliency, promote access and reduces stigma. SBH is currently limited to providing services to on-post schools; however, a pilot program to provide the services to Military Children in off-post schools is underway in the communities surrounding Schofield Barracks, Hawaii.

Child and Family Assistance Centers (CAFAC), are being developed on 10 installations (Schofield Barracks, Joint Base Lewis-McChord, and Forts Carson, Wainwright, Bliss, Hood, Polk, Bragg, Campbell and Drum); the majority not being fully operational due to limited BH provider resources and difficulties in hiring, particularly at more "rural" installations.

Ms. SHEA-PORTER. 6) Do DSPO and the Services have a strategy and the capacity, to provide adequate mental health screening and care for families? If not, how are they partnering with civilian social services and non-profit organizations to fill the support gaps? New Hampshire's National Guard Yellow Ribbon Program, for example, partners with Easter Seals to provide needed support.

General BROMBERG. The Child, Adolescent, and Family Behavioral Health Office (CAFBO), U.S. Army Medical Command, has established collaborative working relationships with national and state organizations and professional entities in order to identify and share best practices in terms of prevention and interventions for behavioral health problems for Army children and Families. CAFBO has also developed, and is implementing, a comprehensive training curriculum for Army Pediatric Primary Care Providers by using evidence-based practices for preventing, screening, identifying and treating common behavioral health disorders in children within the primary care setting.

Partnerships have been established with the following national organizations and universities in order to collaborate on best practices and disseminate knowledge:

- American Psychological Association
- Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics
- Center for School Mental Health, University of Maryland
- IDEA Partnership and the National Community of Practice, Office of Special Education, United States Department of Education
- Military Child Education Coalition
- National Association of State Directors of Special Education
- Center for Deployment Psychology
- The Beach Center on Disability, University of Kansas
- University of South Carolina
- University of Washington
- Mayo Clinic/REACH



- U.S. Department of Agriculture, Operation Military Kids

Ms. SHEA-PORTER. 7) Are family member (spouses and children) suicides being tracked by DSPO and/or the Services? If not, why not?

General BROMBERG. The Army tracks Family member suicides of Active Duty Soldiers; regardless of whether or not the death occurred on a military installation. Suicides of non-Active Duty Soldiers' Family members are not currently tracked due to challenges related to the collection of reliable and substantiated data, identification of data sources, and legal issues related to obtaining and maintaining civilian personal information.

Ms. SHEA-PORTER. 8) What steps are the Defense Suicide Prevention Office and the Services taking in terms of support and treatment, to meet the mental health challenges facing spouses and children? There are some innovative National Guard Yellow Ribbon Programs, like that of our own New Hampshire National Guard, that follow and support families as well as Guard members before, during, and after deployment. Are you talking to the States and incorporating the best practices of such programs?

Admiral VAN BUSKIRK. Navy offers a full complement of programs designed to address the needs of Navy families. Working within the Department of Defense, with other federal agencies, and with state and local partners, Navy identifies best practices and incorporates them into our programs. Navy leadership recognizes the unique challenges our families face and is fully committed to providing them the best possible support as they support our Sailors and our mission.

Navy's version of the Yellow Ribbon Program is the Returning Warrior Workshop (RWW). RWW participants have the opportunity to address personal, family, or professional situations experienced during deployment and receive readjustment and reintegration support from a broad array of resources, including: Navy Reserve Psychological Health Outreach Teams (PHOT), TRICARE Joint Family Support Assistance (JFSAP), Military and Family Life Consultants (MFLC), Personal Financial Council (PFC), Military OneSource (MOS), Chaplains, Fleet and Family Support Centers (FFSC) and Veterans Affairs (VA).

Other Navy and DOD programs to help families cope with the challenges they face before, during and after deployment include:

- Ombudsman and Family Readiness Groups (FRG) are the primary method of family support, outreach and communication with families of deployed Sailors. The ombudsman program supports a volunteer associated with the command—typically a spouse, appointed by the commanding officer, to serve as a confidential liaison between command leadership and the families. Ombudsmen are trained and certified to disseminate information both up and down the chain of command, including official Department of the Navy and command information, command climate issues, local quality of life (QOL) improvement opportunities, and community support opportunities. Ombudsmen also provide resource referrals and are instrumental in resolving family issues.
- An FRG is a private organization, closely-affiliated with the command, comprised of family members, Sailors, and civilians associated with the command and its personnel, who support the flow of information, provide practical tools for adjusting to Navy deployments and separations, and serve as a link between the command and Sailors' families. FRGs help plan, coordinate and conduct informational, care-taking, morale-building and social activities to enhance preparedness, command mission readiness and increase the resiliency and well-being of Sailors and their families.
- Commander Navy Installations Command (CNIC) Deployment Readiness Program. CNIC supports unit level family support and deployment readiness programs with a wide variety of complimentary training and support activities, including: unit level deployment cycle training, online information and individualized one-on-one counseling.
- Navy Project FOCUS (Families Over Coming Under Stress). FOCUS provides resiliency training to military families, including practical skills to meet the challenges of deployment and reintegration, communication techniques, effective problem-solving and family goal-setting.
- The Navy Center for Combat & Operational Stress Control (NCCOSC). Dedicated to the mental health and well-being of Navy and Marine Corps service members and their families, NCCOSC promotes resilience, and investigates and implements best practices in the diagnoses and treatment of post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI).
- The Defense Centers of Excellence are responsible for leading a national collaborative network of military, federal, family and community leaders; clinical

experts; and academic institutions to best serve the urgent and enduring needs of warriors and their families with psychological health and/or traumatic brain injury concerns.

- The Real Warriors Campaign promotes the processes of building resilience, facilitating recovery and supporting reintegration for returning service members and their families.

The Navy supports a comprehensive mental health strategy to provide high quality, evidence-based care for Active Duty Service members, reservists, and their families. Navy Medicine continues to improve and enhance access to care for Active Duty members and their families by increasing the size of the mental health work force and opportunities to interact with behavioral health providers. The Behavioral Health Integration Program in the Medical Home Port has been implemented across 67 Navy sites, as well as 6 Marine Corps sites. This program embeds behavioral health providers in the primary care setting to increase access and reduce stigma.

Navy Medicine continues to focus on the mental health needs of reservists. In FY12, the Navy and Marine Corps Reserve Psychological Health Outreach Program (PHOP) provided over 11,000 outreach contacts to returning Service members and provided behavioral health screenings for approximately 1,000 reservists. Similarly, as of December 2012 over 12,000 military family members participated in our Returning Warrior Workshops (RWWs) for reservists. RWWs are funded through Defense Health Program and Navy appropriations.

Ms. SHEA-PORTER. 9) Do DSPO and the Services have a strategy and the capacity, to provide adequate mental health screening and care for families? If not, how are they partnering with civilian social services and non-profit organizations to fill the support gaps? New Hampshire's National Guard Yellow Ribbon Program, for example, partners with Easter Seals to provide needed support.

Admiral VAN BUSKIRK. Yes; Navy Medicine continues to support a comprehensive mental health strategy to provide ready access to high quality, evidence-based, mental health care for military members and their families. This includes prevention and resilience-building services, as well as more traditional treatment. For instance, Navy's FOCUS program (Families Over Coming Under Stress), which is widely recognized as a model for prevention/intervention psychological health services for military families, provided services to over 91,000 military family members in Fiscal Year 2012. Outcomes have shown statistically significant improvements in anxiety and depression among both children and parents.

Family members can also access mental health care through our Behavioral Health Integration Program, part of Medical Home Port, which embeds behavioral health providers in the primary care setting to increase access and reduce stigma. This program has been implemented across 67 Navy and six Marine Corps sites.

Navy Medicine also continues to place the highest priority on the mental health needs of reservists and their families. In Fiscal Year 2012, the Navy and Marine Corps Reserve Psychological Health Outreach Program (PHOP) provided over 11,000 outreach contacts to returning service members and behavioral health screenings for approximately 1,000 reservists. PHOP staff made over 500 visits to reserve units providing over 800 presentations to approximately 19,000 reservists, family members and commands. As of December 2012, over 12,000 service members and their loved ones have participated in 100 Returning Warrior Workshops (RWWs), which assist demobilized service members and their families in identifying immediate and potential issues that often arise during post-deployment reintegration.

Ms. SHEA-PORTER. 10) Are family member (spouses and children) suicides being tracked by DSPO and/or the Services? If not, why not?

Admiral VAN BUSKIRK. Navy does not track family member suicides. There is no statutory or policy requirement to do so, and no reporting mechanism in place by which to track family member suicides.

Ms. SHEA-PORTER. 11) What steps are the Defense Suicide Prevention Office and the Services taking in terms of support and treatment, to meet the mental health challenges facing spouses and children? There are some innovative National Guard Yellow Ribbon Programs, like that of our own New Hampshire National Guard, that follow and support families as well as Guard members before, during, and after deployment. Are you talking to the States and incorporating the best practices of such programs?

General JONES. A variety of programs provide support for the mental health needs of spouses and dependent children. Each installation has a Family Advocacy Program, which provides outreach and prevention services to families. One novel Family Advocacy Program approach is the New Parent Support Program, which provides

support and guidance in the home to parents screened as high risk for family maltreatment. Educational and Development Intervention Services are provided by a child psychologist for special education children in Department of Defense schools. Other programs provide education on common family issues like good parenting, couples communication, or redeployment integration. Counseling for families is also available. Military OneSource is a Department of Defense program using a civilian network that provides face-to-face, telephonic, or online counseling/consultation to service members and families for up to 12 sessions. Also, Office of the Secretary of Defense-funded Military and Family Life consultants and Child and Youth Behavioral consultants offer confidential, non-medical, short-term counseling services, which address issues common in military families such as deployment stresses and relocation. Family members not able to be seen at military medical treatment facilities have access to services through community TRICARE providers. TRICARE network providers offer an array of services from individual counseling and group therapy, to inpatient behavioral health care. However, these services vary significantly from location to location. This is due to a nationwide shortage of doctoral level child and adolescent psychiatrists and psychologists.

The Yellow Ribbon Program offers resources on behavioral health issues and suicide mitigation and is offered to Reserve and Air National Guard (ANG) Airmen and their families pre-deployment, during deployment, and post deployment. Funded by Yellow Ribbon, the Psychological Health Advocacy Program (PHAP) is designed to assist Reserve Airmen and their family members with a variety of needs, including mental health issues, financial assistance, relationship and family counseling, and substance abuse through referrals. The ANG Psychological Health Program (PHP) was developed to address psychological health needs of ANG Airmen and their families. The PHP places a licensed behavioral health provider at each of the ANG's 89 wings throughout the 54 states, territories and the District of Columbia. The program provides three categories of service: leadership advisement and consultation; community capacity building; and direct services—to include assessment, referral, crisis intervention, and case management—that are available daily. The Wing Directors of Psychological Health are available 24/7 to operational leadership and provide services to ANG Airmen and their family members regardless of whether they are at home or on duty status. Both ANG Wing Directors of Psychological Health and AFRC Psychological Health Advocates work with their local communities to develop resources, referrals, and partnerships to maximize services for Airmen. Additionally, mental health and personnel leaders from ANG, Reserve and each of the services participate in the Department of Defense and the Department of Veterans Affairs level committees on suicide prevention and psychological health where they share best practices and ideas.

TRICARE Reserve Select is available for Reserve Component Airmen and their family members and provides coverage for both outpatient and inpatient treatment. Access to military medical care is available to service members with duty-related conditions through TRICARE and the Department of Veterans Affairs.

Since Air Reserve Component wingmen (e.g. family, friends) are often non-military personnel, the ANG's Wingman Project provides information and resources for suicide prevention on publicly-accessible websites. The ANG tailors marketing and resource materials for each state. The primary goal of the Wingman Project, located at <http://wingmanproject.org>, is to reduce warfighter, Department of Defense civilian, and family member suicides through human outreach, education, and media. The Air Force Reserve Wingman Toolkit is a broad-based Air Force Reserve initiative designed to empower Airmen and their families to achieve and sustain health, wellness, and balanced lifestyles by using the four domains of Comprehensive Fitness. The toolkit is located at: <http://AFRC.WingmanToolkit.org>. The Wingman Toolkit provides Commanders, Airmen, families, and friends (i.e., Air Force Reserve Wingmen), access to a wide variety of resources, training opportunities, a dedicated Wingman Day page, promotion of the Ask, Care, Escort (A.C.E.) suicide intervention model, educational outreach materials, social media (Facebook, Twitter, Etc.), a mobile phone application, Short Message Service (SMS) texting capability ("WMTK" to 24587), inspirational and training videos, a YouTube page, and partnerships with other organizations.

Finally, the Military (or Veterans) Crisis Line, 1-800-273-8255 (TALK), Press #1, [www.militarycrisisline.net](http://www.militarycrisisline.net), or text to 838255 is available 24/7 to all service members and their families. It is a joint venture between the Department of Defense and the Department of Veterans Affairs' call center, which is associated with Substance Abuse and Mental Health Service Administration's National Suicide Prevention Lifeline. Resources include an online "Veteran's Chat" capability and the call center's trained personnel provide crisis intervention for those struggling with suicidal thoughts or family members seeking support for a Veteran.

Ms. SHEA-PORTER. 12) Do DSPO and the Services have a strategy and the capacity, to provide adequate mental health screening and care for families? If not, how are they partnering with civilian social services and non-profit organizations to fill the support gaps? New Hampshire's National Guard Yellow Ribbon Program, for example, partners with Easter Seals to provide needed support.

General JONES. Through the TRICARE network and community organizations, the Air Force Medical Service (AFMS) has a strategy and the capacity to provide mental health screening and care for families. Air Force family members' care typically is provided by TRICARE providers in the community. There are several options to purchase long-term healthcare insurance for Air Reserve Component family members, to include TRICARE Reserve Select, if eligible. TRICARE provides coverage for both outpatient and inpatient treatment.

The Air Force Reserve Wingman Toolkit and Air National Guard Wingman Project Websites provide 24/7/365 support and information. These websites provide links to local, city, state, and national organizations that provide behavioral health services to service members and their families. Organizations include, but are not limited to, the Substance Abuse and Mental Health Services Administration, Military Pathways, and The Center for Deployment Psychology.

Air Force Reserve Psychological Health Advocacy Program (PHAP) staff are present and conduct break-out sessions for the members returning from deployment. During these sessions, the members are given instructions on accomplishment of mental health screening, as well as recommendations for follow-up. This information is also available on the PHAP website, as well as through each regional office.

The Air National Guard Psychological Health Program (PHP) was developed to address psychological health needs of Air National Guard (ANG) Airmen and their families. The PHP places a licensed behavioral health provider at each of the ANG's 89 wings throughout the 54 states, territories and the District of Columbia. The program provides three categories of service: leadership advisement and consultation; community capacity building; and direct services—to include assessment, referral, crisis intervention, and case management—that are available daily. The Wing Directors of Psychological Health are available 24/7 to operational leadership and provide services to ANG Airmen and their family members regardless of whether they are at home or on duty status.

Finally, Military OneSource is a nonmedical counseling option available to active duty, reserve component members and their adult family members.

Ms. SHEA-PORTER. 13) Are family member (spouses and children) suicides being tracked by DSPO and/or the Services? If not, why not?

General JONES. The Air Force does track family member (spouses and children) deaths to disburse monetary benefits and funeral entitlements; however, the Air Force does not track the cause of each family member death (specifically, suicides). We do not have access to specific information about family member deaths other than that in the public domain; the Centers for Disease Control and the American Association of Suicidality. The Air Force is collaborating with the Defense Suicide Prevention Office to study this issue and determine if a reliable process or database can be developed to track this information in the future.

Ms. SHEA-PORTER. 14) What steps are the Defense Suicide Prevention Office and the Services taking in terms of support and treatment, to meet the mental health challenges facing spouses and children? There are some innovative National Guard Yellow Ribbon Programs, like that of our own New Hampshire National Guard, that follow and support families as well as Guard members before, during, and after deployment. Are you talking to the States and incorporating the best practices of such programs?

General HEDELUND. The Yellow Ribbon Reintegration Program supports reintegration efforts by providing access to programs, resources, and services geared to minimizing stressors before, during, and after deployments of 90 days or more. It is not used as a mental health screening vessel. Counselors are on-site for each event to address stress and finances as well as address the common challenges our Service members and their families face. These events are structured to follow a Reserve Marine and family (family is defined as mom, dad, spouse, children, significant other) or their designated representative, throughout their entire cycle of deployment from the call to mobilization and then their re-assimilation to civilian life. The more prominent focus of these events is addressing those areas most likely to trigger stress responses such as employment, finances, and education. By targeting these areas, and making counselors available at every opportunity, we hope to address issues prior to them building and causing a significant stress response by the individual. In FY12 MARFORRES executed 209 Yellow Ribbon events nation-wide, supporting 3,766 family members and designated representatives, and 5,984 Service

members. Supporting programs at each of these events are the Psychological Health Outreach Team for the Unit/Region (PHOP), Unit Personal and Family Readiness Program, as well as local Unit Leadership. Additional assistance remains available on an on-going basis for every Marine and family through the DSTRESS Program, Unit Chaplains, and the Unit Personal and Family Readiness Program.

Ms. SHEA-PORTER. 15) Do DSPO and the Services have a strategy and the capacity, to provide adequate mental health screening and care for families? If not, how are they partnering with civilian social services and non-profit organizations to fill the support gaps? New Hampshire's National Guard Yellow Ribbon Program, for example, partners with Easter Seals to provide needed support.

General HEDELUND. Medical treatment for diagnosable mental health conditions is available to family members through the TRICARE system (either military treatment facility or network providers). Should specialty care not be available within the system, patients may be referred to non-network providers. Marine Corps Community Services (MCCS) offers non-medical, short term counseling programs to Marines and their family members for problems such as anger management, coping with loss or separation, parenting, etc. Family members also have access to counseling from Military OneSource, where they can deal with a credentialed counselor telephonically or in person with a geographically local counselor. Both MCCS and OneSource ensure a warm handoff to the medical system should the family member's condition warrant a medical referral.

Project FOCUS (Families Overcoming Under Stress), initiated by the Navy Bureau of Medicine and Surgery (BUMED) in 2008, provides state-of-the-art family resiliency and psychological health services to military children and families at over 20 Navy and Marine Corps sites and online for those in remote locations. FOCUS is a family-centered resiliency training program developed from evidenced-based interventions that enhance understanding, psychological health, and developmental outcomes for highly stressed children and families facing challenges related to multiple deployments, combat operational stress, and physical injuries in a family member.

Ms. SHEA-PORTER. 16) Are family member (spouses and children) suicides being tracked by DSPO and/or the Services? If not, why not?

General HEDELUND. The Marine Corps tracks suicides by dependents of active duty Marines. The reporting of the information is not required by DOD.

