INVISIBLE WOUNDS: PREVENTING SUICIDE IN OUR NATION'S MILITARY AND VETERAN COMMUNITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY

OF THE

COMMITTEE ON OVERSIGHT AND REFORM

HOUSE OF REPRESENTATIVES

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No additional documents were entered into the record for this hearing.

INVISIBLE WOUNDS: PREVENTING SUICIDE IN OUR NATION'S MILITARY AND VETERAN COMMUNITIES

Wednesday, November 17, 2021

HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND REFORM
SUBCOMMITTEE ON NATIONAL SECURITY
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:02 a.m., in room 2154, Rayburn House Office Building, and via Zoom. Hon. Stephen F. Lynch (chairman of the subcommittee) presiding.

Present: Representatives Lynch, Welch, Johnson, DeSaulnier, Mfume, Wasserman Schultz, Speier, Grothman, and Higgins.

Also present: Representative Maloney.

Mr. LYNCH. The committee will come to order.

Without objection, the Chair is authorized to declare a recess of the committee at any time.

I now recognize myself for an opening statement.

Good morning, everyone. Continuing in the spirit of Veterans Day, which we celebrated last week, I'd like to again thank our nearly 18 million veterans and their families for their distinguished military service and sacrifice on behalf of our Nation.

And keeping faith with our Nation's obligation to our Active military personnel and all those who are veterans, today's hearing will examine the devastating suicide crisis that continues to affect the health and well-being of America's Active military and veteran communities.

Since 2001, the suicide rate among our Nation's veterans has risen by 57 percent, and, on average, more than 6,300 veterans have died by suicide each year. The more than 65,000 veterans that have died by suicide since 2010 exceeds the total number of combat deaths from the Vietnam War and the U.S. wars in Iraq and Afghanistan combined.

According to recent data from the Department of Veterans Affairs, the suicide rate among veterans in 2019 was 52.3 percent higher than for nonveteran adults.

Moreover, Active Duty suicide rates have increased across every single service branch since 2011. In its most recent annual suicide report, the Department of Defense reported an Active Duty suicide rate of 28.7 suicides per 100,000 servicemembers in 2020, the highest rate reported by the Department since it began compiling such data in 2008.

Last year alone, 580 servicemembers died by suicide, including Active personnel, National Guard, and Reserve.

The suicide epidemic among our military and veteran communities is an enduring public health crisis that also carries profound implications for U.S. national security.

As detailed by Brown University in one of its recent "Costs of War" reports, our men and women in uniform have been operating at a persistently high operational tempo since the commencement of the global war on terrorism in 2001. The unyielding pace of deployment has significantly strained U.S. military readiness, intensified the pressure on military personnel and their families, and exacerbated the mental health challenges already facing our military and veteran communities.

To their credit, both the VA and DOD have prioritized the military and veteran suicide crisis within their respective organizations. The VA is increasingly using a public health approach to suicide prevention that employs evidence-based, clinical intervention strategies while also promoting partnerships with community and mental health organizations. And, within the last year, DOD has implemented several pilot programs designed to identify suicide warning signs on social media, encourage servicemembers to seek mental health services, and to promote the safe storage and handling of firearms, medications, and other lethal means.

I look forward to discussing the recommendations issued by the Government Accountability Office detailing improvements that both agencies can make to enhance their suicide prevention and outreach programs.

I'm also very pleased that earlier this month President Biden released a new comprehensive national strategy on, quote, "Reducing Military and Veteran Suicide." The strategy outlines a government-wide cross-section and data base approach to addressing the public health and national security crisis.

In particular, the Biden strategy seeks to expand the use of data to target suicide risk factors, advance suicide research and evaluation, promote skills development to lessen the risk of suicide, and ensure access to high-quality mental healthcare.

President Biden's new strategy also recognizes the important work of community-based organizations and other private-sector stakeholders to prevent and reduce military and veteran suicide.

In the city of Boston, where I live and which I am proud to represent, Home Base, an innovative, family based clinic established in 2009 through a partnership between the Boston Red Sox Foundation, the Massachusetts General Hospital, and Harvard University provides critical, life-saving care to servicemembers, veterans, and military family members as they heal from traumatic brain injury, post-traumatic stress, and other invisible wounds.

I'm extremely grateful to Home Base's executive director, Brigadier General Jack Hammond, for testifying before our subcommittee in person today about their important work.

I'd also like to thank Dr. Carla Stumpf Patton from the Tragedy Assistance Program for Survivors, or TAPS, and Staff Sergeant Johnny Jones from the Boot Campaign for testifying before our subcommittee today.

As well, I know you both are deeply and personally invested in this issue, and we all look forward to hearing your views and perspectives.

I thank all of you for your service and your sacrifice on behalf of our Nation.

I will now yield to the subcommittee ranking member, the gentleman from Wisconsin, Mr. Grothman, for his opening remarks.

Mr. GROTHMAN. Thank you, Mr. Chairman, for holding this hearing to address the public health and national security crisis that is veteran and military mental health and suicide.

I want to personally thank Mr. Jones and Mr. Hammond for serving our country and continuing to fight and work on this issue. I also want to thank Dr. Stumpf Patton for her tireless work on this issue.

Before we get started, I want to play a voicemail Mr. Jones sent us from a veteran he references in his testimony. As you will hear in Mr. Jones's testimony, our government failed this veteran, and he unfortunately is no longer with us because of that failure.

We must not discuss this issue in the abstract. This can be difficult to hear, so if you need to mute or leave, please do so now.

[Audio clip begins.]

Sergeant McDonald. Hi, brother. What's up? It's me. Just give me a call. I need some help, man. Like, the VA told me, you know, they take it by a case-by-case basis. And they're telling me to try to find a local facility and go in on my own dime and my own insurance. And they said, after I find out about if my insurance will pay for it or whatever, they told me to contact them back. But, like, basically, them outsourcing it, I guess, like, they don't want to spend the money on it or whatever else. But I was just seeing, like, what steps you think I need to take, because, you know, they're telling me one thing, and then my insurance, like, it ain't gonna cover more than, like, five or six days. And I just wanted to see what you wanted me to do. Dad thinks I can—have to start contacting newspapers, TV, everything else. But I just want to get your take on it, brother. All right, call me back.

[Audio clip ends.]

Mr. GROTHMAN. Thank you.

To all the veterans, servicemembers, or military families that may be listening, if you or a loved one needs assistance, we encourage you to reach out to one of the many services available. You can call them at 1–800–273–8255 or text them at 838255 or chat at their website.

I'd also ask that each of the nonprofits here today submit their contact information for the record or start their testimony with it.

Thank you.

We are here today to discuss the heartbreaking and largely preventable crisis of veteran and military suicides. In 2019, 6,261 veterans died by suicide, 580 servicemembers, and 202 family members. That accounts for 15 percent, about one in six, of all suicides in America.

Those who choose to fight for our collective freedom should not return home to strife and turmoil and struggle without options for help. This must be a multi-agency and private-sector effort.

The Department of Defense needs to do more for those actively serving. They need to prepare servicemembers for discharge. The Department of Veterans Affairs needs to provide more services, and they need to actively identify vets who are in trouble. And the private sector, primarily nonprofits, need to continue to step up and fill the void by providing services on the ground to the vets and their families. We all need to step up.

The GAO recently released two reports, one regarding DOD and one regarding the VA. It does not appear that either the DOD or the VA have completed any of the recommendations made by GAO. I wish they were here to testify—quite frankly, they should be here to testify—because, otherwise, you really can't—there are so many questions that only they would be able to answer.

Additionally, the DOD Inspector General found that the DOD did not screen for suicide risk or provide uninterrupted mental healthcare to transitioning servicemembers, as required by Federal and DOD guidance.

Mr. Chairman, the DOD and VA have failed to protect our servicemembers from the tragedy of suicide. I hope we have a hearing on this topic with the DOD and VA as soon as possible.

This topic is especially important considering the recent images from the Biden administration's withdrawal from Afghanistan. It's vital we remind veterans, particularly that fought in Afghanistan, that they served their country with honor and worked within the rules of engagement, operating their best, and their actions had demonstrable positive effects on the people of Afghanistan. In fact, because of the resolve of these vets and the determination of Americans, American allies even got evacuated.

Finally, it's important to focus on positives and hope—the VA calls these "anchors for hope." Suicides dropped 399 in 2019, making it the lowest single total since 2017. The reduction of 399 was the largest ever in a single year, so that's good news. There was a 13-percent decrease in deaths by suicide among women, the largest decrease in 17 years.

Well, I'd like to thank the witnesses for being here today, and I look forward to hearing from you.

And I yield back. Thank you.

Mr. LYNCH. The gentleman yields back.

At this time, I'd like to recognize the chairwoman for the full committee, Chairwoman Carolyn Maloney, for an opening statement.

Mrs. MALONEY. Thank you, Chairman Lynch, for holding this critically important hearing and for your unwavering commitment to our military servicemembers, veterans, and their families.

In the 20 years since 9/11, almost 3 million soldiers, sailors, airmen, and marines have answered the call to serve our Nation overseas. Tragically, more than 7,000 servicemembers have made the ultimate sacrifice fighting terrorism in Afghanistan, Iraq, and around the world.

Tens of thousands more have returned home with both visible and invisible wounds of war. Too often, these servicemembers and veterans fight their own battles that the rest of us cannot see. Sadly, many of these battles end in suicide.

While we may never fully understand why any servicemember or veteran chooses to take their own life, we know that certain risk factors can make that tragic outcome more likely. Post-traumatic stress, clinical depression, and other mental health struggles can contribute to feelings of loneliness or helplessness. So can economic insecurity, a lack of access to healthcare or good-paying jobs, and other daily stressors and challenges that we all may confront at some points in our lives.

We also cannot escape the fact that firearms are the most common method that servicemembers and veterans use to take their own lives, and they do so at a much higher rate than the general population.

I applaud President Biden for taking key steps to address this tragedy, including releasing a new strategy earlier this month for reducing military and veteran suicide. This plan adopts a whole-of-government approach to addressing the public health and risk factors that contribute to suicide, while also increasing access to clinical care and improving lethal means, education, and safety.

This is an important framework for reducing military suicides, but it must be implemented in coordination with nongovernment veteran and community organizations. I am pleased that we have representatives here from three organizations to talk about how they are working with DOD and the VA to achieve this objective.

Finally, just as we honor, respect, and care for those military families who have lost a loved one in combat, we owe the same duty of care to those who have lost a family member due to suicide. According to the CDC, family members that have lost a loved one to suicide can experience anxiety, depression, post-traumatic disorder, and can be at heightened risk of suicide themselves.

Chairman Lynch, you have movingly said before that when a young man or woman puts on the uniform of the United States military, they become our children. So, too, are the families of our Nation's servicemembers and veterans our family, and we have a solemn moral obligation to care for them.

This is a very personal issue to me. My brother served our country in Vietnam, and he came home a changed man. He struggled for years after his military service, and he later took his own life. That was years ago, but the pain of my brother's passing is still with me today.

So, Chairman Lynch, thank you for holding this important hearing. I am hopeful that we can make meaningful progress today in protecting those who have served our country and their families.

I'd like to thank all of our witnesses for testifying before our committee.

And, with that, Mr. Chairman, I yield back. Thank you.

Mr. LYNCH. The gentlelady yields back.

I would now like to introduce our witnesses.

Today we're joined by Ms. Alyssa Hundrup, who is the Director of Health Care with the Government Accountability Office.

We're also joined by Brigadier General Jack Hammond. Brigadier General Hammond is a retired U.S. Army officer and a veteran of both Iraq and Afghanistan, serving in the Army for more than three decades. He has led at every level of command, from platoon to brigade, during peace and war.

In 2012, General Hammond was invited to lead Home Base, which is a unique partnership between the Boston Red Sox and Massachusetts General Hospital. Home Base established the Nation's first private-sector center of excellence for the mental health and brain injury impacting our wounded veterans and their families. This clinical program was designed to leverage the faculty and deep clinical resources of Massachusetts General Hospital and Harvard Medical School in order to deliver the best possible clinical care in the country for our veterans and families at no cost to them.

Home Base has reimagined what is possible in the treatment of these complex injuries and developed new and innovative solutions, saving thousands of lives, and caring for more than 25,000 veterans and their families through the funding support from a grateful Nation.

Next, we are joined by Dr. Carla Stumpf Patton, who is senior director for postvention programs at the Tragedy Assistance Program for Survivors, or TAPS, which provides care, resources, and a support system to military families who have lost a loved one.

And, finally, we are joined by retired Staff Sergeant Johnny Jones, a veteran of the wars in Afghanistan and Iraq, who now works on the board of the Boot Campaign, which works to connect veterans and servicemembers with access to health and wellness resources. Staff Sergeant Jones is appearing remotely before us today.

Thank you all for attending. We look forward to your testimony.

It is the custom of this subcommittee to swear all witnesses. Would you all please stand and raise your right hand so we can swear you in?

And, Mr. Jones, will you be unmuted so we can swear you in remotely?

Staff Sergeant JONES. Yes.

Mr. LYNCH. Do you swear or affirm that the testimony you're about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Staff Sergeant JONES. I do.

Mr. LYNCH. Let the record show that the witnesses have all answered in the affirmative.

Thank you. Please be seated.

Without objection, your written statements will be made part of the record.

With that, Ms. Hundrup, you are now recognized for five minutes for your testimony. Thank you.

STATEMENT OF ALYSSA M. HUNDRUP, DIRECTOR, HEALTH CARE TEAM, GOVERNMENT ACCOUNTABILITY OFFICE

Ms. HUNDRUP. Chairman Lynch, Ranking Member Grothman, and members of the subcommittee, thank you for the opportunity to be here today to discuss our work on DOD and VA's efforts to help prevent suicides among the military and veterans.

Suicide is a devastating public health problem that has been a persistent and growing issue for our servicemembers and veterans. As noted, the latest report from DOD shows an increase in military suicide rates in 2020, with an increase of over 40 percent in the

last six years. Similarly for veterans, the most recent data from 2019 shows a suicide rate almost two times higher for veterans than nonveterans.

My testimony today includes information from three recent reports we issued examining various DOD and VA prevention efforts. Specifically, since September 2020, we have made three recommendations to DOD and six to VA to improve their efforts. Both agencies have taken initial steps to implement most of our recommendations, and we will continue to monitor their actions to fully address them.

First, regarding DOD, in our April report, we looked at DOD's nonclinical suicide prevention efforts. We found that DOD and the military services have implemented a number of initiatives aimed at reducing the risk of suicide in the military population, such as through specific trainings and educational efforts. And, in 2020, DOD's Defense Suicide Prevention Office, or DSPO, published a framework for assessing these efforts collectively.

However, DSPO's framework does not provide DOD with information on the effectiveness of its individual initiatives. Given unique risk factors the military population faces, such as higher likelihood of experiencing trauma, it is imperative that DOD also ensure that each of its individual efforts are fully assessed to understand how well they are working, and we recommended that DSPO collaborate with the military services to develop a process to do just that.

DOD agreed with our recommendation and, in June, reported that it is beginning discussions with the services on how to standardize an evaluation approach.

Second, regarding VA, we recently looked at VA's use of suicide prevention teams. These teams are used at local facilities to implement VA's Suicide Prevention Program, which includes various activities such as tracking and reporting on veterans at high risk for suicide and conducting trainings.

VA has added a number of new initiatives to be implemented by these teams. However, the addition of these many initiatives has led to a considerable increase in the team's workload, which, in turn, has led to burnout and turnover at some facilities.

VA officials said they're developing new guidance for their Suicide Prevention Program, but the agency has not conducted a comprehensive evaluation of the effects of the program's growth, and it is using a staffing model that does not account for the increasing workload resulting from the many new initiatives.

We believe these shortcomings could put the suicide prevention teams, and ultimately the care they provide to the veterans they serve, at risk of falling short of the program's goal to reduce the incidence of suicide among veterans.

We made recommendations to strengthen VA's use of and staffing for its suicide prevention teams. VA agreed with these and has since outlined a number of actions it is taking.

Finally, in 2020, we issued a report that found VA had not taken enough steps to develop a full understanding of the prevalence and nature of suicides taking place on its campuses, including making use of all relevant information it collects about these deaths in order to prevent future cases.

We recommended that VA more accurately identify all on-campus suicides as well as expand the information it analyzes. We believe such analyses could, in turn, help prevent future suicides.

In closing, suicide is a tragic issue that needs significant attention and action. DOD and VA have both emphasized the importance of suicide prevention and have several efforts underway. It is critical that they now fully address our recommendations and ensure the quality and effectiveness of their efforts so they can take every step possible to help prevent suicide among servicemembers and veterans.

This concludes my prepared remarks. I would now be happy to answer any questions that you may have.

Thank you.

Mr. LYNCH. Thank you very much.

General Hammond, you're now recognized for a five-minute summation of your testimony.

General Hammond, can you make sure your mic is on and that it is close to you?

There you go. Thank you, sir.

STATEMENT OF BRIGADIER GENERAL JACK HAMMOND, EXECUTIVE DIRECTOR, HOME BASE

General HAMMOND. Chairman Lynch, Ranking Member Grothman, and members of the subcommittee, I greatly appreciate the opportunity to speak with you today on this national tragedy of military and veteran suicide.

Home Base can be reached at HomeBase.org.

This is an issue of profound importance and is deeply important to me. In speaking with my good friend and Medal of Honor recipient Staff Sergeant Ryan Pitts, he describes this as the number-one threat facing our veterans from this generation.

I hope to provide you with an alternative perspective on the challenge, one that is based on my personal experience with PTSD, experience leading troops in combat on multiple deployments to Iraq and Afghanistan, and, of course, my decade of work assisting veterans who desperately want to put the pieces of their lives that were broken on the battlefield back together. When they lose hope for a day without pain or their ability to move forward, then they give up and take their lives. We are in a race against time to reclaim that hope.

There is an implied trust made between our warriors in this Nation that if they are injured, wounded, or killed, we as a Nation have their backs and we will be there to provide them with the care they need, and if they die, we'll care for their families. Ladies and gentlemen, we are failing in this mission.

Three million men and women from two generations of Americans answered the call and deployed to war. They followed the footsteps of our previous generations who came before them and did not question the challenge. They did their job and kept the rest of us safe from harm, asking only to be made whole when they return home.

This is clearly a difficult task, but a veteran will tell you that getting into a canvas-door Humvee with no body armor and driving

into Fallujah while people are shooting at you and trying to blow you up is also quite difficult. But they did it.

This country was bred to accomplish impossible things from its birth to the Moonshot, but sometimes we forget this. Time is not our friend, and each day we waste is costing lives of brave Americans, who leave behind a wake of destruction with their broken families.

For the past decade, as the chairman mentioned, I've had the honor to lead an organization that has reimagined what is possible with veteran care. More than 25,000 folks have been treated by the incredible, talented clinicians at Home Base, all at no cost. And Home Base does draw its faculty from Mass General Hospital, Harvard Medical School, and the Mass General Brigham system, demonstrating what is possible.

Home Base launched a groundbreaking, two-week, intensive clinical program for PTSD and traumatic brain injury six years ago in partnership with the Wounded Warrior Project and three academic medical centers across the country. This program compresses two years of therapy into 14 days. And every two weeks, 24 veterans are flown to Home Base for this care.

Three years later, we modified the clinical program for the surviving spouses of military and veteran suicide, in partnership with our good friend at TAPS.

In 2019, the Naval Special Warfare Medical Command requested a pilot program for traumatic brain injury to address the complex medical needs specifically for these unique warriors. More than 200 Navy Seals, Green Berets, and Delta Force members and other SOF troops have completed this unique program, and 300 more are currently on the waitlist for this care. Seventy percent of these men are on Active Duty, and, remarkably, 97 percent of them return to full duty.

In 2015, we expanded our work to the five counties of southwest Florida, first creating a wellness program and then building clinical capacity with two local hospital systems in order to improve access to high-quality clinical care. These clinicians were flown to Boston and trained in evidence-based treatment, and then funds were raised to support 50 percent of their salary to deliver care to our veterans at no cost.

Additional partnerships are currently underway with Tampa General Hospital and the Florida legislature to expand this further. And, most recently, we have met with leaders from Navajo Nation and Governor Ducey of Arizona to grow clinical access, capabilities, and capacity for veterans and families in the Tribal lands and in Arizona.

This work to grow clinical capacity began in Massachusetts through a statewide suicide prevention program that partnered 125 police departments, the VFW, VSOs, and we trained 75 clinicians across the state in underserved communities. We also trained first responders and veteran service officers to recognize veterans exhibiting at-risk behavior.

We can do the difficult things, and with a limited budget resource, we've successfully piloted many of the key elements contained in the White House strategy.

I believe that the strategy is spot-on, but the most crucial element of the plan is to improve access to high-quality, evidence-based care. However, the six agencies tasked with this have been given a year to develop a plan, and this could mean a three-year delay in implementation, at the cost of another 18,000 lives.

We know how to grow clinical capability. Home Base has accomplished this on a shoestring budget and improved access to high-quality care in multiple states across the country, to include our work with the Navajo Nation. What we need now are actionable plans and funding strategies for each of the priorities in the White House strategy. An 80-percent solution today is much better than a 100-percent solution that never becomes a reality.

My second recommendation is to engage our private-sector hospital systems and academic medical centers. The VA has been in this fight alone, and it is an insurmountable task. They need to look at funding tools used by elements like the National Institutes for Health in its fight to cure illnesses, rare disease, and injury.

Dr. Richard Stone from the VA testified last year that only 6 of the 20 veterans who die by suicide each day had received VA care within the past two years. This means that those 14 received care in the private sector, and that is where we need to recalibrate our focus a bit.

Congress has provided billions of dollars to improve access to private care, but many of these efforts continue to fail because of an inability to create funding mechanisms to pay for that care.

Home Base has met all the requirements to be a VA Choice Provider, was approved as a VA Community Care Partner, but has never received an official referral for care or reimbursement, despite the fact that we've received hundreds of informal referrals from VA providers.

Home Base has delivered high-quality care for more than 25,000 veterans at a cost of $165 million from a grateful Nation. The National Institutes for Health, by contrast, routinely support extramural care through grants, contracts, and cooperative agreements. We need to implement these tools and train and fund clinical care for veterans at the point where it is needed, in many of our community-based health centers. Each of our systems can play a role in the strategy, but a vision without resources is a hallucination.

My final recommendation is for the DOD, and it has to take a more aggressive approach toward suicide prevention in a proactive manner. This work can begin and follow the pathway established by the Special Operations Command through their universal mental health plan and the Preservation of the Force Program.

We must do better to get upstream of these injuries. And, last year, I was asked to join a group of doctors and researchers from Harvard and provide the Army leadership with actionable recommendations to reduce soldier suicide. An amazing team of experts from Harvard and MGH volunteered to serve on this: Dr. Jordan Smoller, Dr. Matt Nock, Dr. Greg Fricchione, and Dr. Ron Kessler, clinical researchers who routinely advise both the World Health Organization and NIH on these same issues.

They developed a plan that leverages and advances on machine-learning-based prediction algorithms to identify soldiers at greatest

risk for suicide. They are then matched up with the most optimum, individualized prevention plans available.

This two-pronged strategy first focuses on enhanced risk assessment that will identify those at the greatest risk for suicide. Studies have shown that clinicians perform no better than chance at predicting suicide. This two-pronged approach also focuses on an enhanced risk assessment tool that will identify who is at greatest risk.

And then a second component of this plan will be to implement a risk assessment, mitigation, and maintenance tool using the data from a decision support tool that is developed that will provide data-driven solutions to match at-risk veterans with suicide prevention strategies that meet the particular needs of the individual at that time.

This entire effort can be accomplished by using existing DOD resources, and it will provide DOD with the greatest predictive modeling capability in the world.

The DOD and VA have both done incredible work to stem the tide of veteran and military suicide, but without engaging the full resources of a grateful Nation, which has demonstrated their support by raising billions of dollars in private funds to care for our veterans, we are attempting to accomplish this task with one arm tied behind our back.

All the while, 20 veterans each day lose hope for a day without pain and take their lives. This leaves many families asking the question, how their veterans could survive the rigors of combat but not peace when they returned home.

I look forward to answering any questions you have. And I'm grateful for the opportunity to speak with you and the attention you're paying to this important matter.

Mr. LYNCH. Thank you, General.

Dr. Stump Patton, you're now recognized for five minutes.

STATEMENT OF CARLA STUMPF PATTON, ED.D., LMHC, SENIOR DIRECTOR, POSTVENTION PROGRAMS, TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS

Ms. STUMPF PATTON. Chairman Lynch, Ranking Member Grothman, and distinguished committee members, the Tragedy Assistance Program for Survivors thanks you for the opportunity to testify on behalf of the 100,000 military and veteran survivors that TAPS supports, including the nearly 19,000 who have lost a military loved one to suicide.

My name is Dr. Carla Stumpf Patton, and I serve as the senior director for TAPS' suicide prevention programs. I'm a surviving spouse of a Marine Corps drill instructor, Sergeant Richard Stumpf, who died by suicide at the age of 24 on October 31st, 1994.

I was pregnant full-term with our first child, who was born several days later when I was rushed to the hospital during the funeral. The devastating tragedy propelled me to find ways to survive and eventually dedicating my professional career to suicide prevention and postvention efforts for 27 years.

To do so, I earned multiple degrees in the fields of psychology and mental health and completed my doctoral dissertation on military families bereaved by suicide. By trade, I'm a licensed

psychotherapist and subject-matter expert in the fields of trauma, suicide, and bereavement.

I am remarried to a Marine who also lost his military dependent spouse to suicide, wherein our two blended military families have experienced this tragedy on multiple levels.

This statement is a representation of the countless individuals, our loved ones, who died by suicide after prevention efforts failed. The emotional crisis they were experiencing did not simply disappear with their suicide but, rather, is often transferred and absorbed by those coping with the death.

Postvention for survivors is imperative to reduce risk and increase prevention, as those who have been impacted must be offered the same care and services offered to the servicemember or veteran prior to their death. It is of equal vital importance that we also include military dependents in prevention initiatives, as the death of a family member can have detrimental effects on the servicemember or veteran. Postvention must be a critical component of any comprehensive suicide prevention strategy.

Based on best practices, the TAPS Suicide Postvention Department developed the field-leading TAPS Suicide Postvention Model. This decreases isolation as well as risk for mental health issues, such as suicide, addiction, anxiety, and depression, and, therefore, increases social connection, peer support, and growth that all promote healing following a suicide death.

TAPS is the only organization formally working with military families coping with a suicide loss, thus contributing to life-saving prevention with information gleaned from our postvention work.

When reflecting on suicide deaths, we often find that military culture does not incorporate mental healthcare as a vital part of wellness and readiness. A significant concern is that prevention initiatives often fail to address what TAPS families have identified as a missing component: that military operations lack the time, attention, and significance needed to tend to mental healthcare, wherein daily readiness often fails to incorporate mental fitness and where access to mental healthcare can be challenging.

Through years of advocacy toward reducing stigma surrounding suicide in the military, TAPS recognizes the most alarming concern being that of the fear of how seeking mental healthcare could negatively impact career development and advancement opportunities.

Many survivors, myself included, share how either they or their loved ones were afraid to discuss or disclose to anyone about such struggles, where far too often there had been tremendous psychological and/or physical suffering that became contributors to the suicide.

Suicide prevention requires a holistic public health approach. Messaging must instill hope and be encouraging. In many cases, suicide is preventable, not inevitable. People must know that the help is available, that it works, and with it comes the possibility to stabilize during an emotional crisis and eventually go on to live a healthy, fulfilling life. The overwhelming majority of people who struggle with thoughts of suicide do not go on to die by suicide but, instead, access the resources and learn the skills needed to cope in safe ways.

This all cannot stem from a single approach but, rather, must consider long-term prevention strategies and comprehensive crisis responses, including postvention care. Also vital to a public health approach is increasing the education that anyone, all of us, can participate in suicide awareness and prevention efforts.

On behalf of TAPS and the survivor community that I represent, I am grateful for the opportunity to testify today and look forward to answering any questions that you may have. Thank you.

Mr. LYNCH. Thank you, Doctor.

Staff Sergeant Jones, you are now recognized for five minutes for your testimony. Welcome.

STATEMENT OF STAFF SERGEANT (RET.) JOHNNY JONES, BOARD OF DIRECTORS, BOOT CAMPAIGN

Staff Sergeant JONES. Thank you all for having me here today. It's an honor to testify before the subcommittee in honor of my friend Sergeant Christopher McDonald.

The issue of veteran suicide has become a trendy topic. Awareness, it seems, is the cheapest currency for the problem, so deeply misunderstood that we continue to lose lives at an astonishingly consistent rate.

As an eight-year Marine Corps veteran with combat deployments to both Iraq and Afghanistan, the latter of which took both of my legs above the knee in August 2010, this trend stormed into my own life the Friday before St. Patrick's Day in 2012, when my high school best friend, Marine Sergeant Christopher McDonald, took his own life.

At the time, I was working as a fellow for the House Veterans' Affairs Committee. My friend Chris was four years removed from a combat deployment where he suffered both physical and mental health injuries. He was prescribed 180 5-milligram tablets of hydrocodone a month for a hip injury he had suffered in Iraq in 2008 but received no treatment for his mental trauma.

Chris was the epitome of hard work and discipline. His father, our middle school football coach and high school technology teacher, is a Marine Corps combat veteran from Desert Storm. And whether it was football, baseball, or academics, Chris gave everything 110 percent and could not accept failure.

The months prior to Chris's suicide, he became extremely addicted to opioids and began to lie, cheat, and steal from his closest friends and family to supply his destructive habit. Finally, at Christmas in 2011, his parents, his roommate at the time, our mutual best friend and Army veteran, and I intervened. We submitted a written affidavit to the local authorities that he was a danger to himself and others, and he was taken to a mandatory 72-hour detox hold. Afterward, Chris admitted his problems and asked us all for help.

Unfortunately, help wasn't what the VA offered. Not real help. He was told his case wasn't severe enough for in-patient rehabilitation. He came to me, desperate. And, even working in Congress, or maybe especially working in Congress, I felt helpless to save my best friend's life.

Ultimately, he decided taking his own life was the only way to ensure he no longer hurt or let down those he loved. But as anyone

who's lost a loved one to suicide knows, that couldn't be further from the truth. This one act of finality hurts the innocent every day for the rest of their lives.

We can't stand by and allow those who serve to think this is the only option. Today, I work with many nonprofit groups to identify, assess, treat and/or facilitate treatment for veterans struggling with post-traumatic stress, traumatic brain injury, addiction, chronic pain, and insomnia.

Veterans are turning to organizations like Boot Campaign, Boulder Crest Foundation, Brain Treatment Foundation, the Shepherd Center's SHARE Program, Camp Southern Ground—and let me add, the organizations that are also testifying today have a great reputation and are those organizations as well—and veterans turn to others to find quick, individualized, and nontraditional treatment protocols developed independently from the catacombs of bureaucracy and antiquated, one-size-fits-all methods that currently plague our VA.

I'm not a physician, a psychologist, or a psychiatrist. I don't have a doctorate or masters in any field, much less mental health or medical treatment. But I challenge you to find someone with more passion and concern on this topic. I have dedicated the last decade of my life to understanding this issue in its entirety, not just through the lens of some awareness campaign or appeasement initiative.

With that experience and with the help of some of the aforementioned organizations, working on this issue every single day, I've identified the following areas I feel are either overlooked, oversimplified, or misunderstood altogether.

First, the role of prior-to-service trauma and trauma not directly caused by military or combat experience. Many, if not most, veterans who legitimately claim what is commonly known as post-traumatic stress, sometimes disorder, experienced trauma as a child. Many others experienced trauma from life, like infidelity, guilt from not being close to a dying relative, not seeing their children grow up, financial stress, and other everyday American experiences that can contribute and sometimes cause the deterioration of mental health.

Second, the DOD must take responsibility for vetting, treating, and transitioning veterans. The VA gets all the blame, and it is clear, more must be done to improve how we treat veterans. But to have a paradigm shift in this issue, we must look at root causes.

We spend 3 to 12 months training a civilian to be a servicemember, we train them for six months to deploy, and we spend years grooming them for their next promotion. But when it comes time to leave the military—for many, facing their first experience with civilian life as an adult—we spend two weeks or less training them in this transition.

As someone who has seen the worst horrors war has to offer, I can honestly and earnestly say that transitioning out of the Marine Corps was the single most traumatic and least-trained-for experience in my entire military career.

And, last, we must acknowledge and assist the good work that is being done by nonprofit organizations and private healthcare providers. The VA and the Federal Government at large move slow.

Sometimes that's by design, and sometimes ulterior or even partisan motives are at work. I'm not here to demonize the VA or complain about how things get done in government, but I can tell you that there are treatment protocols and outreach successes being made by these organizations that are absolutely saving lives. Many of these organizations need grants and financial resources, while others merely need a seat at the table and access to data to expand the reach of their success and save more lives. We won't solve this problem with a government-only solution.

I want to thank you all for this opportunity. I know government often seems like nothing more than a team sport, but, for this issue, I commend you all for leaving your partisan politics at the door and standing ready to do your job with integrity and selfless concern for America's heroes.

As a veteran and a grateful American, please consider me a resource and a dedicated soldier in this fight against our third war and most deadly war over the past two decades. It is our responsibility to do everything we can to save our military servicemembers from the enemy within, a war fought here at home, fought in our homes and among our friends and family.

And, with that, thank you.

Mr. LYNCH. Thank you, Sergeant. Thank you for your testimony and your perspective and for the good work you continue to do.

Before moving to questions, I understand that Representative Tlaib, a member of the full committee, has asked to be waived on to the hearing so she can submit a statement and questions for the record.

So, without objection, the gentlewoman from Michigan, Ms. Tlaib, shall be permitted to join the subcommittee and be recognized to submit her questions.

Mr. LYNCH. I now recognize myself for five minutes for questions.

First of all, I want to say thank you to all of our witnesses. You enrich this whole process, and you help us grapple with this difficult issue. And thank you for your work, your service within government and within the military, but also thank you for your continued service outside of that on behalf of veterans and Active military.

General Hammond, we have a dual system here that we've all talked about. One is, the VA provides services to veterans, and then we've got DOD for Active military. I want to talk about the situation with the VA right now that the good sergeant just raised.

So I'm blessed in my district, I've got three VA hospitals. I've got one in Brockton, one in West Roxbury, one in Jamaica Plain. Yet, when I read the data on the suicide report, so many of the veterans who are victims of suicide are not participating in the VA system, they are not registered, or they're not getting their mental healthcare from the VA. So there's a disconnect.

And look, my VAs do a great job, but if someone is not coming in the door, then there's that disconnect, right? You can't help somebody who doesn't enroll and participate in the VA.

So there's a disconnect there that—I believe, listening to what Boot Campaign is doing and what your organization is doing and what TAPS is doing, it seems to me that, in a way, you're filling that gap, you're curing that disconnect.

Can you talk about that? And, Dr. Stump Patton, I think you have a similar perspective on how that works and how that fills that gap. But, General Hammond, why don't you have a crack at it?

General HAMMOND. Yes, sir. Thank you.

So one of the things that oftentimes gets lost in translation is, throughout the last 100 years, 15-20 percent of our veterans receive care from the VA. When they come home from war, they begin their lives, they get jobs, they have insurance, and they go that way. And, oftentimes, there was always a hesitance to receive care, because it was like a zero-sum-game mentality, where the veterans didn't want to take some of that care from somebody who might need it worse, because "I've already got my Blue Cross." So, if you've got a good health system, you're part of that, you don't think to go into that system. And it's not a reflection of the VA; it's just a fact of life.

Mr. LYNCH. Yes.

General HAMMOND. In 2001, when this all started, there were 25 million veterans in the country, and only 3.9 received care from the VA. That's a significantly small percent. That's grown a bit, but we've also lost—from 25 million, as you mentioned earlier, we're down to 18 million, and in the next 20 years we'll be down to about 12 million.

So we can't keep making a 550-percent increase in the VA budget to try and grow it at a time when the veteran population is shrinking. We have to think smarter, how to sustain this and how to give the best possible care under the rubric of the VA but by reaching out to community-based health centers and hospitals that are willing to do the work.

They just need the resources, and we need to figure out a way to get those resources to those community-based health centers where veterans live, where they go for care routinely.

Mr. LYNCH. All right.

Dr. Stumpf Patton, any perspective on that, on filling that gap between the VA and the people who need the services?

Ms. STUMPF PATTON. I think working collaboratively is a very powerful point. Suicide is a very complex, widespread problem that cannot be, you know, answered or responded to with any one single agency or organization. So, when we're all speaking the same language, when we're all on the same page, working in tandem, we present, you know, a united front.

And I think the military Reserves members, family members, the military community need to know that they are not only valued, but there needs to be a message that this care is there for them, that they should want to seek care and know that they're going to be in the trusted hands of people who are there to serve them, rather than feeling a mistrust and not choosing to go to the systems that are theirs, you know, to be there to serve them.

Mr. LYNCH. Thank you.

And, Sergeant Jones, you touched on this very issue in your opening testimony. Any perspectives on that, on how we might—and how Boot Campaign actually fills that gap on behalf of the veterans that you serve?

Staff Sergeant JONES. There's really two issues at—and thank you for the question. There's really two issues at once here. One is, how do we look at those dealing with suicidal thoughts that are already veterans, that have already left and disconnected and now we're trying to reengage them.

The second part of your question, really, and the answer is, the solution is, to never have them be disengaged to begin with. And that goes back to the DOD and their responsibility to properly assess veterans leaving the military from every aspect that causes mental health issues, from finance to family situations, the whole nine yards, so that, as they transition out, that line of communication is already there.

One of these issues is, how do we address the population we already have? But it'd be irresponsible to acknowledge that problem and not look back and say, how can we preemptively stop that problem from persisting as those leave the military.

And, statistically, you're going to have more veterans come to the VA after a war than during a war, because they're going to finally say, "You know what? I've got problems, and there's not a mission in front of me that I feel obligated to, so I'm going to go ahead and get out and get treatment."

And so now is the time that start looking at this. Obviously, any day before today would've been great, but now is a very important time.

Mr. LYNCH. Thank you very much.

My time has expired.

I now yield to my friend, the gentleman from Wisconsin, Mr. Grothman, for five minutes.

Mr. GROTHMAN. Thank you so much.

My first brief question—you know, we're given some papers before we come here, and there's a graph here showing veteran deaths by suicide from 2001 to 2019. We're around 6,000 in 2001.

Does anybody know where we were 20 years before that? I kind of wish that graph went further. How many suicides in, like, 1980, 1990? Nobody knows?

OK. That's the type of thing I think the VA would know, and that's why I kind of wish they were here, because it would give us greater perspective.

My next quick question—and this is something I don't know what to make of. I think referencing the same graph, in 2001, it says 20.2 percent of the people who committed suicide in this country were veterans. In 2019, that was down to 13.7 percent. So that's a significant drop of veterans compared to the rest of society.

Can anybody comment as to why that is, make any observations on it?

General HAMMOND. I would just offer this: that, No. 1, when we look at our veteran population and our military population, it's drawn from the top 30th percentile of the American population. As of today, roughly 70 percent of young Americans of military age do not meet the minimum requirements to join the military and become a private in the United States Army based on physical, mental, legal, and moral issues. And so we start with a very high, healthy, mentally healthy, physically healthy population that's

been screened, not extensively but screened to the point where 70 percent don't meet that requirement.

So we're starting off with a good group, and then we work on resiliency issues. And, traditionally, in peacetime, that's worked. When we add the complexity of combat, the transition issues, and all these other pieces, that's when we see these rises.

And, starting in Vietnam, we started seeing increases in suicide with the Vietnam generation during the war. And you look at the treatment they received, and we start looking at bad transitions when you leave the military, questioning your service. We're starting to see some of that——

Mr. GROTHMAN. OK.

General HAMMOND [continuing]. With this generation, because, you know, there's been this dichotomy——

Mr. GROTHMAN. OK.

General HAMMOND [continuing]. Where a lot of folks want to support the troops, but——

Mr. GROTHMAN. Yes.

General HAMMOND [continuing]. It's been pretty vocal about getting out of Afghanistan, getting out of Iraq, whether it was worth it. And when you question your service and sacrifice, it does play with your mind a bit.

Mr. GROTHMAN. Yes. Well, the question was actually why are things getting proportionally better.

But, Mr. Jones, your testimony highlights three recommendations. I want to ask you about two.

First, the DOD needs to take more responsibility in this space. And a DOD IG report recently said that Department of Defense failed to screen for suicide risk for transitioning servicemembers. How does the IG finding make you feel?

Staff Sergeant JONES. It's unsurprising. The biggest problem—I mean, even when you lose your legs and can leave the military, the number-one problem is the VA and DOD's inability to communicate with one another. I don't know what this root cause is, other than the VA is incredibly resistant to transitioning lines of communication and platforms and things of that nature.

When I worked for the House Veterans' Affairs Committee, the Improvised Disability Evaluation System, which, I mean, simply allowed the VA and DOD to assess your injuries at the same time, was borderline controversial, because there was agreement on doing it but no agreement on how to do it.

And so it's very difficult to get the DOD and the VA to communicate. And so it's much—very difficult to get the DOD to assume responsibility for something that probably most in the DOD see as a VA problem.

Mr. GROTHMAN. OK.

You also said that the VA needs to do more work closely with nonprofits. Last year, President Trump signed a bill, S. 785, that gave the VA additional resources to do that. Has the VA done so? And, if not, what do they have to do?

Staff Sergeant JONES. That's a good question. I've spoken with a gentleman named Ken Falke, who started Boulder Crest Retreat and the Warrior PATHH transition program. He testified before

Congress on behalf of that bill. I spoke with him about that bill, and the frustration was just through the roof with him.

What we do at Boot Campaign is largely detached, actually, from the VA. We really don't have an opportunity to work with the VA because—if I were going to put this in layman's terms, I would say the government would rather spend money on a study to find out something doesn't work than spend money on something that anecdotally very much is working but doesn't want to spend a million dollars to study it, or doesn't have the scientific recognition from a traditional medicine community to get that type of data.

I understand the necessity to be responsible, especially fiscally responsible, but we have organizations that get good work done every day, that literally save and change lives, and because they haven't done some expensive research packet or study, they have less of an opportunity to get Federal grants. And I think that's the problem.

I think that the government is overlooking nontraditional treatment. And, to an extent, I understand why the VA leans into what is, you know, acceptable in the medical community but maybe not so much what is actually working today, with technology and other things that just haven't been around for a very long time.

Mr. GROTHMAN. OK.

Could I—just in general, like I said, when it comes to inadequacies of the VA, it would be nice if they were here.

Do you feel, Mr. Jones—or I will also ask Dr. Stumpf Patton—should we have the VA here today, the VA and the DOD, do you think?

Staff Sergeant JONES. Absolutely.

Mr. GROTHMAN. OK.

Ms. STUMPF PATTON. Yes, sir.

Mr. GROTHMAN. Thank you. Four for four. Good.

OK. That's enough. Thank you for the time.

Mr. LYNCH. The gentleman yields back.

The chair now recognizes the chairwoman for the full committee, Mrs. Maloney, for five minutes.

I think we're having trouble with the technology there.

We will recognize the gentlelady from California, Ms. Speier, for five minutes.

Welcome.

Ms. SPEIER. Mr. Chairman, thank you.

And thank you all for your presentations this morning.

I am deeply concerned about the level and increase of suicides among our servicemembers and our veterans. And I chair the Military Personnel Subcommittee, and, in the NDAA this year, I have language in there that will require an independent review committee to look at the three highest incidence of suicides at three installations, to look at why it's happening at those locations and what we need to do.

Let me start with you, General Hammond. To what extent does the OPTEMPO impact the likelihood of suicide ideation?

General HAMMOND. I think as we saw back in the early 2000's, that OPTEMPO where soldiers, marines, airmen, and sailors deployed for a year, sometimes 18 months, came home for six months, redeployed, we did see a spike in that.

We also saw the impact on their families. And you can't discount that because we look at the external stressors. So not only do you have the challenge of going and putting yourself in harm's way, but you know that you're placing your family in a very difficult situation. And sometimes there are those external stressors, to include food insecurity, housing insecurity, with a family behind for 12 to 18 months.

So I think the OPTEMPO certainly played a big role in this, as did the type of battle that was fought in that asymmetric environment, where it was not on a linear battlefield, and greater numbers were exposed to combat action. And when I say that, there was no safe place in Iraq or Afghanistan. You could be in what we consider support troops that normally are well behind the lines and aren't exposed to danger, and every one of those bases was rocketed, shot with mortars, or had insider threats that were constantly on someone's mind. And so you had high stress and anxiety that many of these young men and women came back with——

Ms. SPEIER. Thank you, General.

General HAMMOND [continuing]. In addition to the traumatic injuries.

Ms. SPEIER. Thank you.

I'd like to go to Dr. Stumpf Patton.

In your testimony, you said that "the military has no room in its schedule for mental health care . . . there is not enough downtime to care for mental health in the military. Daily readiness does not incorporate mental wellness."

There's also a reference in, I believe, one of the reports that one-third of our servicemembers are afraid to seek mental health services because they fear it will affect their promotion.

Can you speak to the OPTEMPO, the stigma, what we need to do to address that?

And I'd also like our representative from GAO to do so as well.

Ms. STUMPF PATTON. Thank you. I think that's a very important question.

I would say, what we are doing here is a perfect example of that. We have to talk about this openly, directly. We cannot be afraid to talk about suicide. Prevention really starts in being proactive before a crisis ensues, before somebody is in an emotional crisis. So we need to be aware of what we're looking for. We need to be comfortable with having those conversations with one another and promoting the idea that help exists.

I just want—can you just rephrase one more time the question that you had? I'm sorry, I just lost my train of thought.

Ms. SPEIER. It was about the stigma associated with——

Ms. STUMPF PATTON. OK. And so, by doing so—that's the point—by doing so, we therefore are already reducing some of the stigma around help-seeking that is so critical.

I know for myself and countless survivors that we represent and work with at TAPS, that stigma is often one of the largest barriers when it comes to seeking care, of how that is going to impact one's career through, you know, advancements and promotions, how they might be considered and viewed among their counterparts.

I think ultimately what we need to do is, addressing the mental wellness here is just as critical as we would look at physical fit-

ness, which is—you know, we acknowledge that that is critical to being ready for operations. So when we look at that equally, that if somebody were suffering from any type of other medical injury or illness, we would treat that with emergency care, that when left unaddressed that could be——

Ms. SPEIER. Thank you, Doctor. I just want to get——

Ms. STUMPF PATTON. OK.

Ms. SPEIER [continuing]. Ms. Hundrup to be able to respond as well.

Ms. HUNDRUP. Thank you. I would just add very quickly that we have seen in our work as well as our research that stigma certainly is an issue, in terms of the concern about having career implications.

In terms of finding ways to overcome that, I think that, clearly, access, ready access, to mental healthcare is going to be very important. And we've seen anecdotally that even just doing things like allowing telehealth or allowing care that can be in a private setting—you know, we've heard that sometimes just going into the office, and they have to wear the uniform, and they're concerned about perhaps seeing others, that there might be perceptions of negativity there.

So I think we have to get creative in thinking about ready access to that mental healthcare and how to do that in a way that's comfortable and appropriate and, of course, of quality.

Ms. SPEIER. I totally concur.

I yield back.

Mr. LYNCH. Thank you.

The gentlelady yields back.

The chair now recognizes the gentleman from Louisiana, Mr. Higgins, for five minutes.

Mr. HIGGINS. Thank you, Mr. Chairman, for holding this hearing. And I thank my veteran brothers and sisters for being with us today.

We should discuss, as a committee, from our heart, exactly what is impacting our veterans across the country. I've buried many friends. You know, a lot of veterans move into police work. It's sort of a natural transition, especially if you have combat experience and, you know, you have certain skills that have been honed through the years in the military. It's a common thing, to find that your tactical police officers across the country are prior military. And a lot of cops commit suicide. When they do so, it's considered a veteran suicide, because a lot of the cops that commit suicide had been veterans.

So PTSD is a very real dynamic and in my own history. And my heart goes out to my brothers and sisters across the country and the world that suffer.

I think we have to be courageous as a committee and deal with a couple of things that we're facing right now that's going to exacerbate what we have already experienced as a Nation regarding PTSD within our veteran populations: the disgraceful retreat from Afghanistan, turning the Afghanistan theater over to the Taliban and arming them with scores of billions of dollars of American weapons systems, abandoning Americans and American allies.

You know, many of my friends that are veterans, you know, they're very discouraged about that. And this has injured them, I think, on a very deep level. They're asking why—you know, why did they risk their lives? Why were they maimed? Why were they left with the endless horrors and nightmares of war? This is a significant question.

And I'm going to turn the floor over to my veteran brother, Staff Sergeant Jones.

As a veteran of the war in Afghanistan, I'm going to give you the floor, sir. You have a couple of minutes. I ask you to just take a deep breath. I'm going to give you the remainder of my time so that you can—you just speak to America from your heart and reflect upon our retreat from Afghanistan and what impact you would feel as an Afghanistan veteran and how you think it would impact our veteran brothers and sisters across the country.

I give you the floor, good sir. And thank you for your service.

Staff Sergeant JONES. Yes, sir. Thank you.

I have to give an honest opinion on this. What happened in Afghanistan shook me. I've buried two dozen Marine EOD techs that come from the job that I came from in the last six or seven years—I guess over the last 10 or 11 years, longer than I remember, I guess—and each one of them hurt. Afghanistan was the first time that servicemembers I didn't know hurt almost as bad. Maybe it's just age and maturity, or maybe it was the, obviously, looking on and seeing, man, this didn't have to happen.

But I'll be honest, it was a straw on the camel's back. It was not a definitive moment for me. As someone who lost my legs above the knee and several dozen friends in 2010, I've seen this coming for a long time, quite honestly. I've seen four, if not five, administrations in a row play the partisan politics of war, rather than the strategic advantage of what we should or shouldn't do. It's my belief we haven't spent 20 years fighting a war; we've spent 10 two-year wars. Because, for some reason, Presidential elections and midterms really shape how, in my opinion, Members of Congress view the war and want to talk about it publicly.

And that's not to point a finger. It's just to say, if that's the only time it's being talked about, then I'm led to believe that's the only time it matters. And then our defense strategy is playing second fiddle to, you know, the age-old questions of will this get me reelected or will it stop me from getting reelected.

That's the frustrated Marine in me talking. I don't mean any disrespect to anyone. That's the feeling I have as a private citizen and an American who sits and watches—you know, I was a part of the push in al Anbar, I was a part of the push in Helmand. I fought in two surges under President Obama and felt like we were incredibly successful for both of them—and I guess the al Anbar surge actually was in 2008, so President Bush and President Obama—and then immediately watched both of those successes essentially be squandered.

When I got to Afghanistan in 2010, President Obama had already told the world that we were going to retreat less than a year later, in 2011. And so we understood in that moment that the Taliban would bide their time and focus on a few key areas, one of them which I was fighting in, so fighting got much worse for me.

I don't believe, you know, that's a partisan thing because I saw two Presidents do it. I saw President Trump announce a retreat from Afghanistan, and then I saw President Biden do it.

And so I think that veterans sitting at home are just left with not a lot of faith in the leadership, both from our military and our government, when it comes to fulfilling their side of this commitment, which is, if I go die or my brother dies, we're going to make sure it's for a purpose. And so that's the tough part.

I understand in my personal life and in the connections and conversations I have that there's more at play. But if you ask me, what are veterans feeling at home, a lot of veterans are sitting there going, "Yes, well, that's about what I expected to happen, because that's about how it's been going for a while." And that was kind of the sentiment in the veteran community.

Mr. HIGGINS. Thank you for sharing your heart. And God bless you, brother. You know, you are free to speak your mind in my office at any time.

Across the aisle, in my colleagues' offices, I know their hearts are poured out and dedicated to our veterans. This is not a Republican or a Democrat concern.

And I very much thank you, Mr. Chairman and Ranking Member, for holding this hearing today. And I look forward to working with my colleagues on both sides of the aisle to seek resolution for our veteran brothers and sisters.

Mr. Chairman, I yield.

Mr. LYNCH. The gentleman yields.

The chair now recognizes the full committee chairwoman, the gentlelady from New York, Mrs. Maloney, for five minutes.

Mrs. MALONEY. I thank you, Mr. Chairman.

As they leave the structured life of the military, servicemembers and their families can lose a sense of purpose and belonging as well as the tight-knit support system that they had with their brothers and sisters in uniform. The transition period from Active Duty to veteran status can be one of the most vulnerable times for servicemembers. Some studies have found that the risk of suicide is two to three times higher for transitioning servicemembers.

While the Department of Defense and VA have programs for servicemembers, too often these efforts fail to catch all of the servicemembers that are in need of the mental healthcare. The IG explained that these assessments are increasing over time. Very few have this help that they need.

And I just would like to ask General Hammond, why is it important for transitioning servicemembers to have access to continuous mental healthcare?

General HAMMOND. Thank you, ma'am. That's a great question. And, really, I believe the issue is, that is when they're at their most vulnerable.

These men and women have served on high-performing teams, in their minds, in some cases, saving the world, right? That's what we tell them, that they're there, they have a sense of duty and purpose. And when this gets taken away from them, that identity, they hurt, and then they're in this state of flux.

And when they leave the military and then suddenly they go from project-managing million-dollar construction projects with lit-

tle or no training, serving as the equivalent to the Secret Service guard for the President of Iraq or Afghanistan, they have all of these important positions and they're on this amazing high-performing team, and then suddenly they're unemployed, underemployed, living back with their parents, feeling not so great, then they start to have some of these mental health issues start to weigh on them.

And if they don't receive the care they need at that moment, they can start going down the drain, literally. They'll start putting on weight, they'll start self-medicating, and then these problems get worse and worse. And then they kind of retract further, and we see them withdraw from their friends and their family, and the situation gets worse. And when they lose all hope, that's that pivotal moment when they make that really horrible decision.

And so that transition to get them moved from the military experience, that life, into a purpose-driven life, dealing with their medical and mental health issues, and then embracing some type of community or having a community embrace them, those three elements are key to a successful transition.

Mrs. MALONEY. Well, the IG also found that DOD was failing to provide uninterrupted care in part because it has, quote, "inconsistent processes for and oversight of suicide risk screening and mental health assessments for transitioning servicemembers."

Ms. Hundrup, I know you can't speak for the DOD IG, but why is it important for the Defense Department and the VA to have consistent procedures and up-to-date policies for providing mental healthcare to transitioning servicemembers?

Ms. HUNDRUP. Yes, thank you. I think, certainly, the IG's recent findings shed light and bring, certainly, the troubling findings to start a clear demonstration of the need for consistent execution. I think, you know, they highlight what is called for, in terms of mental health screenings for all transitioning servicemembers as well as a warm hand-off.

But what they don't have is a way to consistently execute that, so—which, you know, I think the IG's findings would show that what they do have captures, certainly, some segments of the population in the military, which is very important. But, for example, not having a consistent screening process, their current physical separation exam does not include mental health screenings.

Now, they have indicated that they're developing a new one that will hopefully address this. But then they need to have consistent execution so that they're able to reach all military members.

Mrs. MALONEY. Is this an area GAO may be interested in examining further for the Oversight Committee?

Ms. HUNDRUP. We would certainly be happy to work with your staff regarding potential work. As noted, of course, the transition is such a key time, and we do think, you know, continued collaboration and really examining how DOD and VA are doing that is certainly an area we would be happy to work with you on. Thank you.

Mrs. MALONEY. And, in closing, the men and women who serve in our Armed Forces have the—when they leave the military, their battles with their, what I would call, invisible wounds of war do not end. So it is our duty to ensure they continue receiving the care

that they need and don't be forgotten, that they don't fall through the cracks.

My time has expired, and I yield back. And thank you, Chairman, for this important hearing and focusing on this important need. Thank you.

Mr. LYNCH. Thank you, Madam Chair.

The gentlelady yields back.

I did see Mr. Welch earlier, but he is not visible on the screen, so we are going to ask the gentleman from Georgia—Mr. Johnson, you are now recognized for five minutes. Welcome.

[No response.]

Mr. LYNCH. I now see Mr. Welch.

Mr. Welch, you're recognized for five minutes.

Mr. WELCH. Thank you, Mr. Chairman. I really appreciate this.

You know, I want to ask General Hammond: Your description of what the transition is was so compelling. You know, it's these young people, a lot of Vermonters, that had no idea how smart they were, they had no idea how qualified they were, they had no idea how brave they were, and suddenly they're, as you say, running these extraordinarily important operations, where the life and death of their comrades depends on them doing their job well.

And you used that term, "purpose-driven." And I'll ask your reaction on this, but whenever I talk to folks who have served—and I have not; I'm grateful to all of you have—what they say they're fighting for is oftentimes to save the person next to them. And they have this bond that only they can have. And then they come back, you know, to Winooski, Vermont, or to Brattleboro, Vermont, and all of us who've been living our daily lives have no idea of what it is they've been through.

And I just wonder if you could comment on, what do you think some of us in the community can do to just acknowledge this extraordinary transition that folks have to undergo when they get back?

General HAMMOND. Thank you, sir. And that's a big issue. As my colleagues at Mass General point out, in general, people are mammals, and mammals are pack animals, and we do find comfort when we're with our tribe, as they call it. And Sebastian Junger wrote an amazing book called "Tribe" that highlights the importance of that connectivity. And when that gets broken, it causes significant impact for our warriors.

And, as we look at this, we've seen communities where our veterans and warriors are embraced. Any opportunity that we can pull folks together is a benefit. So, at Home Base, one of things we do are these things called Adventure Series events, where all sorts of people—and we have ski trips up in Vermont, New Hampshire, skating on Frog Pond in Boston. Whatever it is, it's designed to pull people together and——

Mr. WELCH. That's great.

General HAMMOND [continuing]. Allow them to engage with people with a shared experience.

Mr. WELCH. So the connectivity is really essential, to reestablish it. Well, thank you so much.

And, Dr. Stumpf Patton, your written testimony was quite eloquent, and I want to thank you for that. But one of the things you

said is you felt completely alone, with no direction on surviving your devastating loss.

Can you discuss some of the reasons you found it difficult to find help after and support after the terrible loss of your husband?

Ms. STUMPF PATTON. Thank you, sir, for asking that question.

I will say, as a reminder, my loss was quite—you know, quite a few years ago, in 1994. And, at that point, there were no resources. There was no crisis line. There were no suicide prevention coordinators within the VA. This was not being addressed. It was something that was really kind of swept under the carpet and surrounded by a lot of stigma.

And so it was very isolating. I was very alone. That was something that personally compelled me to try and find that support and, eventually, to try to be a part of that support.

I know what I instinctively needed for myself and my family. I didn't know what it was called at the time. And what that was is "postvention," the care and the services and the support that we give to those who have been impacted by a suicide loss. And that is our primary focus and what we do at TAPS, in providing that postvention care.

This is critical when we are addressing suicide prevention because survivors are a very high-risk population, given the graphic and oftentimes traumatic loss that they have endured by suicide loss.

So, you know, when we're talking about suicide prevention, that postvention aspect is something that we must look at in how we treat a suicide when it has occurred, how we talk about it, how we support all of those who have been impacted, including comrades and brothers and sisters in arms. They are survivors. They have lost their fellow servicemembers and veterans to suicide. And I believe that is a missing piece that we are not looking at, around the grief and loss issues of our servicemembers and veterans who are struggling with those losses, specifically if they have lost somebody to suicide, and could be vulnerable themselves.

Mr. WELCH. Thank you very much. Understood. Thank you very, very much.

I yield back.

Mr. DESAULNIER. [Presiding.] Thank you, Mr. Welch.

We now recognize Mr. Johnson from Colorado for five minutes—Georgia.

Mr. Johnson, the floor is yours.

Mr. JOHNSON. Oh, do you mean Mr. Johnson from Georgia?

Mr. DESAULNIER. Yes. It's yours.

Mr. JOHNSON. OK. Thank you.

Mr. DESAULNIER. Sorry about that.

Mr. JOHNSON. Thank you. That's quite OK.

Almost 10 years ago, I, along with other Members of Congress, sent a letter to the Senate and House Armed Services Committees to ensure that the high rate of suicides among servicemembers was addressed in the NDAA.

Despite the attention and actions of Congress, the VA, and the private sector, servicemember suicides continue to increase. Almost three times as many Active Duty servicemembers and veterans of

the global war on terror have died by suicide than those killed in military operations during the same period.

Dr. Stumpf Patton, thank you for your work in ensuring that the families of servicemembers who fall victim to suicide are not left behind.

To survive a loved one's suicide is a unique grieving process. In what ways can Congress provide families with more resources that they could use in the aftermath of a loved one's suicide?

Ms. STUMPF PATTON. Thank you so much for pointing that out, that important question.

What we do at TAPS in providing the postvention support for survivors is critical at saving lives for this high-risk population. I think supporting one another, supporting nonprofits and other organizations and agencies who tirelessly do this work behind the scenes to be able to sustain the difficult work that we do. Survivors tell us what they need.

We also know that, when they are connected to care, when they are connected to peer support, not only is it lifesaving, but this is instrumental in stabilizing them after their grief and getting them the resources that they need so that they can find a healthy journey and readjusting to their life through the grief of their loved one.

I would also say, one of the most critical things that we need to address is that, in addition to the grief of loss these family members and loved ones often are enduring, there's an added element of trauma that is oftentimes overlooked. And so survivors and those who have been impacted and coping with a loss by suicide are oftentimes either coping with symptoms of trauma or developing post-traumatic stress, which oftentimes is going to need additional treatment.

And TAPS is an honored partner to have worked with Home Base, where we have developed such a program so that the trauma piece is not being overlooked. And we know that to be lifesaving for our survivors who have been struggling with that.

Thank you.

Mr. JOHNSON. Thank you.

General Hammond, mental toughness is of utmost importance in the military, as detailed on every branch's website and in articles on military.com, which gives steps on how to improve mental toughness.

Can you talk about how the culture of mental toughness in the military and the stigma that accompanies mental health evaluation and treatment can discourage servicemembers and veterans from seeking mental health assistance during a crisis?

General HAMMOND. Yes. Thank you for that question.

I would tell you that their mental toughness and the resilience they buildup to be self-reliant problem-solvers that can play hurt, technically, is what saves them on the battlefields. And it's extremely important in that aspect. It's also the exact same issue that causes them the greatest amount of pain when they return home and they're suffering from these invisible wounds.

We'll be quick to point out that there's two types of injuries. You're either hurt or you're injured, when you're in the military, when you're on a mission. And if you're hurt, you suck it up, as

you mentioned, you push through it. If you're injured, you require a medevac.

And for the mental health injuries, because there's no physical aspect to it and everybody else seems to be continuing, it leaves people feeling "less than" if they need help. And that's the crux of the issue. Getting them to understand and admit that they've got an injury that you just can't see and they need clinical care is a long pole in the tent.

And through our work with our special operations team members, which are arguably some of the toughest people in the country, we've seen 200 warriors come through our ComBHaT Program, which is our Comprehensive Brain Health and Treatment Program. And, as we do our diagnostic evaluation, they're coming there primarily for brain injury issues and musculoskeletal injuries. Out of the 200, I would say 99 percent of them do not have PTSD, according to them in self-reporting, and almost 100 percent of them have it in their exfil report, where we give them their diagnosis.

And the interesting question is, "Well, I told you I don't have it," and the doctors will say, "Well, I didn't ask you this time, and if you trust my judgment on these other issues, you'll trust it on this." Their response is unbelievable: Immediately, they say, "All right, what do I do about it?" Because, deep down, they knew they had these injuries; they just don't want to say it out loud.

And, to your point, getting them to demonstrate the courage—and I can tell you from personal experience, the toughest step I took was walking into a clinic to get help. I would've rather went gone on another patrol in Fallujah before I did that. But based on the care and based on the impact, it enabled me to return back to Afghanistan healthy enough to do my duty.

Mr. JOHNSON. Well, thank you for your service.

And thank you, Mr. Chair, for holding this very important hearing. And, with that, I will yield back.

Mr. LYNCH. [Presiding.] The gentleman yields back.

The chair now recognizes the gentlelady from Florida, Ms. Wasserman Schultz, for five minutes.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

Mr. Chairman, I have the privilege—and I appreciate you holding this hearing today—I have the privilege of chairing the Military Construction, Veterans Affairs, and Related Agencies Appropriations Subcommittee. And that's the committee in the Congress that touches the lives of our servicemembers throughout their entire lifecycle. And it's the only committee that has that jurisdiction.

One of our top priorities as chair has been strengthening mental healthcare for our country's veterans and their families. For Fiscal Year 2022, our bill made significant targeted investments to improve veterans' mental health, including a record level of $599 million specifically for suicide prevention outreach programs, like supporting the Veterans Crisis Line, enhancing community-based efforts, and implementing proven clinical strategies.

With suicide rates among Active military and veteran communities at crisis levels, we'll continue to be devoted to funding programs and services that can intervene and save lives.

And I have a couple of questions focused on mental health and wanted to first start with General Hammond.

General Hammond, you have worked with both Active Duty servicemembers and veterans throughout your career. Would you agree that the military should train soldiers to strengthen their mental health and resilience in the same way that they train for physical strength and endurance?

General HAMMOND. I would agree with that 100 percent.

As we look at our physical health—when I came in the Army, we ran in boots, we didn't stretch, and we did all of these things that can hurt yourself. And somebody had the brains to stay: Stop doing that, stretch before you work out, and you will last longer, your knees will last longer, et cetera. Now, soldiers would never consider starting their physical training without all these stretching exercises, because it works.

We've done it with all these other things. There isn't a piece of equipment the military operates, whether it's our 40-year-old helicopters and tanks that work great because we have a great maintenance program—we do a pre-maintenance and post-maintenance on everything. But, when it comes to mental health, when we return from deployment, we'll get asked a question, "Do you have any mental health issues?", and if you raise your hand and say yes, you go on medical hold, which is a real disincentive for somebody who's been away from home for a year to do that.

Getting out in front of this and working—and I would tell you, the special operations community has embraced this, and they are working this mental-health-strengthening thing where they work on block breathing and all these issues to work on—stress reduction, anxiety reduction—which enables them to do their job much better. So preventive maintenance is really what it comes down to for good health and readiness, is the key.

Ms. WASSERMAN SCHULTZ. I couldn't agree more. And as a softball player, I can tell you, when I didn't stretch before a game, I pulled a hamstring, and it caused me problems for months. So it only stands to reason that we should be also making sure that we're focused on mental health just as much as physical strength and endurance.

Can you elaborate a little bit more on what types of programs and services we could implement in military units and at DOD and the VA to strengthen the mental health of our servicemembers and our veterans?

General HAMMOND. Yes, ma'am. I would say, I'd start off with that first tool I talked about, that team at Harvard I worked with, especially on the suicide prevention: the risk assessment. You know, right up front when they first join the military, determining who's at risk. And the researchers I talked to from Harvard explained to me that 90 percent of our suicides come from about a 30 percent high-risk group that they can identify using machine learning and AI. And so we can focus those deep, deep resources for folks that need that level of care for high-risk.

But the universal care that they have started in the comprehensive programs that the special operators use now ensure the readiness of these warriors. And if you look at their operation tempo over the past 20 years, especially the last 10, the operators we see have 15 to 20 combat deployments, which is remarkable. And to do that, they've got to manage that stress level. And when they don't

do that, we see the outcomes of the 20 a day and the 300-percent increase in operator suicide from 2017 to 2018.

Ms. WASSERMAN SCHULTZ. Thank you.

And talking about the much higher risk of our younger servicemembers, I want to just ask Dr. Stumpf Patton, why are our younger servicemembers and veterans among the highest risk for suicide, would you say?

Ms. STUMPF PATTON. Oh, gosh. You know, let me just respectfully say that, when we're speaking about suicide, when it's your loved one, it's an "n" of one, or a population of one. You know, every case is somewhat different.

Each age demographic is going to have, I think, its unique challenges and risk factors. Sometimes with younger servicemembers, they might not have the long-term experience, the life experiences, some of the wisdom. Maybe they have not developed some of the coping skills that maybe older servicemembers have. But, you know, other senior servicemembers could have other risk factors as well.

I mean, my husband's case, he was 24 years old at the time of his death. So he was a sergeant and kind of on the lower end of the spectrum, you know, beginning his career, about six years into it. He did have previous stressors in his life. He was a combat veteran from the Gulf War, went into a very highly stressful position as a drill instructor in the Marine Corps. We were a young military couple with a baby on the way. I thought, you know, we were working on our dreams, you know, had a house and a life together. Meanwhile, he was dealing with an extremely stressful job.

I don't think he had the coping skills at that point. He also didn't trust the system about asking for the care that he needed, as far as being honest about some of the struggles that he was dealing with. He was coping in very maladaptive ways and turning toward things, you know, such as alcohol, probably to self-medicate with some of those stressors of life and being, you know, a young person within a marriage and developing a family and combining with that trying to balance a military career.

But, ultimately, that really speaks to suicide, again, as a very complex phenomenon that has multiple factors that can contribute to that, which ultimately can kind of vary and be very unique in a case-by-case basis.

Ms. WASSERMAN SCHULTZ. Thank you. And I'm so sorry for your loss.

And, Mr. Chairman, thank you again for allowing us the opportunity to really dive deeply into this multidimensional, multifaceted problem of suicide and how we can prevent it.

I yield back the balance of my time.

Mr. LYNCH. I thank the gentlelady. And I thank her for her work on this issue as well.

The chair now recognizes the gentleman from California by way of Chelmsford, Massachusetts. You're now recognized for five minutes.

Mr. DESAULNIER. Yes, I'm a proud native of the great Commonwealth of Massachusetts, Mr. Chairman. I want to thank you, and I do want to thank the ranking member, as well, and the panelists.

I am fortunate to chair the subcommittee of Education and Labor called "HELP"—Health, Employment, Labor, and Pensions. And we've had really wonderful discussions about behavioral health, stress, depression, and suicide that have been bipartisan, "wonderful" in the sense that all of us, Republicans and Democrats, are focused, I think, very appropriately on the extraordinary discovery that we're living in about neuroscience, how our brain works and how we struggle with that.

And as a survivor of suicide, I have strong feelings about this. Almost 32 years ago in April, my dad, who was a Marine combat veteran in World War II, took his life. He's buried in Arlington. I have been in therapy since then, and I came to accepting that and embracing the humanity of it without being self-indulgent, I think.

And when my story got told by accident to my constituents, I found—first, I thought, in horror, that—I was filled with shame and stigma. My dad, a proud Marine—if there was TiVo when he was alive, we would have watched "Flying Leathernecks" every day.

But dealing with that stigma and shame. And I'm so grateful that, in my lifetime, we've seen this opening up, that this is part of humanity. And the way we avoid it is not to try to repress it as a culture but to accept it, not that it has to happen, but we can address it.

So, Dr. Stumpf Patton, I wanted to ask you, in your experience both personally and professionally, and understanding, to some degree, the grieving process, although my dad was 68—so, as painful as that has been, I can't imagine losing one of my sons to this—how do we deal with the generational and family support, now that we can identify these things, where we change that and get people the support?

And I sense a real acceptance and joy in the fact that we are identifying these things. But when I talk to people at UCSF in the area that I represent, San Francisco, and their neuroscientists—all this discovery, but the deployment of that knowledge so we can avoid what happened to you, to my family, as soon as possible.

So there's this sort of dichotomy, as I look at this, as I'm really encouraged by the progress we've made, but a sense of urgency that if we could deploy this knowledge accurately and more quickly to family members, support groups like yours, get you the resources, we could save so many lives. And then we could break the generational inheritance that too often are mistakes for thousands of years we have inherited and passed on.

First, Doctor, and maybe the General could respond to that observation.

Ms. STUMPF PATTON. Thank you, sir, so much for acknowledging that. And I also honor the loss, and I commend you for speaking about that openly.

I think that, again, is a first step here in this conversation. When we share that, it opens up the dialog, which, therefore, reduces the stigma. And in cases with suicide, the silence that often surrounds the stigma is what prevents people from seeking the care. It's an obstacle, and, ultimately, it can be fatal.

And so talking about that really is the first step. Coming from an era, as you can understand, when it was not talked about, and

seeing this transpire and grow over the years, I was and still am an eternal optimist about the fact that we are in a new window of time, that this is on the forefront, that we are talking about it, that the military community is addressing it directly, that we are here today. For me, this is monumental, that we are sitting here and we are addressing this topic to save lives. It is possible.

And I think it's important that we send that message of hope, that this doesn't have to be inevitable. You know, people are not broken and beyond repair. The help exists. It works. And we can save lives in doing so.

I think when it comes to postvention, we know the sooner, the better. If we can get to people in the hours, days, and weeks, the sooner we can get to them after a suicide—and this speaks even specifically within a military unit. When we can stabilize that and address those issues, we know that drastically reduces the risks of those people who have been impacted by that suicide where they, therefore, could be vulnerable and at risk themselves.

It also sends the message that they are not alone, they do not have to go through this by themselves, which that, in itself, combats suicide because it reduces that isolation, and it promotes that sense of belongingness and connection that can save lives.

And I will turn it back to you.

General HAMMOND. I think one of the greatest challenges this generation has is the prevalence of veteran suicide, military suicide. I don't know a veteran of Iraq or Afghanistan that doesn't personally know someone who's taken their life, and usually it's two or three. And there's not another career path that anybody could make that claim on such a broad scale.

Our work with TAPS is some of the most meaningful work we do at Home Base. And we consider the primarily women, the spouses, that have come in and the parents to be some of the most injured people we deal with, far more than any Navy Seal or Green Beret. Many of the women that have come to us from TAPS have witnessed a suicide, and you can imagine what that's like, at the kitchen table, with your children present. And we've talked to them about the fact that children as young as eight years old are now demonstrating ideations because of the trauma they've been exposed to.

So, without treatment plans and programs for this, we're going to lose this next generation of folks because we can't intervene fast enough. And so we work very closely with TAPS to try and innovate and develop new types of programs, but the scale is not there yet to take care of everybody that needs it.

I think the normalization of this has been incredible over the last 20 years. Most combat vets I know, especially that were in line units, whether they're Marine regiments, infantry battalions, they now have these buddy systems on Facebook where they watch closely when somebody starts talking about something that's a trigger. And guys will get in a car and drive to a house, they'll drive three states over, to go intervene if they don't pick up the phone.

And so there's no stigma; it's anger about, "Don't you do it." And we do see that effect that we spoke about a moment ago, that it can be contagious. You know, we see it in a unit where there's not a postvention, and then suddenly there's two or three more. And,

frankly, I've lost more soldiers to suicide than I did in three combat commands. So it is prevalent, and it can cascade.

Mr. DESAULNIER. Thank you, Mr. Chairman.

Thank you. This is really terrific. I think I see real hope here. And I see an opportunity that I hear from my colleagues on both sides that we can be really supportive and transformative so that other families won't have to go through this.

Thank you so much.

Mr. LYNCH. The gentleman yields back. I thank him for his participation as well.

Before we close, I would like to offer to the ranking member an opportunity if he had any closing thoughts.

Mr. GROTHMAN. Could I ask one more question of Mr. Jones?

Mr. LYNCH. Please.

Mr. GROTHMAN. Mr. Jones, are you still on here?

Staff Sergeant JONES. Yes.

Mr. GROTHMAN. OK. You gave us an anecdote before concerning an over-prescription of painkillers. And I think we've made a lot of progress on that in the civilian sector.

Do you feel there are problems there in the military, where they maybe haven't caught up on the amount of painkillers you could prescribe? Like I said, I believe in the last four or five years we've made so much progress. But could you comment on where you think the military is on that?

Staff Sergeant JONES. My friend—first of all, real quick, multiple members of this committee have asked about stigma, and I just wanted to, if I could, touch on that real quickly.

Mr. GROTHMAN. Sure.

Staff Sergeant JONES. As the one person on this panel that I know—the General may have, but I was a troop, a low-ranking enlisted—stigma, that's a cultural problem, not an administrative problem per se. And what I mean by that is, you're not going to solve that problem with a PowerPoint and a policy. You're going to solve that problem by going where you make leaders and engraining it into leaders to treat their troops in a way that they can communicate with their troops about problems.

It's a one-on-one conversation, not a classroom conversation. That removes that stigma and gives servicemembers the opportunity to be honest about what they're going through with people around them.

It's cultural. And it's the hard way, not the easy way. It's not the "let's write a policy and make a PowerPoint that everyone gets once a year." It's a "when we make leaders, we instruct those leaders on how to communicate with their troops" and do things, just like the General was saying, where we change the perspective from "I can play hurt" to "I can play a heck of a lot better fully healthy."

And back to your question about painkillers, the anecdote I gave, the friend I had was being prescribed by the VA. I can't really speak in this moment how the DOD prescribes painkillers because I didn't even consider it an option when I was in the military. I didn't even know that was even something I could get.

But with the VA, the problem there that my friend had, and it still persists, is the lack of communication between a physician in

the VA assigned to mental health and the primary care manager for that servicemember.

I belong to a VA in Atlanta. I've had so many different primary care physicians at the VA that I couldn't name them. I finally found one that I trusted and believed in, and when I went in for a monthly checkup last month, I was notified she's no longer there. And so, all that trust I built with that physician, she's not there anymore. If I went to a physician out in town, they've been there for 30 years.

And so that type of trust, communication, and that primary care physician understanding everything that veteran is dealing with, that's the problem, because that primary care physician would be in charge of issuing me pain medication, and that's the person that would know I'm also seeking mental health or dealing with mental health issues.

I went to the VA when I first moved to Georgia, and the doctor literally sat there at the computer and asked me these questions like, "Have you thought about killing yourself?" He never even looked away from the screen or introduced himself to me. I don't know anyone in this world that feels comfortable revealing that information to someone who has yet to introduce themselves or even look them in the eye.

These are cultural problems. They're not something you just simply solve with a change in policy. It's a full education and cultural shift.

And that's why I'm such an advocate for what is usually a much more intimate interaction with nonprofit organizations and private healthcare providers that want to work in concert with government entities like the VA, not aside from. They're being forced to work on their own. They want to work in concert with. And I think that it's the responsibility of you all to help make that happen.

Mr. GROTHMAN. Thank you.

Mr. LYNCH. The gentleman yields back.

I just have a couple of quick questions, and one of them actually fits nicely—it's a nice segue from the Sergeant's comments. And that is, Ms. Hundrup, the Government Accountability Office, have we looked at that issue where we try to encourage collaboration between the VA, let's say, and some of the community organizations, whether it's the Home Base program or TAPS or even—in my district, we have a lot of community health centers that are aware of who the people are. And so it might serve us to, you know, make that connection.

Has the GAO looked at any of that?

Ms. HUNDRUP. I will just mention, we do have current work underway that's looking at VA suicide prevention and mental health agreements. That is something that's currently ongoing that we do anticipate issuing in early 2022.

But I do think, given the complexity of the issue and the fact that there's not a single solution or a single entity, that looking at the partnerships and the possibility for VA and DOD to partner further with states, locals, the important folks at the table today, and the nonprofits, the community, it is truly not one single entity that is going to solve this.

So I think that is an area that, you know, understanding where there could be some synergies and additional attention would certainly be warranted.

Mr. LYNCH. That's great. Thank you. I look forward to following up on that.

The other question I had was really a followup to Ms. Speier's question. I notice she didn't ask you this, but, you know, as the chair of this committee and as ranking member in times when my Republican colleagues were in the chair, I've had the luck, I guess, to visit Iraq and Afghanistan between 30 and 40 times and deal with some of the issues that some of our men and women in uniform are dealing with.

And I don't know, it may be anecdotal, but I had always had a custom of asking every servicemember that I got to sit with—and there were thousands—I said, how many tours have you done so far?

And I remember, one of my most recent visits was during the withdrawal process in Camp Leatherneck in Afghanistan. And I was with a small group of about—it was a rifle company, maybe 20 or 30 young Marines. And I asked them, how many here are on your first tour? And maybe two or three hands went up. And then, how many are on your second tour, how many are—I got all the way up to seven tours of duties before I ran out of Marines, right?

And it just seems to me that that OPTEMPO, that wear-and-tear—do we have any data? Have we looked at that? And I've asked others in the past if we've got data to show any correlation between the frequency that we ask these men and women to serve, pulling them away from their families—and you can only imagine the conversation telling your spouse that you're going on your third deployment or fourth deployment and what that means at home and the sacrifice that your family embraces.

So do we have any data to reflect a correlation or, you know, what the connection might be there?

Ms. HUNDRUP. We certainly know that's a risk factor, one of many risk factors. I am not aware of specific data on that, but that's a great question. And that could be something to target to our colleagues at DOD and VA, to see what information they have. And if that is a gap, that is perhaps an important area to be looking at.

Mr. LYNCH. OK. Thank you.

Well, in closing, to our Active military and veterans, as the ranking member said at the outset, let me say as well, you are not alone. If you're struggling or need help, please reach out. If you or someone you know is experiencing a mental health crisis or contemplating suicide, the National Suicide Prevention Lifeline is available 24 hours a day, seven days a week. At any time you can call 1-800-274-8255 and dial 1 or text 838255. Again, that number is 1-800-274-8255 and then dial 1, or you can text 838255.

I want to thank all of our witnesses for their remarks today. And we are grateful for your continued service.

I want to commend my colleagues for participating in this important conversation, both Republicans and Democrats.

And, with that, without objection, all members will have five legislative days within which to submit additional written questions

for the witnesses to the chair, which will be forwarded to the witnesses for their response.

And I ask our witnesses to please respond as promptly as you are able.

Mr. LYNCH. This hearing is now adjourned. Thank you.

[Whereupon, at 11:55 a.m., the subcommittee was adjourned.]