

**HEARING TO RECEIVE TESTIMONY ON THE
PROGRESS IN PREVENTING MILITARY SUI-
CIDES AND CHALLENGES IN DETECTION
AND CARE OF THE INVISIBLE WOUNDS OF
WAR**

TUESDAY, JUNE 22, 2010

U.S. SENATE,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The committee met, pursuant to notice, at 9:35 a.m. in room SD-G50, Dirksen Senate Office Building, Senator Carl Levin (chairman) presiding.

Committee members present: Senators Levin, Lieberman, Akaka, Webb, McCaskill, Udall, Hagan, Begich, Burris, McCain, Inhofe, Thune, and Collins.

Committee staff members present: Richard D. DeBobes, staff director; and Leah C. Brewer, nominations and hearings clerk.

Majority staff members present: Gabriella Eisen, counsel; Gerald J. Leeling, counsel; and Jason W. Maroney, counsel.

Minority staff members present: Michael V. Kostiw, professional staff member; Diana G. Tabler, professional staff member; and Richard F. Walsh, minority counsel.

Staff assistants present: Jennifer R. Knowles, Hannah I. Lloyd, and Breon N. Wells.

Committee members' assistants present: James Tuite, assistant to Senator Byrd; Nick Ikeda, assistant to Senator Akaka; Greta Lundberg, assistant to Senator Bill Nelson; Gordon I. Peterson, assistant to Senator Webb; Tressa Guenov, assistant to Senator McCaskill; Roger Pena, assistant to Senator Hagan; Lindsay Kavanaugh, assistant to Senator Begich; Amanda Fox, assistant to Senator Burris; Anthony J. Lazarski, assistant to Senator Inhofe; T. Finch Fulton and Lenwood Landrum, assistants to Senator Sessions; Richard Perry, assistant to Senator Graham; and Ryan Kaldahl, assistant to Senator Collins.

OPENING STATEMENT OF SENATOR CARL LEVIN, CHAIRMAN

Chairman LEVIN. Good morning, everybody.

The committee meets today to receive testimony on the status of our efforts to prevent military suicides and the challenges in detection, treatment, and management of the so-called “invisible wounds of war,” which we consider to include traumatic brain injury, and concussive events, post-traumatic stress, and other combat-related psychological health concerns.

A hearing on military suicides was requested by Senator Inhofe several weeks ago, and we all appreciate that request. Due to our committee markup schedule, we were unable to schedule a hearing until this week. Originally, this hearing was meant to focus on suicide—excuse me—on service suicide prevention policies and programs. But, given the recent disconcerting reports alleging poor diagnosis and treatment of servicemembers suffering from traumatic brain injury and post-traumatic stress, I felt it important to broaden the scope of our discussion today to include those topics as well, especially given the fact that they can often occur concurrently, making diagnosis of any or all of these illnesses difficult.

The increase in suicides by military personnel in the last few years is alarming. In 2007, 115 Army soldiers committed suicide. In 2008, the number increased to 140, and to 162 in 2009. Similarly, 33 marines committed suicide in 2007, 42 in 2008, and 52 in 2009. I understand there are a number of additional cases where the Armed Forces medical examiner has not yet concluded whether the deaths are by suicide. So, the 2009 numbers will likely be even higher.

These increases indicate that, despite the Services' efforts, there is still much work to be done. We must improve our suicide prevention efforts to reverse the number of servicemembers taking their own lives.

I am greatly concerned about the increasing number of troops returning from combat with post-traumatic stress and traumatic brain injuries, and the number of those troops who may have experienced concussive injuries that were never diagnosed.

Studies indicate that mild traumatic brain injury, or concussion, is associated with PTSD, depression, and anxiety. These conditions, in turn, may contribute to the increase in the number of suicides.

One key to suicide prevention is to make greater efforts to end the stigma that too many perceive attaches when they receive mental health care. Another key, of course, is the proper and timely diagnosis and treatment of traumatic brain injury and post-traumatic stress, and increasing awareness of, and access to, mental healthcare resources, as well as leadership support for those seeking such care.

We hope to hear from our witnesses today the approach that each service and the Department of Veterans Affairs is taking to help detect, treat, and manage psychological health problems, to include post-traumatic stress and traumatic brain injury.

The numbers of suicides have increased in every service, but significantly more so in the Army and Marine Corps, the two services most heavily engaged in ground combat in Iraq and Afghanistan. Congress has recognized the strain on these ground forces, and has, over the past several years, authorized significant increases in the active Duty end strengths for the Army and Marine Corps. It is our intent that these increases will help to relieve the stress on those forces, but we also have to make sure that we provide all the assistance that our troops need to cope with the stress that they are experiencing.

The professionals tell us that common issues leading to suicide include relationship problems, financial problems, and legal problems, as well as mental health issues. And I know that each of the

services, as well as the VA, have programs to address those as part of the suicide prevention efforts. Undoubtedly, deployments and lack of dwell time have contributed to these underlying problems that are linked with suicides.

The Army is working with the National Institute of Mental Health on a 5-year longitudinal study to help identify and develop intervention and mitigation strategies to help decrease the number of suicides in the Army. While this is an important effort, we cannot wait for the full 5 years to occur for these results. We must identify actions, and take them now, to reduce suicides.

General Chiarelli, we look forward to hearing about interim findings from the study, and how the Army might use those findings now to better target suicide prevention efforts. We must learn more about traumatic brain injury and concussive events, and their relationship to post-traumatic stress and suicide. Unfortunately, these brain injuries remain relatively unknown territory in both the military and civilian medical environments.

We look forward to learning more about the policies and programs each service has in place to handle incidences of traumatic brain injury and concussive events, both in theater and at home. We also look forward to learning what policies, programs, and initiatives each of the services and the VA has implemented and identified to ensure that our servicemembers, in both the active Duty and Reserve components, military veterans, and their families, receive all of the support that we can provide, and that our All-Volunteer Force can continue to perform its mission with the health and other services that they need and deserve.

I'm pleased to welcome our witnesses. We have with us General Peter Chiarelli, Vice Chief of Staff for the U.S. Army; Admiral Greenert, the Vice Chief of Naval Operations of the U.S. Navy; General Amos—General James Amos, Assistant Commandant of the U.S. Marine Corps; General Carrol Chandler, Vice Chief of Staff of the U.S. Air Force; and Dr. Robert Jesse, the acting Principal Deputy Under Secretary for Health, for the Veterans Health Administration of the Department of Veterans Affairs.

General Amos, since Secretary Gates has just announced his recommendation to the President to nominate you to be the next Commandant of the Marine Corps, I know we all offer our congratulations and great hopes for you in the future.

Senator McCain.

STATEMENT OF SENATOR JOHN MCCAIN

Senator MCCAIN. Thank you, Mr. Chairman.

And let me thank our witnesses for joining us today.

I'd like to also acknowledge Senator Inhofe, who initiated a request in April for a full committee hearing on the tragic and important issue of suicide in our military. And I'm very pleased—and thank you for your initiative, Senator Inhofe—I'm pleased that we've got—having this hearing.

It's our privilege to serve the distinguished men and women of our Armed Forces, who, even after more than 9 years of war, love their country and risk everything to defend her. We have greatest admiration and appreciation for them and for their families. And we'll always honor their courage and sacrifice.

The burdens of our missions in Iraq and Afghanistan are tremendous, and so are the consequences for those who serve. Many of our servicemembers have answered their country's call, with multiple deployments to combat and little time for rest and recovery at home.

The enemy's signature weapon, the improvised explosive device, causes multiple injuries to parts of the body and brain. And, as is the case with every war, many of the deepest wounds are those that wrack the minds and souls of our citizen soldiers, wounds that continue to plague them long after they've returned home from the field of battle.

The Department of Defense has documented nearly 2,000 sacrifice—suicides from 2001 to 2009. And today the Services report more than 140 during 2010.

Although the Air Force and Navy have previously experienced rates of suicide higher than those reported today, rates for the Army and Marine Corps are at historic high levels. These are casualties that our Nation cannot accept and that our armed services must work to prevent, both among troops who have deployed and those who have not. We must erase cultural barriers and attitudes from peers and leaders that may cause soldiers who need care to turn away from it. And we must conquer any bureaucracy that stands in the way of compassionate care for a man or woman who seeks it.

Since the attacks of September 11th, we have devoted billions of dollars to improving care, for wounded and ill servicemembers and their families, provided not just by the Defense Department and Veterans Administration alone, but by many agencies of government and the private sector.

One important example is the National Suicide Prevention Lifeline. Crisis counselors respond to hundreds of calls from current and former serving members of the military every day. As a Nation, we can be proud of these efforts, but not yet content with their results. Teaching our servicemembers and their families to navigate complex pathways to care is necessary, but leading them there is essential. For, as in all military campaigns, the quality of leadership will determine our success or failure.

Several of our witnesses report that military servicemembers continue to distrust informing their chain of command that they have a brain injury or that they're experiencing stress or considering harm to themselves and others, for fear of bringing a sense of shame to themselves and their unit. This is unacceptable. There's no shame in admitting that you are struggling with the hidden wounds of war, for those wounds are every bit as real as those that are visible on the surface.

The services must increase focus on transforming the culture of leadership, and must train more leaders to understand that emotional and physical health are critical factors in military readiness, and hold them accountable if they fail.

Americans expect that high quality health and mental health care, matched by compassionate involvement of military leaders, can and will make a difference that is capable of saving lives that would be lost to suicide. To meet this rightfully high expectation, leaders at every level must exercise their sacred obligation to take

responsibility for their subordinates, know about their lives and families, have conversations with them, and listen to their concerns. These powerful human interactions, which are the essential character of the core military values of trust and cohesion, can save lives. Our servicemen and -women and their families deserve nothing less.

I thank you, and I look forward to hearing the testimony of our witnesses.

[The prepared statement of Senator McCain follows:]

[COMMITTEE INSERT]

Chairman LEVIN. Thank you very much, Senator McCain.

And we'll start with General Chiarelli, and we'll just go right down the table line.

General Chiarelli.

**STATEMENT OF GEN PETER W. CHIARELLI, USA, VICE CHIEF
OF STAFF, U.S. ARMY**

General CHIARELLI. Chairman Levin, Senator McCain, distinguished members of the committee, I thank you for the opportunity to appear before you today to provide a status of the Army's ongoing efforts to reduce the number of suicides across our force, and also detect and care for soldiers suffering from post-traumatic stress, traumatic brain injury, and other behavioral health issues.

I've submitted a statement for the record, and I look forward to answering your questions at the conclusion of our opening remarks.

As you are all aware, it remains a very busy time for our Nation's military. We're in the ninth year of the war, being fought in two separate theaters. The pace of operations is exceedingly high, and will likely remain so for the foreseeable future.

I'm proud to report that the men and women serving in our Army today are doing an absolutely outstanding job. They are well trained, highly motivated, and deeply patriotic. Our Nation has asked a great deal of them and of their families, and they've exceeded expectations by a long shot.

However, the prolonged demand continues to put a significant strain on our force. One of the symptoms of this, albeit the most severe, is the historically high number of suicides we've experienced in recent years. Fortunately, we've seen a fairly significant reduction in suicides among Active Duty soldiers this year, as compared to last year. However, we've seen an unexpected increase in suicides among our Reserve-component soldiers not on Active Duty—in particular, the Army National Guard.

Needless to say, the loss of any soldier, Army civilian, or family member to suicide is tragic and unacceptable. Each of these suicides represents an individual and a family that has suffered an irreparable loss. Over the past 12 months, we've learned a great deal about suicides. For example, we know—now know that soldiers with one or no deployments represent 79 percent of all suicides. First-termers represent 60 percent of all suicides.

I've worked closely with my colleagues in the—from the Navy and Air Force, and particularly with my good friend Jim Amos. Our Army and Marine Corps ground forces share a similar mission, and we're working together on many of the same issues.

You have my word that we will continue to work diligently to learn even more, in an effort to further reduce suicides in our force.

In the meantime, we've learned a tremendous amount about the broader challenge of behavioral health issues affecting many of our soldiers, Army civilians, and family members. After 8-plus years of war and multiple deployments, many are suffering from depression, anxiety, traumatic brain injury, and post-traumatic stress, often referred to as the "invisible wounds of war." These and other highly complex injuries and conditions involving the brain pose unique challenges, especially as compared to easily detectable wounds, such as an amputation or a burn. In particular, the comorbidity of symptoms can make diagnosis especially difficult, in many cases, a fact not well understood or appreciated by many.

The reality is, the study of the brain is an emerging science, and there is still much to be learned. But, we're making progress. Over the past 12 months, the Army's commitment to help promotion, risk reduction, and suicide prevention has changed Army policy, structure, and processes. We have realigned garrison programs, increased care provider services, refocused deployment and redeployment integration, and enhanced treatment of PTS and TBI, and promoted tele-behavioral medicine.

Our success notwithstanding, we still have much more to do. We face an Army-wide problem that can only be solved by the coordinated efforts of our commanders, leaders, soldiers, program managers, and health providers.

This is a holistic problem, with holistic solutions, and that is how we're approaching it. We remain focused on investigating ways to promote resiliency, reduce stressors caused by a variety of factors, improve leaders' and soldiers' ability and willingness to identify when they or their buddies need help, and be able and willing to take advantage of the resources and support that are available to them.

I can assure the esteemed members of the committee there is no greater priority for me and the other senior leaders of the United States Army than the safety and well-being of our soldiers. The men and women who wear the uniform of our Nation are the best in the world. And we owe them and their families a tremendous debt of gratitude for their service and many sacrifices.

Mr. Chairman, Senator McCain, members of the committee, I thank you for your continued and generous support and demonstrated commitment to the outstanding men and women of the United States Army and their families. I look forward to your questions.

[The prepared statement of General Chiarelli follows:]

Chairman LEVIN. Thank you very much, General.
Admiral Greenert.

**STATEMENT OF ADM JONATHAN W. GREENERT, USN, VICE
CHIEF OF NAVAL OPERATIONS, U.S. NAVY**

Admiral GREENERT. Thank you, sir.

Chairman Levin, Senator McCain, and distinguished members of this committee, thank you for the opportunity to testify about the ongoing efforts to prevent suicides in our Navy and to discuss what

have been referred to as the “invisible wounds of war”—namely, post-traumatic stress and traumatic brain injury.

Each suicide is a tragic loss that can destroy families, devastate a community, and impact unit cohesiveness and morale. While the contributing factors of suicide are unique to each person, a common thread is a personal perceived inability to cope with stress.

Our focus of effort is to better understand the stressors that sailors and their families face, and equip them with positive methods to cope with stress. We want to foster resilience in our sailors and their families, increase unit- and family-level vigilance, and encourage early intervention and care.

Our acronym, or our brand, in this, is ACT, A-C-T—to “Ask” about a shipmate, to “Care” for the shipmate, and to help that shipmate get “Treatment.” A first step in this is awareness and training of the providers, the sailors, and the families. To that end, in fiscal year 20—2010, training workshops for leaders, for first responders, and for suicide prevention coordinators has been conducted at 20 locations in five countries, with five more being planned for the end of the fiscal year.

A new training video, called “Suicide Prevention: A Message from Survivors,” was distributed, just this April. Interactive training programs, such as front-line supervisor training and peer-to-peer training, have been distributed, aimed at strengthening a culture of support. We have trained about 120,000 people, so far, in operational stress control.

A key in all of this is taking control of stressors. Stress is a fact of life. We want to reframe the issue, in terms of operational stress control, a comprehensive approach to address the psychological health of sailors and their families amidst a period of high operational tempo, a dynamic work environment, and increased deployments. It’s a program designed to be implemented by leadership at all levels, providing them with practical decisionmaking tools for sailors, for leaders, and for families to build resilience and improve their awareness of stress response, and to take every action to mitigate the effects of stress as part of a healthy lifestyle.

Our sailors deployed to Iraq and Afghanistan face a dynamic environment with unique experiences and a preponderance of events that could manifest post-traumatic stress. Accordingly, we are focused on preventing PTS, building resilience, and eliminating barriers or stigma associated with the treatment after deployment.

Prevention efforts include incorporating operational stress control continuum and stress first-aid principles for all our sailors, from basic training to flag officer development, Web-based information resources, and Navy career courses. Our project FOCUS—that is, Families Overcoming Under Stress—is an example of a selected intervention for families responding to the challenges of deployment and related stresses. It has reaped tangible results, and it is being instituted DOD-wide.

The combat and operational stress first-aid training is designed to guide our sailors, our leaders, and caregivers to provide support in a manner designed to overcome the stigma of requesting help.

Now, while there are several injury patterns in theater, an important area for all of us remains traumatic brain injury. The diagnosis and treatment of TBI is a top priority. There is still much we

do not know about the injuries and their long-term impacts on the lives of our servicemembers. But, through a collaborative effort with other services, Defense Centers of Excellence, Defense and Veterans Brain Injury Centers, and the Department of Veterans Affairs, and academia, we are committed to a full assessment of blast injuries, immediate attention to injuries, and ensuring that every sailor affected subsequently receives the best medical treatment available.

Surveillance for injuries across the deployment continuum is essential to the early identification of TBI. Predeployment screening, which will establish a baseline, monitoring and treating, in situ, sailors involved in a blast event, and instituting tracking mechanisms for followup care are key elements.

I want to thank you for your attention and commitment to the critical issue of suicide prevention, and your interest in the best possible care for the silent injuries of war: PTS and TBI. By teaching sailors to navigate stress, our Navy will make our force more resilient. By assisting in treating those with TBI and PTS, we could eliminate a potential cause of depression and suicidal behavior.

Our Navy is committed to a culture that fosters individual, family, and command resilience and well-being. We honor the sacrifice and the service of our members and their families, and we will do everything possible to support our sailors so that they recognize that their lives are truly valued and truly worth living.

And, on behalf of the men and women of the United States Navy and their families, thank you for your attention and commitment to the issues. And I look forward to your questions.

[The prepared statement of Admiral Greenert follows:]

Chairman LEVIN. Thank you so much, Admiral.

General Amos.

**STATEMENT OF GEN. JAMES F. AMOS, USMC, ASSISTANT
COMMANDANT, U.S. MARINE CORPS**

General AMOS. Thank you, Chairman Levin and distinguished members of the committee, for inviting me here today to discuss the issues of suicide, traumatic brain injury, and post-traumatic stress.

On behalf of the more than 240,000 Active and Reserve Marines and their families, I'd like to extend my appreciation for the sustained support Congress has faithfully provided its Corps.

As we begin this hearing, I would like to highlight a few points from my written statement:

You have rightfully focused on three of the most difficult challenges facing our Corps today. Let me assure you that the leadership of the Marine Corps recognizes the seriousness of the challenges we face with TBI, PTS, and suicide, and we are doing all that we can to prepare and to protect our young men and women.

We have learned much in the last several years about the effects of concussive events and combat stress on our marines that we just simply did not know several years earlier in this long war. With the knowledge we have gained, we have made progress in training to develop resiliency in diagnosing and treating TBI and PTS, and at educating our marines to prevent suicides.

We also realize that we have much more to do. And, with the benefit of research coordinated by organizations such as the Defense Center of Excellence for Psychological Health and TBI, we will continue to improve our diagnostic tools and treatment for these injuries.

The tragic loss of a single marine to suicide is deeply felt by all of us who remain behind. We have experienced about the same number of suicides this year as we had last year at this same time. And we recognize that our considerable efforts to present—prevent suicides must continue if we are to turn the trend of the last few years around.

We are building on the NCO training program that we launched, late last year, to reach the rest of our Marine Corps. And we continue to examine each suicide carefully and forensically, and disseminate the lessons learned from that across all Marine Corps leadership.

I have personally been involved, along with General Chiarelli in the Army, in the development of theater guidelines for the detection and treatment of mild traumatic brain injury. The newly established concussive protocol and regulations we have in place for marines deployed in Afghanistan are squarely aimed at the leaders and medical personnel, all in an attempt to further care for our wounded marines and sailors. It will ensure that those exposed to concussive events will be properly diagnosed and receive immediate attention, and that this information will have been properly recorded for future reference. The long-term objective of this protocol is to reduce the chances that a marine or sailor will suffer the effects of a blast injury at some later date, perhaps even years later.

As you know, post-traumatic stress is a real injury that is often difficult to diagnose. Many marines are reluctant to recognize the fact that they are injured, and even more reluctant to come forward. Our efforts to reduce this injury begin early on in our training regimen by training marines to be more resilient to the stresses of combat. We have embedded mental health professionals in our combat units to reduce the stigma and the barriers to seeking help. We are exploring new ways to ensure that marines have access to care, including the establishment of a new crisis hotline aimed at marines, for marines and their families.

Partnering with the medical community, we are commitment, as a Corps, to making sure every marine struggling with stress gets the support and, if needed, the treatment they need. While there is no single answer that will solve the challenges of rising suicides, traumatic brain injury, and post-traumatic stress, we are committed to exploring every potential solution and using every resource we have available. We will not rest until we have turned this around.

Thank you again for your concern on these very important issues. I thank each of you for your faithfulness to our Nation and your confidence in the leadership and commitment of your Corps.

I request that my written testimony be accepted for the record. And I look forward to your questions.

[The prepared statement of General Amos follows:]

Chairman LEVIN. Thank you, General.

The testimony of all of our witnesses will be made part of the record, and we thank you for that.

General Chandler.

**STATEMENT OF GEN. CARROL H. CHANDLER, USAF, VICE
CHIEF OF STAFF, U.S. AIR FORCE**

General CHANDLER. Thank you, Mr. Chairman, distinguished members of the committee. Thank you for the opportunity to address suicides in the Air Force, as well as the detection and care of our airmen suffering from post-traumatic stress disorder and traumatic brain injury.

The Air Force is strongly committed to the physical, emotional, and mental health of our airmen. And we appreciate the linkage between health of the force and mission readiness. The number of airmen taking their own lives has been rising, despite our commitment to prevention. Similarly, PTSD in an— is an area increasing concern. And finally, our ability to detect and treat TBI continues to be challenging.

The mental state of individuals contemplating suicide, and the actual condition suffering PTSD and TBI, are similar, in that they often do not manifest themselves in visible ways. The Air Force suicide rate recently reached slightly more than 14 suicides per 100,000 total-force airmen. Nearly two-thirds were not receiving assistance from mental health professional, despite concerted effort to reverse a long-held bias against seeking mental health assistance.

While no segment of the Air Force is immune to suicide, there are known high-risk populations and known common risk factors, like relationship problems, legal issues, financial troubles, and the history of mental health diagnosis. The Air Force recognizes suicide as a public health concern that requires active and persistent involvement from commanders, supervisors, and peers, often referred to as “wingmen,” at all levels of the organization. Their increased involvement is made easier and more effective through more available professional counseling service and focused training. All part of our improved resiliency program.

Total Force—in the Air Force—initiated the Total Force Resiliency Program, in February of this year, to holistically address the root causes of suicide. The Air Force program reflects a broad-based approach to supporting airmen and their families, recognizing that physical, mental, and emotional health are critical to the quality of life and readiness of the force.

Airmen Resiliency and the Air Force Suicide Prevention Program are complementary efforts that rely on leadership and engagement. Immediate family involvement and wingmen support is key components. In May, the Air Force Chief of Staff directed a servicewide Wingman Day to reinforce the significance and role of every airman as mutually-supportive critical components in suicide prevention and resilience. There is no substitute for airmen knowing their subordinates, knowing their coworkers, and well enough to recognize challenges in—changes in attitude, behavior, and personality, and then intervene when something is not right.

Part and parcel of these programs is an effort to expand availability of professional counseling. The Community Action Information Board, which provides a forum for court—cross-organizational

review and resolution of individual, family, installation, and community issues, is now chaired by me, the Air Force Vice Chief of Staff, to provide adequate oversight, in light of our increasing suicide rates. Also, professional counseling is available, now more than ever, through primary care clinics, the Airmen Family Readiness Center, and through DOD's Military One Source Referrals for confidential no-cost counseling. Complementing this increased capacity are training programs to better prepare our individual airmen.

Resiliency training is delivered in a tiered fashion, based on risk factors. Those most at risk receive the greatest and most structured exposure to resiliency and suicide prevention training, while basic education and training is made available to low-risk audiences, via unit briefings, chaplain services, financial classes, and computer-based training. Additionally, the Air Force is identifying strategies to ensure all accessions are exposed to Total Force Resilience and Suicide Preventions early on. Additionally, airmen will get additional training and assistance as they deploy from combat.

A Deployment Transition Center, at Ramstein Airbase in Germany, will open next month to provide 2 days of training to assist in the transition from deployment to home station for airmen regularly exposed to significant risks of combat-related death, like convoy operators, explosive ordinance disposal personnel, and security forces, and OSI. The goals of the Center include providing reconstitution, wingman support, and fostering individual resiliency skills for our most vulnerable airmen, those exposed to traumatic situations, situations that may lead, in fact, to PTSD and TBI.

In 2003, more than 600 United States Air Force personnel were diagnosed with PTSD. And in 2008, that number had increased to over 1500, with over 78 percent of the diagnosis stemming from deployment-related events.

Efforts to prevent, identify, and treat PTSD begin and end at home, with screening and education, the use of forums, like the Community Action Information Board, and the use of traumatic stress response teams at each installation. All aim to foster resiliency through focused education and psychological first-aid.

While deployed, combat operation stress control teams seek to prevent or minimize adverse effects of combat on our airmen. Of note, even nondeployed airmen, like those piloting remotely piloted aircraft and some of our intelligence personnel, must be monitored for post-traumatic stress symptoms, as well. They, too, are actively engaged in combat operations.

Where it may not be possible to pinpoint the instant PTSD has onset in an individual, this is rarely the case with traumatic brain injury. TBI is recognized in the Air Force as a physical condition that can cause lifelong symptoms.

From 2001 to 2009, 1,008 airmen were diagnosed with TBI, accounting for 4 percent of all Department of Defense TBI cases. Baseline testing of deployers and education of commanders and medical personnel is increasing as we work to apply the best joint practices to prevent, identify, and treat TBI. Our goal is simply to provide the best possible treatment, minimize the impact on long-term health, and maximize rehabilitation, recovery, and reintegration.

In conclusion, airmen are our Air Force's greatest asset, the key component of our ability to partner with the joint and coalition team to win today's fight. There is a commonality among suicide, PTSD, and TBI, beyond their obvious impact on individuals and the mission. They all require heightened awareness and understanding if we're to identify, prevent, and treat them effectively.

Again, thank you for your continuing support for our airmen, and thank you for the opportunity to discuss these important issues today. I look forward to your questions.

[The prepared statement of General Chandler follows:]

Chairman LEVIN. Thank you so much, General Chandler.

Dr. Jesse.

STATEMENT OF ROBERT L. JESSE, ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Dr. JESSE. Good morning, Chairman Levin, Ranking Member McCain, and members of the committee. Thank you for inviting me here to discuss the Department of Veteran Affairs efforts to respond to, treat, and minimize the impacts of traumatic brain injury, post-traumatic stress disorder, and veteran suicide.

My written testimony provides greater detail about our programs and about our cooperation with our partners at DOD and the services, but, in the few minutes I do have now, I'd like to highlight a few key factors for the committee.

Before doing so, I would like to express our gratitude to the committee for their insight into the importance of these issues, and for their ongoing support of all of the initiatives that are intended to mitigate this.

The VA has developed and implemented a range of innovative programs to ensure that it provides world-class rehabilitation care for veterans and servicemembers with traumatic brain injury. We offer services, at 108 facilities across the country, through an integrated network that brings together some of the best minds in medicine. We deliver comprehensive clinical rehabilitative services through interdisciplinary teams of specialists, while providing patient and family education and training, psychosocial support, and advanced rehabilitation and prosthetic technologies.

VA has placed nurse liaisons in military treatment facilities to support coordinated care, patient transfers, and shared patients. In terms of the population we treated between March 2003 and March 2010, VA has seen, at our state-of-the-art Polytrauma Rehabilitation Centers, almost 1800 patients, more than half of whom are Active Duty servicemembers.

Second, the Federal Recovery Coordination Program is a successful joint VA/DOD initiative that provides severely injured veterans and servicemembers with access to the benefits and care that they need to recover. Our 20 Federal Recovery Coordinators work with military liaisons, member of the service's Wounded Warrior programs, Service Recovery Care coordinators, TRICARE coordinators, and various VA staff members, to bridge the transition from VA to DOD.

Each enrolled client has a specially tailored Federal individual recovery plan based on the goals and needs of the veteran or

servicemember, and based upon input from the client and his or her family. This plan serves as the basis for returning our wounded warriors to the highest level of functionality independence they can achieve.

Third, VA has implemented robust screening protocols for post-traumatic stress disorder, TBI, and suicidality. We screen every veteran from Afghanistan and Iraq for brain injuries, and we screen every veteran we see, for PTSD, depression, and problem drinking. If the PTSD or depression screen is positive, we require an evaluation for suicidality. VA repeats the screening at consistent intervals, since problems can arise at any time. Any positive screen leads to further evaluation in the primary care setting, followed by specialty care services as needed.

VA has established access standards for mental health that require prompt contact of new patients, within 24 hours of referral, by a clinician, to evaluate the urgency of the veteran's needs. If the veteran has an urgent care need, we require our staff to make appropriate arrangements, including an immediate admission to one of our facilities. If the need is not urgent, the patient must be seen for a full mental health and diagnostic evaluation and development initiation of an appropriate treatment plan within 14 days. Across the system, the VA is meeting the standard over 95 percent of the time.

And finally, VA's suicide prevention efforts are having a meaningful and positive impact on those veterans who come to us for care. A suicide by a servicemember or veteran is a tragedy for the individual, his or her friends and family, and to the Nation.

We have initiated several programs to put VA in the forefront of suicide prevention. Chief among these is establishing a national suicide prevention hotline, placing suicide prevention coordinators at VA Medical Centers, significantly expanding mental health services, and integrating primary and mental health care to alleviate the stigma of seeking mental health assistance.

The return on investment of—on—for these efforts is significant. Our suicide prevention hotline has saved the lives of more than 9,000 veterans and servicemembers since its inception. Other data demonstrate that younger veterans who come the VA for healthcare services were 30 percent less likely to die from suicide than those who don't come to us for care. And, more broadly, the rate of suicide among veterans receiving healthcare from VA has declined steadily since 2001. From a public health perspective, this decline is significant, corresponding to about 250 fewer lives lost as a result of suicide.

These are considerable accomplishments that both VA and the Congress can proud of. But, it is imperative that we reach more of our veterans and servicemembers, and deliver them the care that they need.

In conclusion, VA and DOD maintain a longstanding relationship that shares best practices, identifies joint solutions, operates centers of excellence, and works to support the brave men and women who wear the uniform.

Thank you again for the opportunity to discuss these important issues with you today. And I'm prepared to answer your questions.

[The prepared statement of Dr. Jesse follows:]

Chairman LEVIN. Thank you very much, Dr. Jesse.

Thanks, to the VA also, for the important work that they do in the area, and the joint work that is being done between the VA and the Department of Defense.

We are lucky that the chairman of Veterans Affairs Committee in the Senate—Senator Akaka—is also on the Armed Services Committee, which has allowed us to do a lot better coordination on these matters. And it's a real break for us, and, more importantly, for our troops and our veterans, that Senator Akaka is a member of this committee.

Let's try a 7-minute first round, here.

General, let me start with you. A couple of weeks ago, National Public Radio reported that the military is failing to diagnose brain injuries in troops who served in Iraq and Afghanistan, that the injuries were not documented on the battlefield, that soldiers with TBI don't always get the best medical treatment. And interviews of soldiers at Fort Bliss revealed that some soldiers with TBI, who were crying out for help, still had to wait more than a month to see a neurologist. Also, they reported that many military doctors have failed to accurately diagnose TBI. Can you give us your response to those reports?

General CHIARELLI. Mr. Chairman, I provided a complete response to National Public Radio in which I detailed my problems with the report. I've got three basic problems with the report:

Number one, it criticized the leadership for not caring or not doing anything about it. I think that's far from the truth.

I took great exception with the report stating that our doctors don't seem to care, and are not properly diagnosing these injuries, without explaining the real issue here. And you cannot isolate traumatic brain injury without talking about PTS.

As I mentioned in my opening statement, the comorbidity of symptoms between these two make it very, very difficult for doctors to make that diagnosis. Of my Army wounded warrior population—the most severely wounded population I have, with a single disqualifying injury of 30 percent or greater—60 percent have either TBI or PTS—43 percent PTS, 17 percent TBI. And I really believe that when you fail talk about both PTS and TBI in this issue of comorbidity, you're doing a great disservice, because, to state it flatly, our science for the—on the brain is just not as great as it is in other parts of our body. And researchers are struggling today to find the linkages and to learn everything they can about the brain, and because of this we're going to see some misdiagnosis.

I can tell you, of the folks that the National Public Radio talked about, they had over 200 appointments apiece. And there's no doubt, you could go to any one of our posts and find soldiers who are struggling because of our inability to nail down and to diagnose exactly what treatment they need for these behavioral health issues. But, I promise you, it is not for a lack of trying or real care on the part of our doctors. And our leadership is totally committed to working these issues.

Chairman LEVIN. In terms of the wait that the—one of the soldiers, I guess, claimed, of a month or more to see a neurologist?

General CHIARELLI. I will tell you that a neurologist is not the answer, necessarily, to these soldiers' issues. I have a total of 52

neurologists in the United States Army; 40 of them are currently practicing. Forty. And that's when I include my child neurologists. The team that will work with somebody on any behavioral health issue is a team of a neurologist, a—possibly a psychiatrist, nurse case manager, who will look at the entire file or medical record of care given to that soldier, and work to provide them the best that they can.

But, the—one of the problems we have here—and this—I get this from talking to doctors—is, even the medications for PTS and TBI are totally different. So, if we misdiagnose, at the beginning, and provide a diagnosis of PTS, when in reality it's TBI, the medications we're going to put that soldier on are going to be different than what the real problem is, and may be different from another behavioral health issue that that soldier may have, because it's not all TBI and PST. There's anxiety issues, depression issues, other issues that are the product of this—these wars—that are causing us so much difficulty in this area.

I've got 79 percent of the psychiatrists currently assigned to the United States Army, based on my authorization prior to 2001. And I know that that authorization is lacking, but I only have 79 percent. And, it's not just an Army problem. This, I think you will all agree, is a national problem, a shortage of behavioral health specialists.

Chairman LEVIN. So, there are some areas of professional need where we are short. And is there—is this a matter of funding? Is this a matter of finding people? Or, what is it?

General CHIARELLI. No it—I don't believe it's a matter of funding, at all. I think it's a matter of finding folks, of getting them to move to some of the places where the Army is stationed. When you have shortages, it's much—you know, I think a psychiatrist might prefer to be in Nashville than in Clarksville, Tennessee. So, we have to rely on the TRICARE network, many times, to provide some of the behavioral health specialists that we need.

Chairman LEVIN. And, in terms of this—the delay issue, is the delay the result of a lack of resources, in the cases that were talked about on NPR, or is that a matter of the complexity which you just described?

General CHIARELLI. I would argue it's the case of the complexity, I really would. And I'm not saying that, in every instance, that we're getting soldiers in exactly when we want them to be, but when soldiers are assigned to our WTU, they have a primary care manager, at the rate of 1 per 200, a primary care manager, where you or I would have a primary care manager at a ratio of 1 to 1200 to 1500. They have a nurse case manager at a ratio 1 to 20, and they have a squad leader at a ratio to 1 to 10 or less.

So, we've done everything we can to focus our resources, our limited resources, in this area. But, I will tell you, we are short behavioral health specialists.

Chairman LEVIN. But, again, that's not a funding issue.

General CHIARELLI. It is not a funding issue.

Chairman LEVIN. All right.

Now, Dr. Jesse, I—the VA, as you, I think, testified, screens all of our Iraq and Afghan veterans who receive care from the VA for TBI. Does that screening for TBI indicate that there is a routine

failure in the military to properly diagnose TBI before you see that veteran, when they're still on Active Duty?

Dr. JESSE. No, sir. I don't think we can say that. The problem with TBI is that there's no hard, fast diagnostic test. There's not a lab test that you can send off and get a solid answer back. And the other one is that of temporal issues that—often it takes time for it to manifest some of the effects that would have—that show up.

So, I don't think that it's a failure, on the Department of Defense side, to find these people. I think, it's—it may just be—the complexity of disease, as you've heard, takes time to manifest in ways that we can then identify it.

Chairman LEVIN. Thank you.

My time's up.

Senator Inhofe.

Senator INHOFE. Thank you, Mr. Chairman.

First of all, let me——

Chairman LEVIN. And, again, thank you, Senator, for your initiative in this area.

Senator INHOFE. Yes, sir.

It was called to my attention—it's—oddly enough, of all of the subcommittees of the Armed Services Committee, the one I've never served on is Personnel. I don't know a lot about these issues. But, when it was called to my attention, the propensity of these suicides, and we started looking into it, I made the request, Mr. Chairman—and, also the request, which I think you may be doing in another hearing, actually bringing in some of the medical experts and soldiers, with their experiences.

General Chiarelli, I know that you have really made a study of this thing. And you said something to the effect—that I didn't see—it wasn't told me; it was in your written testimony—that on Active Duty, you've actually had a reduction, but an increase in the Reserve component. Is this correct?

General CHIARELLI. That's correct, Senator.

Senator INHOFE. Well, you know, what it just seems to me—and I can remember back during the 1990s, when we were downgrading the size of military and all of this stuff, then, of course, when September 11 happened, we have all these deployments—we hear—everybody up on this side of the table hears from our people back home, our Guard and Reserve, the OPTEMPO is just not livable. And that goes all the way across services. And I would think that, since you made that statement, that perhaps the OPTEMPO might be some leading cause of these, in that the OPTEMPO for the Reserve and the Guard's is much higher. Do you see that relationship?

General CHIARELLI. I see that as one of the factors, Senator. We've had an increase—and, it's really interesting—we've had a decrease of 15 Active-component suicides this year, compared to last year. And I will tell you, when I talk Active, I'm talking about the 547,400 we've got in the active-component force, plus about 200,000 that are mobilized at any one time out of the Reserve and National Guard. So, it's about a 700,000-person force.

So, once the—a Reserve soldier is made an Active Duty soldier, he is counted in my Active component numbers. And we are down

15. We are down 2 with our Reserve component soldiers not on Active Duty. We up 21 in our National Guard soldiers who are not on Active Duty. And that concerns me greatly. I think—

Senator INHOFE. So, that—

General CHIARELLI.—it's three things. I think its multiple deployments for them. I don't think we're getting enough time with them at the DEMOB station to give them the kind of checkouts they need—behavioral health checkouts that they need. And, third, I think—Senator McCain said it in his opening statement—this lack of human interaction, at least with other soldiers, that they have when they leave the service within 5 to 7 days after a 12-month deployment, I think, is a real issue here.

Senator INHOFE. Well, it gets—that is OPTEMPO, that's what we're talking about. And that—there is an article—and perhaps you had implied that—on the public radio thing, that that was not totally accurate. And I agree with you.

There's another article, just—on the 14th of June, in USA Today, that talked about—and it was pretty critical, because it talked about the law that was passed in 2008, and one of the main persons was this Representative Bill Pascrell, of New Jersey—which said, there have to be both “post” and—“pre” and “post”—and apparently we're short on the “post” end of it. Can you elaborate on that a little bit?

General CHIARELLI. Senator, we followed the law when it was passed. And the law stated that we were to use the ANAM as a screening tool in pre- and post-deployment. We still use the ANAM in predeployment to get a baseline on cognitive skills of our soldiers. But, what we found when we used the ANAM in post, was that we were getting a number of false positives, a high number of false positives, way too high. And we were tying up our limited behavioral health specialists in working their way through these false positives from the ANAM.

Now, we still use the ANAM in post if a soldier demonstrates any of the symptoms of TBI or any cognitive issues. So, we are still using it. We're not—we're just not making it mandatory for every soldier, so we don't take our short behavioral health specialists and wade through a whole bunch of false positives, which the test tended to produce.

We have other things that we're using. Virtual behavioral health is something I'm very excited about, where we can give every soldier a 30- to 40-minute triage session with a behavioral health specialist, using the Internet, using virtual—putting together a virtual net of providers who can take an entire brigade and put everybody, from brigade commander to the youngest private in that unit, through a 30- to 40-minute screen. I mean, this is the kind of thing I would like to be able to provide to Reserve component soldiers when they get back, but I don't necessarily have the time necessary to do that.

Senator INHOFE. Yeah. Well, I really appreciate the attention you've given to this issue.

Do any of the rest of you want to comment on that, in terms of how it relates to the law that was passed in 2008, in our authorization bill?

General CHANDLER. Senator, if I could, I would say that we still use the ANAM, pre and post. We're fortunate, in a way, based on the numbers that we're dealing with, that we can do that, even with the false positives. Like the Army, we also have other tools that we use. A fair amount of success with a Post-Deployment Health Assessment, which takes place in theater, face to face, or shortly after return. One of the things that I think is very important is, 6 months later, there's a post-deployment reassessment. That assessment has yielded 16 percent of those airmen that we're treating for post-depression—or post-deployment stress syndrome. So, we think that 6-month follow up is extremely important, as well.

Senator INHOFE. All right.

General AMOS. Senator, we're in agreement with the Army and the other services here. We test, using the ANAM test, 100 percent of our marines, prior to deployment. We are not doing that when they come back. It is used occasionally by our mental health professionals, if they don't have anything better. But, the issue of false positives, and the lack of reliability in the ANAM on the post-TBI incident, especially when you come home, leads our Navy doctors, our mental health professionals, to seek other ways to take a look at our marines. And so—and, we're doing that.

And, much like General Chandler talked about, we screen both those marines—100 percent of the marines as they're coming out of theater, and then, within 90 to 180 days later, we do it again. And, just to give you some numbers, we—for PTS, 15 percent of those that are screened coming out theater answer some questions positively, which would lead you to further screening. And of that further screening, 7 percent see mental health professionals. And then, by the time you dwindle this thing down, it's about 2 percent of the marines actually need mental health care when they come out.

Senator INHOFE. Right.

General AMOS. So, it's just not that reliable on the back side, sir.

Senator INHOFE. That's very helpful. I appreciate that.

My time is expired, but I wanted to ask you a question, just could be answered for the record, if that's all right, Mr. Chairman.

Chairman LEVIN. Yes.

Senator INHOFE. And that is, the article—another article—and this is January 14th, "When Soldiers Deploy, Family Deploys." It's talking about the—tying in the OPTEMPO with the families, with the deployments. And they—apparently, there was—the New England Journal of Medicine did a study, that I've—I read this article, and then did a little bit more research on it—that some of the findings that they're having, in terms of the families—the wives, the kids—and nothing was really said during the opening statements about that.

So, I'd like to—for the record, to have the four of you address how—what we might be doing, in terms of the wives, the children, that might be having the same problem in same ratio that the troops themselves, or the actives and the Reserve components, are having, if we could do that.

Thank you, Mr. Chairman.

[The information referred to follows:]

Chairman LEVIN. Thank you, Senator Inhofe.

Now, Senator Inhofe, made reference to a bill that was—been introduced by Congressman Bill Pascrell, who was the cofounder and cochair of the Congressional Brain Injury Task Force. We have received a statement from him, which we will make part of the record.

[The information referred to follows:]

Chairman LEVIN. Senator Akaka.

Senator AKAKA. Thank you. Thank you very much, Mr. Chairman, for scheduling this hearing on these vitally important topics.

And I want to thank my brother and friend Senator Inhofe for bringing—helping to bring this about.

And I want to welcome our distinguished group of witnesses, and thank each of you for your dedicated service to our country. And I also want to thank the men and women that you lead, and thank them for their outstanding service.

Like you, the topics at hand today are ones that I care deeply about. And continuing to work with you and my colleagues, we can refine efforts to prevent military suicides and to look for better ways to treat, detect—to detect and treat and care for those suffering from invisible wounds of war.

General Chiarelli and General Amos, suicide prevention is difficult and challenging. And, for all of you in our panel, this has come about, of course, because of what we call “combat stress.” And, as was mentioned, this includes PTSD, TBI, and behavioral health issues that we are facing here.

As was previously stated, the services have experienced a rise in the number of suicides since the wars in Afghanistan and Iraq started. And there is a need to understand suicide, look at the causes, and get a point where we can prevent it.

Generals Chiarelli and Amos, and also Dr. Jesse, how can the DOD and VA better collaborate in the area of suicide research and prevention? This has been mentioned, by General Chiarelli, as a great need here. And I'd like to have the three of you give your perspectives on this.

General CHIARELLI. Well, I will—

Senator AKAKA. General Chiarelli?

General CHIARELLI.—argue, the cooperation between the VA and the services, I believe, has never been better. I think the disability evaluation pilot that we're running at different installations is proving to be a great success for the United States Army. And the wonderful thing about this is, is that when a soldier goes through the DES, we ensure, that, if they are leaving the service, that they're in the VA system. And this is something that has never happened before, as far as I know it. The—it is a wonderful benefit of this, that when a soldier makes the decision to leave the service, he is in that VA system. Before, we would, in fact, have soldiers separate, and it would be their responsibility to work their way through the process to get in to receive both their medical benefits and other benefits through the VA system.

I think that you've hit upon a key piece, here. And that is, stressors. But, it's not only combat stress, it's individual soldier stress and family stress. And when we look at those across a continuum, what we're seeing in the Army, with the high OPTEMPO

that we're on today, that a soldier, in the first 6 years he or she spends in the United States Army, has the cumulative stressors of an average American throughout their entire life. And that's when you combine high OPTEMPO, individual soldier stressors, and family stressors.

So, this is an area we're looking at very, very hard. And when you realize that 79 percent of our suicides last year were soldiers in—60 percent in their first term, 79 percent one deployment or no deployments, I think, it points to doing everything we possibly can to mitigate those stressors, whenever possible, and as the—as we're working so hard to do in the Army, work to increase the resiliency of our soldiers, particularly in their younger years.

Senator AKAKA. Thank you.

General Amos?

General AMOS. Senator, I'll be happy to talk about, not only the relationship, but the handoff between the military and, in my backyard, the Marine Corps and the Veterans Association. Like General Chiarelli, I have never seen it better. It's—the entire organization is well led, from the top down, from VA. They are compassionate. They are passionate about the care of our young men and women that enter their system. I've never seen it better. I'm fortunate to get to travel around and visit a lot of our VA hospitals and our wounded, and I come away just completely wowed by what I see.

There is a systematic handoff. In the Marine Corps, this is done through what we call our Recovery Care Coordinators. We take some marines—we have them around the Nation, and they are not part of the Federal Recovery, but they are linked to it—but, they are U.S. Marines whose job and life is to know everything they can about the VA system. And so, when a marine transitions—especially one of our wounded marines—transitions out into the—in—heading into VA-land after a disability board, and he's moving on to the next half of his life, that Recovery Care Coordinator contacts a recovery—a Federal Recovery Care Coordinator, the District Injured Support Marine we have out there, our network of Marine for Life, to put our arms around this guy.

But, I've seen it firsthand, where the actual handoff for a needy marine, in some cases 2 years after the injury—after the initial injury—I just saw this last—about last month, down in Corpus Christi, Texas. A young marine, TBI, 2 years ago, his life is unraveled right now. And through the Federal Recovery Coordinator and the VA in San Antonio, and our Care Coordinator we were able to plug this marine, get him back into a hospital right now for further care.

So, I've never seen it better, Senator.

Senator AKAKA. Yes.

Let me ask, Admiral Greenert, for your comments, as well as General Chandler, after you.

Admiral GREENERT. Thank you, Senator. I think General Chiarelli and Amos hit the nail on the head. The cooperation is very good. In fact, we meet monthly with the leadership of the VA and leadership of Department of Defense to streamline the defense—the disability—excuse me—evaluation system.

I would say that what we are finding in our study of suicides, the transitional period seems to be a spike in stressors. And this

is an area we need to watch very closely, this transition period, and be sure that our sailors have the social support network that they've had as they've moved through their career in the Navy, as long as it is. So, it's also a focus area, to watch out for those stressors.

Thank you.

Senator AKAKA. General Chandler?

General CHANDLER. Senator, we have approximately 700 airmen in our Wounded Warrior Program. These are young men and women whose lives have been changed forever, and that we are dedicated to taking care of, from the time they've been wounded until they no longer need our services in the Air Force, and we make the transition to the Federal system, if, in fact, that's required and we're not able to bring them back to the Air Force.

We use much the same system that General Amos described, with Care Recovery Coordinators that allow us to do that around the Nation, to service the young men and women that require that kind of treatment and that kind of handling. We're very comfortable with our relationship with the VA and the way that's working.

Senator AKAKA. Well, I'm glad that we've been working on what we call "seamless transition." And it appears that we are moving along in that.

Dr. Jesse?

Dr. JESSE. Thank you, sir. So, as not to reiterate things that have already been said, I'd just like to point out a couple areas where this level of integration has really become manifest. The first is in the post-deployment and health reassessment exercises. The VA generally has a presence at those exercises, not to administer the exams, but to be present to make sure that those servicemembers are aware of all of their benefits that the VA can provide. But, also, if there are immediate health, and particularly mental health, issues that arise, that they are there and can literally make an appointment on the spot. They can get them enrolled in VA, make an appointment. And if we need to take them into our care at that point, we can do that, so that we participate in that.

And the second is the Polytrauma Networks, which really are—while the VA has four, and going on five now, Polytrauma Centers of Care, those are very tightly integrated into the Wounded Warrior Programs at Walter Reed, in Bethesda. In fact, I had the real honor to accompany Deputy Secretary Gould and Dr. Stanley on a tour of Walter Reed, and then come directly down to Richmond and look at the seamless way that the—both patients and their information move back and forth through those networks, including the fact that there are VA representatives stationed in the DOD facilities, and DOD clinicians in the VA Polytrauma Centers, so that we ensure that any movement of patient is a warm handoff and not just being sent to another place.

And then, finally, in the mental health area, I think there's just been an extraordinary collaboration going on for some time now. There was a joint conference, in the fall of '09, that led to an integrated VA/DOD strategic plan. And the real goal was to make sure that when, for instance the—there are evidence-based therapies for

post-traumatic—treatment of post-traumatic stress, that the VA and the services agree on how we treat those patients so that as treatment begins in the services, and then transitions in the VA, we're not abruptly stopping one form of therapy and entering into another. And I think this is a hugely important point of collaboration, that we've gotten that far.

Senator AKAKA. Thank you for your responses.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator Akaka.

And the testimony of our witnesses, saying that the integration of planning and diagnosis and treatment of our troops that are veterans is going along at a good pace, is important news to both of our committees. It's something we put a great focus on, both Veterans Affairs and Armed Services. And our wounded warrior legislation was aimed at accomplishing that. So, this is important testimony, and good to hear.

Senator COLLINS.

Senator COLLINS. Thank you, Mr. Chairman.

We've all got this strange echo today.

General Chiarelli, I want to follow up on a question that Senator Inhofe asked you.

And, Senator Inhofe, I want to thank you for suggesting this hearing, as well as the Chairman, for holding this important hearing.

In the past year, I have met with a retired general in my State, with returning members of the National Guard, and with a whole variety of healthcare professionals, to discuss the mental health needs of our troops and the troubling rise in suicides. To a person, each of them has told me that it's insufficient dwell time between deployments that they believe is the biggest factor, that there's not sufficient recovery time before deployments occur again. How important do you think that factor is to the increase in problems with mental health and the suicide rates?

General CHIARELLI. I think, for the National Guard soldiers, it may be higher than we're seeing with the active-component soldiers. As I indicated, 79 percent of our suicides last year were soldiers who had never deployed or only deployed one time. So, that would argue that, in that group of 700,000, there's a bit of resilience that grows with repeated deployments. I—I'm not—I'm just giving you the numbers we're seeing out of NIMH, and as we start to pull the early results.

I really believe, though, that what—the real issue here for our National Guard soldiers is that, when they come back off of multiple deployments, that second or third deployment, that we have sufficient time at the DEMOB station to do the kind of medical tests, such as a virtual behavioral health counseling or other things, to ensure that, number one, we get a good read on how they're doing; and, number two, that they fully understand the medical benefits that they're going to have when they return to their State.

One of the hardest things for any of us is that the benefits for a National Guard soldier differ from State to State. We've made great progress with TRICARE Reserve Plus. And you add that to TAMP, which gives you 6 months of care when you come back

home. If we can get the soldier to enroll in TRICARE Reserve Plus, we can provide them continuous medical care to the next deployment. And I think this is critical.

So, I think we have to look at this population a little bit different, and realize—and, again, as Senator McCain said, I am able to wrap leaders around returning Active-component soldiers for the entire time that they're back. We take a Reserve-component soldier today and, within 5 to 7 days, he's back in his community, on his own.

Senator COLLINS. A related problem, at least in a rural State like mine, is an absence of mental health professionals in those rural communities. Even though the VA will provide the assistance, or the National Guard will provide the assistance, it's often many hours away. And that's a problem that's in our society as a whole. And you've mentioned the shortages that you're facing, and that it's difficult to match the mental health professionals with where bases may be located. But, that's an even worse problem when you're talking about National Guard members or reservists who are going back to their home communities, their regular jobs in small communities that may not have any mental health professionals at all.

General CHIARELLI. If I could just quickly comment.

Senator COLLINS. Yes.

General CHIARELLI. We started a program, last August, which gives counseling, 24–7, without a TRICARE referral, to anyone who's authorized for TRICARE. And it is done online. It falls short of psychotherapy or prescription pain management, so we can't do that online. But, where I really see us making up for this shortage is to really explore what we can do with tele-behavioral health.

Senator COLLINS. I agree.

General CHIARELLI. Because this gets at stigma issues, it gets at the kind of shortages you're talking about in rural areas, Senator. And I really think that this is something that will fix us now, rather than wait til we grow the necessary providers that we need over time. I really think we should be exploring this as hard as we possibly can.

Senator COLLINS. I completely agree. There's great potential, particularly since so many of these young troops have access to computers in their own homes, because the stigma still is there. Despite all of our efforts, it's still there. So, I'm delighted to hear you put an emphasis on that.

General Amos, even though we've given a lot of attention to the Army's rising suicide problem, I was struck to see, in 2009, that the branch with the highest rate of suicides among Active Duty personnel was actually the Marine Corps. What is the Marine Corps doing—the Army's clearly done a great deal—is the Marine Corps matching that effort, in stepping up your programs and trying to tailor them to the culture of the Marines?

General AMOS. Senator, that's a great question. And the short answer is: absolutely, yes. We are joined at the hip with our programs that we mutually share across—cross-boundary. We are aware of all that each of the other services do. We collaborate. We share best practices. We steal good ideas from one another. So, the answer is yes.

We are—in 2009, we led the Department of the Defense in suicides, percentage-wise. We had 52. That's double what we had in 2005, when we had 25. So, you ask yourself, you know, "What is it that's caused this?" We don't have all the answers on this thing, and you wouldn't expect me to, but you would expect me to be trying to find out and do something about it.

Interestingly, the Marine Corps is the youngest service, age-wise, of all the other services; for instance, 67 percent of all of our 202,000 marines, between the ages of 17 and 25. If you compare that to the other services, we are woefully more—when I say "immature," I'm just talking about years—as a whole-cloth force. So, that, in and of itself, causes some issues. Our population, where our marines are killing themselves, are between 17 and about 23/24; it's male; it's about half married, half single; white. And the deployment—for instance, this year alone, we've had nine young marines take their lives that had never seen their deployment. We have had marines come right out of boot camp, and, after having spent 12 weeks in what is arguably a "legendary boot camp," which calls out an awful lot of folks who just can't handle the stress, they kill themselves. They go home on leave, and every now and then they'll take their life. And they've never seen deployment one. And they've just completed the most rigorous, probably, physical and mental examination they—that they've ever had in their life. So, what causes that?

We had a young lance corporal just check into his unit, who were deployed in Afghanistan 2 weeks ago, his very first day, he goes on duty, walks outside the perimeter, and shoots himself. And he did this—as you, kind of, do the forensics on this thing—his girlfriend left him just before he left. He has issues with his family at home, his mother and father. And so, these are the kind of things that we're seeing.

So, what are we doing about it? First of all, and foremost, in our organization we're focusing on the leadership of the Marine Corps. I know that sounds trite, but we're an organization that's based on leadership, everything we do. So, we start with the very top. The Commandant of the Marine Corps, the sergeant major of the Marine Corps, are adamant about this, and it's flowed all the way down through our senior leadership, that we have to absolutely pay attention to this. This is not something to be taken lightly, and it is an issue. So, that's the first thing, the senior leaders' focus.

We developed, last—it took us about 6 months to develop—we pioneered it last—about July, a noncommissioned officers suicide prevention half-day course. And it was—it's video, it's film, it's in the vernacular of the NCOs, because looking at that population of our young marines that are taking their lives, it's that 17-to-22/23. That's where the noncommissioned officers—they own those marines. They know them better than anybody. So, we focused this effort on them. High reviews, just great reviews from the noncommissioned officers. One-hundred percent of our noncommissioned officers have gone through this thing, and they're taking that training down to the young marines below them.

Interesting, we've seen a drop in suicides this year, even though right now we are on the same plateau as we are last year. If you consider—and that's probably not very encouraging—but if you

consider this vector we've been on since 2005, which has been very steeply vertical, the fact that we are even where we were last year is an encouraging sign.

The further piece of news that's encouraging is, this NCO course, we think—too soon to tell—but, last year, 92 percent of our suicides were in this age group that I just described, about 23 to 17, and a lot of them were noncommissioned officers. We've seen a drop this year down to 84 percent, as of today. So, we've taken that—we've said, "Okay. Let's take a look at those real young marines, the privates through lance corporals; let's take a look at the staff NCOs; and let's take a look at our young officers, lieutenants to captains, and let's build a very similar program." We're in the throes of that right now. It should be published within the next 2 to 3 months. And we're going to do that whole thing for the entire Marine Corps.

So, we think it's going to work. We think it has worked. Too soon to tell. But, ma'am, we're doing that. We've got—we're—we have increased our resiliency training by—immersion training for our young marines, all that predeployment stuff, trying to make our marines more resilient.

I have a list of things down here that I could go through. But, I just want you to know this has our attention. This is job one with the Marine Corps.

Senator COLLINS. Thank you.

Chairman LEVIN. Thank you, Senator Collins.

Senator Udall is next.

Senator UDALL. Thank you, Mr. Chairman.

Good morning, to the panel.

And, General Chiarelli, I want to, in particular, note the attention you've paid to these important issues. I had an opportunity to travel with you to Fort Carson earlier this year. I know you've immersed yourself in these difficult discussions. And I know we don't have all the answers yet, and that's why we're holding the hearing, in part. And I trust my questions will be received in that spirit, as well.

And I want to—I wasn't here earlier, during the questioning about the ANAM test. I think you said that, while the Army uses it, predeployment, for a baseline, you don't use it post-deployment, not usually, because of the false positives that often result, or result, to some extent of the time. Here's my question. By definition, a baseline is supposed to give us something to look back at, in the aftermath, a way to compare. So, if we're not using, what is it, close to 600,000 pre-deployment assessments to compare to the post-deployment assessments, what are we doing with them? Why use ANAM at all if it's not being used in that post-deployment situation?

General CHIARELLI. Sir—Senator, I will tell you, we are using the ANAM on post-deployment, but only if the soldier demonstrates some kind of a symptom of having cognitive issues. And that may be cognitive issues that could be caused by TBI or some other behavioral health issue.

So, the baseline is very, very important, because it gives the doctor an additional tool that, when symptoms are demonstrated, or in a post-deployment screening we have reason to believe we

should have that soldier go through the ANAM, we go ahead and use it. What we're just not doing is doing a post-deployment ANAM for every soldier irregardless—or regardless of—my English teacher would have just been—thank you very much.

Senator UDALL. Mine too, General. [Laughter.]

General CHIARELLI. Yeah—regardless of whether they show those symptoms, because we were getting so many false positives. And we just don't have the folks, the behavioral health specialist folks, to work through all those false positives and give the care we need to, to the rest of those who need care.

Senator UDALL. That's helpful, and we'll continue that conversation. My next question will follow on that. I want to talk about the Post-Deployment Health Assessment, the PDHA. And it's supposed to catch things that weren't caught in theater, as I understand it. And a soon-to-be-published study has shown that the standard screen on the PDHA fails to catch 40 percent of those who sustained a TBI in theater. And this comes from research at Fort Carson, in my home State of Colorado.

I've been there, as I've mentioned, on a number of occasions, to get briefings on how they're handling TBI patients. I think they're doing it right. They're—by using a more thorough exam, with clinical interviews to augment the PDHA. And there's a concern, as I understand it, that those—that individualized approach would take too much time, and require scarce personnel to administer, and that such an approach can't be replicated across the force. But, I'm told that at Fort Carson it only takes about 15 to 20 minutes to—in addition to—to do this. Could you speak to Fort Carson's approach and whether the Army's looking at maybe applying this elsewhere?

General CHIARELLI. I'll tell you, I disagree with Fort Carson. I want them to institute the virtual behavioral health screening, so that we can ensure that we get everyone. I don't want to use any form. I don't want to use any series of questions that automatically says that a soldier does not have those issues. And I think that what we really need to do is to get to a standard that says we're going to give everyone a post-deployment screen; follow that up, 90 days later and 180 days later.

Here's my problem with the Fort Carson approach. The Fort Carson approach focuses on soldiers with doctors that they have assigned when they come back. And they may get through a 15- to 20-minute screening of a select population who's demonstrated, based on a questionnaire, that they may have issues, they may be medium to high risk. But, when you do that, you take away the doctors that are providing care to those folks that we have already found, because you're focusing on this group. That's why this virtual network is so important, that you can do an actual triage and get the number down to those that you can treat with those people you have on base. I've had discussions with Fort Carson about this.

And, I've got to tell you, until I get doctors to use the virtual method, they—many of them push back, and they push back because they have never done this before. I—but, what we're finding is that those who go through it, the doctors—those doctors are the biggest supporters of it, because we find that this generation, in many times, opens up much greater using either Skype technology

or some kind of high-definition VTC, even more so than sitting across a room, like you and I are right here. And they really feel they're able to get at some of these issues and do a good evaluation.

Senator UDALL. Well, I respect the passion in your response. Let's continue the conversation. And, again, it points out how—General, how involved you are, and how much you've paid attention to details and individuals—soldiers.

Let me turn to another—perhaps a bit of a difficult conversation that's tied to the NPR story. They report a term that's used by researchers, “the miserable minority,” to refer to those who suffer from mild traumatic brain injury, who have long-term repercussions. And it's true, from what I learned, that most soldiers recover from mild TBI, but some who seem to have symptoms persist for months or even years, and if you get a repeat of a TBI incident, you can aggravate that mild TBI.

The NPR story intercepted an email from one of General Schoomaker's advisors, Dr. Hogue, who questioned the importance of even identifying mild TBI accurately, asking, quote, “What's the harm in missing the diagnosis of mild TBI?” Can you help me understand whether finding ways to diagnose and treat mild TBI is important to the Army?

General CHIARELLI. It is extremely important to the Army. And Dr. Hogue represents a population of psychiatrists and psychologists, quite frankly, who—you can find one who will support just about any different way of attacking this. It is not this well-developed science that we have in other areas, such as heart surgery. I think the dialogue is good. I didn't necessarily agree with Dr. Hogue when he wrote in the New England Journal of Medicine. But, he did do a study—peer-reviewed study, where he talked about this.

I think, the great disservice that NPR did to everyone was to try to isolate TBI from PTS. And that is just not possible. As I indicated before, the comorbidity of these two is what's giving us the difficulty today. And I also think that they did a disservice when they indicated that PTS is a psychological problem. It is not just a psychological problem. It is a physical injury that occurs. And, if anything, I think could be best described as a chemical injury, because that frontal cortex doesn't turn on and stop the flow of those things that keep this—a person at this altered state for 4 to 6 hours. So, I think we have to look at these two together and realize the real difficulty that doctors are having trying to separate and understand the symptoms 100 percent in every single case.

Senator UDALL. General, thanks. Let's continue this spirit of discussion.

I want to thank all the members of the panel, as well. And I thank you for your service.

Thank you.

Chairman LEVIN. Thank you, Senator Udall.

Senator McCaskill.

Senator McCASKILL. Thank you, Mr. Chairman.

I thank all of you for being here.

There are basically three areas I'd like to try to cover, quickly, that I think are important. An overarching concern is that of confidentiality. So many of the issues surrounding mental health,

whether it is brought on by a brain injury or whether it's brought on by substance abuse, alcohol abuse, or prescription drug abuse, so much of the problem we have in the military is the stigma associated with getting help, particularly for Active military, Reserves, and National Guard.

And I'm sure you all are aware of the pilot program that is ongoing—I know General Chiarelli and I have talked about it—for the confidentiality of alcohol and substance abuse treatment at three different facilities, where these soldiers are not being referred to their chain of command after they have sought treatment.

I would like—General Chiarelli, could you address how that program is going, and whether you think this pilot program shows real potential for allowing folks to get help without the negative impact to their careers that so many of them fear right now?

General CHIARELLI. Tremendous potential. We've done it at three installations. We start in Fort Carson in August. We're expanding it to two others. The only thing that's not—and the secretary of the Army approved this, a month ago—the only problem that we're having is trying to recruit the number of drug and alcohol counselors that we need in order to ensure that, when someone self-refers themselves for this problem, that, in fact, they can be seen immediately and not be told, "Well, come back 6 weeks from now and we'll take care of you." But, we're seeing great results from the three installations that we have started the pilot at.

Senator MCCASKILL. Well, and I—that leads to one of the other areas that I wanted to cover today, and that is the availability of counselors. As you know, in 2009 I was successful at getting a provision that required the Institute of Medicine to do a study whether licensed mental health counselors should be allowed to practice without supervision within the military for purposes of this kind of counseling. That study was released in January, and supported the conclusion that they should be able to practice without that extra layer of supervisory personnel. And I'm curious now, with that, Do you see the ability for us to staff up at more appropriate levels to get at this problem that we see, in terms of availability of mental health professionals for our men and women who need help?

General CHIARELLI. Yes. This is a wonderful provision. And we've come to about 92 percent of our pre-2001 authorization. But, I—we've done an exhaustive study. And just as we reach, or are getting close to reaching our goal, because of the increased amount of drug and alcohol issues that we've got in the Army—and I'm not going to paper that over—we need about 225 more. So, we have got authorization to hire an additional 225, and this is going to be a great help to us.

Senator MCCASKILL. I think it's so important that we look at this as just as important as so many of the other tools we give to our fighting men and women. Our heroes need, not just the protective armor of the battlefield, they need the availability of help when they need it. And, I know that you've made this a huge priority, I know all of you on this panel have.

I want to make sure that if there's anything that we can do, as members of this committee, to continue to reinforce this at the highest levels of leadership in our armed services, that you let us know. Because, I think—the idea that we would stand between

more help for our men and women who are struggling, that we need to get more people on board, is very frustrating. And I want to make sure that you know that there are many of us that want to—we want to go to battle over this, if necessary.

And that brings me to the final thing. Unfortunately, Missouri has had one of the highest rates of suicide in our National Guard. And that is this notion of embedding, particularly for our National Guard and our Reserves—embedding mental health counselors within units. As you probably know, this has been done in California, at a surprisingly low pricetag, because the availability of the embed is for the weekends and for the 2-week training, as opposed to, you know, 365 days, around the clock. And that help, during those weekends and during those weeks of training, I think, could be a huge assistance to our National Guard members. And would want your reaction to that.

I know that we don't have a member of the Reserves on the panel, or National Guard, but if——

General CHIARELLI. No, I look for any way that I can get behavioral health specialists down to National Guard units, and I think embedding is an outstanding idea. I will work with the surgeon—they have not brought that program to me. We've been trying to expand at the telehealth capabilities to our National Guard armories. But, I promise you, Senator, I'll look into that and talk to the National Guard surgeon general about just that.

Senator McCASKILL. This is really important, because in California, which has the largest Guard component in the country, it has 40 different units—Guard units, in California—the cost for 1 year of mental health embeds was 820,000. That's a bargain, particularly when we see this kind of increase.

We've lost 5 members of the National Guard in Missouri, already this year, to suicide. That is something that is unacceptable, and something we clearly—and I know the general of the Missouri National Guard, General Danner, is very concerned, and wants to move toward some kind of embed program. And I would love—I think the support of the people at this panel this morning would be crucial for that to move forward. And I think we could also, obviously, do it for the Reserve units.

General CHIARELLI. We need to look across the National Guard, because, as I indicated before, we've had an increase of 21 suicides across the National Guard, at the same time we're down in all other categories. So, this has really got my attention and, I know, the attention of Ray Carpenter.

Senator McCASKILL. Okay. I'll continue to follow up on that.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator McCaskill.

Senator Begich.

Senator BEGICH. Thank you very much, Mr. Chairman.

I want to follow up, if I can, on just a few of the comments and responses to some of the questions that were given earlier.

First, General Chiarelli, I want to, one, thank you for the work you're doing. You are definitely passionate about trying to resolve this issue, or at least move forward in a positive way, and I really appreciate that.

So, let me ask, if I can—because I appreciated your comments on telemedicine. And I know, Dr. Jesse, you’ve been subjected to my conversation before on this issue, through the VA, for the Veterans Committee. And I do believe this is a huge opportunity that both the DOD and the VA can really exploit in a positive way. With the new generation of young people who—you know, you think, 10 years back, where we were with PDAs and telephones and cell phones and computers, to where we are today, is unbelievable. And so, I’m curious, because I hear what you said—your comment about the doctors, some doctors push back on this new technology. How are you getting them to see the value?

And I say this in a—in as polite way as I can. You’re the military. One thing I’ve learned about the military is, when you want to do something, you just do it and get moving. I understand that doctors have to grow into some of these things. But, time is of the essence. So, how—what are you using to get these doctors to get up—get on step with telemedicine? Because that is the future, when it comes to mental health services, especially in a State like mine, where, you know, these folks come back from serving, and they’re sent out—back home, to a village—and I’ll use the Guard as an example—back to a village of 200 people. No medical services that they can tap into, from a veteran’s perspective. But, what are you doing to get those doctors to get on step and get on with the program, here?

General CHIARELLI. We’re doing exactly what you would expect us to do now. We published an overall comprehensive behavioral health plan. We’re standardizing how we’re going to treat soldiers when they come back. Part of this time, I believe we’ve seen a thousand flowers blooming, and I think it’s time—[Laughter.]

—to move away from that, ensuring that we look for innovation and new kinds of treatments, but, at the same time, we have standard program for returning soldiers, that not only takes them from the day they return home, but at the 90-, 180-daymark, when so many of us, I think, would agree, we start to see many of these programs—problems pop up.

Senator BEGICH. Right.

General CHIARELLI. So, we’re doing it exactly in the military way that you allude to, Senator.

Senator BEGICH. Okay.

General CHIARELLI. And we’re going to make sure that it’s standardized across our force.

Senator BEGICH. I think that’s great. And I want to—if—Dr. Jesse, I know we’ve talked, but I’d love you to put on here—I actually just saw some technology development, done by an Alaska native corporation, on utilization of BlackBerrys, PDAs, and others, on alcohol screening and alcohol abuse—kind of, follow-up for those that decide to move forward. And I—you know, I saw that technology, and I—it was impressive to me, because what it shows is, it’s reaching into how to get to these young men and women in their world of technology, versus what we think is right way, bringing them into the office, sit them down. We’re touching them in a different way. So, that technology is very unique. And, I know the VA is starting to look at some of that.

Can you just put on the record a little bit of what you're doing around electronic telemedicine?

Dr. JESSE. Well, sure. As you know, we've got quite a long history in telehealth, the—actually, dating back even to the '80s, with home monitoring of pacemakers, as, you know, one of the—using TTM technology. We've invested heavily in home telehealth by putting, if you will, “boxes” in patients' home. I think we've got 43,000 of them deployed. But, as you mention, the new technology is using smart phones, where you don't even have to invest in something that ties somebody to their home. Anybody who's got a kid in their 20s now knows you don't even bother to call them, you just text them.

Senator BEGICH. That's right.

Dr. JESSE. They don't answer their phone, but they'll text you back.

Senator BEGICH. Right.

Dr. JESSE. And, interestingly, as an example, you're all aware of the VA's suicide hotline, which people can call in to, but, about a year ago, they started a chat line for—you know, the younger folks are much more used to chat lines on the Web than they are to having phone conversations. And that's been, I think, an important, you know, emerging way to contact, for the younger people. So, as we deploy that mental health technology, along with all of other medical capabilities, using new technologies that the people who need it understand and prefer to use, I think, is going to be vital. So—

General CHIARELLI. Could I mention—

Senator BEGICH. Yes.

General CHIARELLI.—one other—

Senator BEGICH. Please.

General CHIARELLI.—thing? We just signed an MOU with the VA on credentialing and privileging, which is a key and critical piece, here. And we can do that with the VA so their doctors can be part of our virtual behavioral health—

Senator BEGICH. Excellent. Yes.

General CHIARELLI. But, that is a real issue when you're trying to provide the same kind of care across State lines, and even within State lines. And in the area of behavioral health, I think we really need to look at some of those rules, and think about, Do we—do they need to be the same for this branch of medicine as they do, say, for a heart surgeon or someone else?

Senator BEGICH. You just got to my next question, so I'm going to start with you and then come down the row here. I'll leave my friend, Howie Chandler to last.

But, let me—if I—you just hit on—and that is—my next question was, What do we need to do—I mean, it's kind of the question that hasn't been asked; I think Senator McCaskill kind of started to get to it—What do we need to do, here in Congress, to help make it easier for you to deliver the services that you know, instinctively and as well as data has shown you, to the young men and women? And what you just made a comment about, making sure—delivering these services over State lines, or—I want to—maybe you could elaborate, but I—what are those one or two things, each one of you, if you could just expand—because part of what we should

be doing here, honestly, is—what do we need to do to support you? It's great to have a hearing, but what's the next step?

General CHIARELLI. I would mention credentialing and privileging. Give you just a quick example. I can go ahead and provide a TRICARE referral for a soldier at Fort Campbell, Kentucky, to drive 100 miles to Nashville to see a psychiatrist. I cannot hook him up over the Internet if he is not at military installation, and privileged and credentialed from that location. So, I can't hook into his office in Nashville, yet I can put a soldier in a car and send him 100 miles to go see that doctor, as a TRICARE referral.

Senator BEGICH. Good example. I mean—my time is up, but I wanted to give—if each one of you can just give a quick one, and then I'll close out.

Thank you, Mr. Chairman.

Go ahead.

Admiral GREENERT. Senator, for the Navy, if we could look at the age of healthcare professional appointments and mandatory retirements, there are a lot of people want to help, out there, that may be over the age of 42. And that, I think, if I understand it right, is the limit for a lot of our healthcare providers, particularly mental. That could be helpful.

Senator BEGICH. Very good.

General AMOS. Sir, for us the—your continued support for our deployment cycles and the—in sustainment of our Marine Corps while we are in between those deployment cycles, with programs like the Yellow Ribbon Program, our Returning Warrior Programs, those kinds of things that help our families—it's—that is a modest investment that has paid rich dividends. So, your continued support on that would be great.

Senator BEGICH. General Chandler?

General CHANDLER. Senator, I would echo what my counterparts have said, and also add to that, thanks for your support for the bonuses and special pays. That has allowed us to recruit, frankly, almost the numbers we need, in most areas. We're suffering, as the Nation is, in a shortage of mental health nurses. But, that's really the only shortage that's dramatic at this point. And we appreciate your support for that.

We've had some promising research at Lackland Air Force Base, in San Antonio, with TBI and hyperbaric treatment. Any support that we could receive in that area would also be very helpful.

Thank you.

Senator BEGICH. Very good. Thank you very much.

And, Dr. Jesse, we've already had our conversation. I'll leave that, if I can, because my time is expired. And I'll be tapping you, don't worry. [Laughter.]

Mr. Chairman.

Chairman LEVIN. Thank you, Senator Begich.

What kind of support do you need for that hyperbaric treatment?

General CHANDLER. Sir, we're actually in our infancy, quite honestly. If I can take that for the record and get back—

Chairman LEVIN. Is it a—

General CHANDLER.—in terms of costing.

[The information referred to follows:]

General CHANDLER. But, as most things go, it becomes a personnel and dollar issue. But, we've had some fairly promising results with hyperbaric chamber treatment.

Chairman LEVIN. If you can just give us any example—and this goes for all of you—where there is a funding shortfall on the appropriations side, we would more than welcome it. We're determined we're going to get you whatever funding you need to address this issue.

Senator Lieberman.

Senator LIEBERMAN. Thanks, Mr. Chairman.

Thanks, to all of you. I apologize that I was drawn out to another meeting in between.

I appreciate, very much, the work that all the services are doing on these problems, particularly, obviously, suicide prevention programs. And I know, for each of you, this is a deeply personal issue, and I thank you for the time that you're putting into it.

In my own work on this, I have become familiar with some statistics that surprised me. And I want to offer them, not to diminish the problem that you and we are facing among servicemembers, because every suicide is a tragedy, and we want to prevent them all. But, what's interesting to me is that—and obviously the most significant factor for all of us is the extent to which the suicide rate among Active Duty U.S. military personnel has increased, over the last decade, from 9.1 per 100,000, in 2001, to 15.6 per 100,000, in 2009. The increase is in comparison to a rate among the civilian population of 11.11 percent per—11.11, per 100,000 population. But, what's really striking to me, and shows, really, a broader societal problem—if you take out the young male population in the country—and the military is still disproportionately composed of young males, as compared to the overall population—the rate of suicide among 18- to 24-year-old males is 17.8 percent.

So, this—I mean, this is—this suggests a broader societal problem, which was a total surprise to me as I went over the numbers. And it doesn't diminish the—in any way, the importance of the efforts you are making, and we're trying to support you in making. But, what it says is that rate of suicide among young males in military was actually significantly lower than the general civilian population. Certainly, a decade ago, now has come up, but still is lower. And obviously, we'd like it to be zero.

But, I want to suggest, in these statements, no attempt to minimize the problem, but to say that this cries out for some larger societal response that deals with young males in our society.

I don't know whether any of you want a response to that—or want to respond to it.

General CHIARELLI. If I could, real quick. The—you know—

Senator LIEBERMAN. Yes—

General CHIARELLI. We've—

Senator LIEBERMAN.—General Chiarelli.

General CHIARELLI. Sir, we've run across something that's very, very interesting. As I indicated—I threw out some numbers—but, when we look at the number of soldiers who are first-termers—

Senator LIEBERMAN. Right.

General CHIARELLI.—who join the Army between the ages of 28 and 29, they account for three times their expected rate of suicide.

In other words, they're only 5 percent of the first-term populations, but they account for 15 percent of the first-term suicides, which would indicate that not only is it youth, but it is also this combination of additional stressors.

Senator LIEBERMAN. Interesting. Well, those are compelling numbers.

Let me go on to a question. And, I apologize, I gather, from staff, this hasn't been dealt with in depth, so I'll run the risk of asking it again. And this is the question of how the services diminish the understandable human fear, that anxiety in a member of the service, that going for help will be detrimental to that serviceperson's career and advancement. I know that the Air Force actually quantified that in their study. But, my own sense, from conversations with members of other services, is that this is a pervasive problem. And I—so, the question—you all, obviously, are deeply concerned about this and focused on how to make it better. And, in some sense, my question is, How do you transfer that concern down the chain of command so that individual members of your services feel that, you know, you go for help for a mental problem, just like you go for help if your leg is bothering you?

General CHANDLER. Senator, I wouldn't minimize that problem for the Air Force, quite frankly. I think it still exists, and I think there is a stigma attached to that. I think the basic answer to your question is, it becomes a leadership issue, directly down to the senior NCOs and officers that look the young men and women in the eye every day, that can recognize whether or not they have an issue, and then act accordingly.

We have the same demographic issues that you described earlier, in terms of young male airmen that are taking their lives. We diverge a little bit from the other services, in that our biggest issue, in terms of suicide, are relationships; about 70 percent of Air Force suicides involve relationship issues of some kind.

Senator LIEBERMAN. You mean within the military—

General CHANDLER. Yes, sir. These—

Senator LIEBERMAN.—or—

General CHANDLER.—are typically personal relationships.

Senator LIEBERMAN. Personal. Yeah.

General CHANDLER. Second would be legal issues that a member might have. And then, thirdly, financial. Only 20 percent of our suicide victims had been deployed in the last year. So, we deviate, again, a little bit from the Army and the Marine Corps, as we do that. But, if you look at the elements of the Air Force where that occurs—those specific career fields—those, in fact, are young male members, primarily in terms of security forces, EOD—explosive ordnance disposal—and those kinds of duties. But, at the same time, those career fields are also under a fair amount of OPTEMPO, as you know. Security forces are at 1-to-1, in terms of dwell time.

So, I wouldn't minimize the way we get at this in the Air Force, but we have moved our mental health care providers into our primary care clinics, to try to keep people from having to necessarily go someplace else, behind a curtain, to see a mental health provider. Our airman family and readiness centers also provide military health counselors, where you can actually go get help with your family members or for yourself. And, of course, the military

One Source provides, at no cost—I believe the number is six visits that you can arrange for yourself to do that. Again, all of these are confidential kinds of ways to do this.

So, there are ways to get at it, including our Chaplain Corps, which are all trained in suicide intervention, as well. So, we can approach this from a number of different directions. But, I think the stigma issue is one that's going to be very, very difficult to overcome.

Senator LIEBERMAN. Thanks.

You know, my time's up, but I wonder if any of the others of you want to briefly comment on that. What—essentially, what you're doing to try to remove this—the—what General Chandler called—I think, appropriately called, a stigma.

General AMOS. Senator, you're absolutely right. And I think this is evolutionary. Just 5 years ago, you—we wouldn't have even been talking about this in a battalion or a squadron or some type of deployed unit. We would be sloughing this off. So, now, my sense, in the Marine Corps, is, we have the senior leadership of the Marine Corps, both the enlisted and the officer side, that are believers. They understand that this stigma is real and that we have to set the conditions to get around it. I'm not convinced that our middle-grade staff NCOs and our young officers have the same sense of appreciation. I think it's probably because they're younger, there's less—

Senator LIEBERMAN. Right.

General AMOS.—they've been exposed to it less. But, this is a leadership issue that we're working on. To get around this and to try to mitigate this, we've put mental health—we call them OSCAR teams—we put them in the deploying battalions that are forward-deployed. We have gone through—and that's got mental health providers, corpsmen; we brought our chaplains involved in these things. So, now we have embedded these units with every single forward-deployed unit in Afghanistan right now. So, we're trying to get away from that.

And the final thing—I mean, there's just a host of things we're trying to do to deviate around this, or sneak around behind the backdoor of this stigma thing—but, the last thing is, is that, on the suggestion of our young marines, we are establishing, right now, with TRICARE West, everything west of the Mississippi, a Marine Distress Hotline. It's manned by marines, plugged into the TRICARE West, 21,000 healthcare—mental health care providers. And the whole idea behind that, it's completely nonattribution. Family members can use it 24 hours a day. You can call and say, "I'm having serious issues with post-traumatic stress," "I'm having issues with whatever." And it can be a—and it's all anonymous. So, we're—

Senator LIEBERMAN. Right.

General AMOS.—working around it, Senator.

Senator LIEBERMAN. Mr. Chairman, I know my time's up. I leave it to you. I don't want to intrude on Senator Hagan's—

Chairman LEVIN. Admiral, that's fine. You can go ahead. I'm sure—

Admiral GREENERT. Real quick, Senator, if I may. We have a, kind of, statistically different situation. The—our demographics for

those that committed suicide is sort of spread across the age spectrum, and location and rating and seniority. The last three suicides—we had a 40-year-old senior enlisted individual, right before deployment; a 50-year-old captain about—entering retirement; and an 18-year-old sailor, just out of boot camp.

So, what—looking across that, our focus has been, no one's immune to the stressors, and, if you can't deal with the stressors, to a bad choice.

Senator LIEBERMAN. Right.

Admiral GREENERT. So, it's a—to us, a leadership issue. We focus on operational stress control and management. And for those that still have a stigma—and it does exist—we have what we call Deployment Health Centers—there are 17 of them, they're spread around where our fleet concentration area is—where folks can go and see a clinician or a counselor, with really no—it—the stigma's not attached. It's not attached to the hospital, it's not attached to the fleet family support center; it's located away, where our sailors feel more comfortable. We find that, once they go there, then they'll see there's nothing wrong seeking treatment, and they tend to migrate to the clinic.

Thank you.

Senator LIEBERMAN. Good. Thank you.

Chairman LEVIN. Before I call on Senator Hagan, let me mention this. I'm going to have to leave. There's a question, that I'm going to ask you to answer for the record, about the status of our Centers of Excellence for Traumatic Brain Injury.

[The information referred to follows:]

Chairman LEVIN. And, if Senator Lieberman is not able to stay, then I would ask Senator Hagan to adjourn the committee after she is done.

Thank you.

Senator Hagan.

Senator HAGAN. So, that means we might be here a while. No. [Laughter.]

I think this is a very important hearing. And I think anytime we have one suicide, that's one too many. And certainly, the numbers that we've been seeing is certainly unacceptable. So, I really appreciate the time that the services is putting into helping address this issue.

General Chiarelli and General Amos, you have underscored the importance of mental resiliency programs, proper and timely diagnosis, transferring the culture of leadership with regards to the invisible wounds, the strain of our forces, limited dwell time; and personal problems, such as financial and relationships, are certainly among the many challenges that we have to overcome. However, we do have a responsibility to effectively institute mental resiliency programs to prepare our servicemembers for the combat stresses that they will ultimately face. What are the services doing to institutionalize resiliency training at the predeployment and the post-deployment stage?

General CHIARELLI. Our program is comprehensive soldier fitness. And, as you know, Senator, we've been working with the University of Pennsylvania. We have trained over 1200 master resilience trainers, through a very intensive course. Our goal is to get

them down to every battalion in the United States Army. We are focusing those trainers, right now, at the basic entry levels of our soldiers, because we know we have to build their resiliency early on in their career. It is absolutely critical.

In addition to that, we have the Global Assessment Tool that is a requirement for every soldier to fill out, to understand where they stand when it comes to resiliency. And we've had, now, over 780,000 folks fill out the GAT. Plus, online instruction, based on the results you get on the GAT, that is available for a soldier to take, to work resiliency.

So, this is something that finally starts to get us to the left, and not waiting until we see soldiers with problems, but try to attack resiliency as far to the left as we possibly can.

Senator HAGAN. Thank you.

General Amos.

General AMOS. Senator, we, in the Marine Corps, believe it's two-part. Resiliency is both physical and mental. The beginning stages of a marines recruit training at Parris Island or San Diego builds—begins to build that physical strength. And we attribute a lot of our ability to be able to do the things the Marine Corps does for this Nation as a result of its physical strength training. So, it begins there.

Values-based training was instituted about a year ago in the Marine Corp, at boot camp and at schools of infantry—at North Carolina, at Camp Geiger, and out in San Diego, at Camp Pendleton—which teaches some of these things, along with suicide prevention, sexual assault prevention, those behavioral health issues. So, that's where it begins.

When the marine enters his first unit and is preparing to deploy, we believe the best thing we can do for them is to not only get them physically fit, conditioning-wise, which we have a combat fitness regimen we put them through, but the second piece is what we call immersion training. In other words, it's—we want the marine to experience, back home, before he or she leaves, most of what—the fear, the anxiety, the confusion, the fog of war. So, we have built—we started on the West Coast, we're now migrating to Camp Lejeune, going out to Hawaii, and and we'll do the same thing in Okinawa. But, a—but, an immersion trainer, inside a building—it's a huge building—and we've got—we transition from an Iraqi village to an Afghan village. We've got role players, we got amputees in there, we've got RPGs that fire, we've got music, we've got—well, we've got everything in there. You couple that, and you rerun the scenario over and over again, so the young marines become accustomed to fear, and they become accustomed to the uncertainty of warfare. You take that, you put them in an IED lane that's as—2 and half miles long, walking through villages, IEDs are going off, RPGs, more role players. And so, you get the idea that our last attempt to build this resiliency is to immerse them, as much as we can, and help them know that their training is adequate and they will be okay.

We find that, if we do that, that when they are—when they hit their first firefight, their chances of them surviving are greatly enhanced. And we believe, intuitively, that they'll probably have less cases of PTS, down the road.

So, that's what we're doing to build that resiliency. And we follow along when they come home.

Senator HAGAN. Thank you.

Admiral Greenert, you mentioned, in response to Senator Begich's question, the last question that he asked, something about the age of 42. And I didn't quite get that. Could you elaborate on that?

Admiral GREENERT. Yes, ma'am. Healthcare providers who desire to enter service, there's a limit—maximum age of 42. That allows them 20-year—for a 20-year career, age-of-62 mandatory retirement. That was the point. If we could raise that age—because there are a lot of folks older than 42 that—

Senator HAGAN. Okay.

Admiral GREENERT.—want to help.

Senator HAGAN. That's what I thought. Thank you.

Many of the burdens associated with the wars in Iraq and Afghanistan have been shouldered by the Reserve and the National Guard members. And when these citizen soldiers redeploy, they are almost immediately demobilized and returned to their civilian lives. Unfortunately, for many, the lives and the jobs that they left are not what they return to, which is compounded by the isolation of not having a support structure that's comparable to what is available to those on Active Duty.

I've got—one of the questions is, What efforts are being made to ensure that our members of the Guard and Reserve have a soft landing when they return home?

General CHANDLER. Senator, if I could. I would—

Senator HAGAN. Great.

General CHANDLER.—I would tell you that, in your reintegration and redeployment process, you need to go all the way back to the beginning, obviously, before you start your deployments, to make it successful. Our Guard and Reserve total force, if you will, in the Air Force, and that includes Air Force civilians, all have access to the same things that our Active Duty people do, as well.

Your point is well taken, in terms of how we reintegrate those people once they come home. I would tell you that the Yellow Ribbon Reintegration Program, that's been a very good part of our Guard and Reserve, has been very successful at, not only preparing members and families for deployment, but caring for families during deployment, and then giving us the opportunity to reintegrate those Guard and Reserve members when they return.

In my discussions with the commander of the Reserve and the director of the Guard, they seemed to be very happy. We're happy, at this point, with the results that we're getting. And we're getting the resources to do that. And for that, we appreciate your support.

General AMOS. Senator, for the Marine Corps, we will deploy almost two types of—we don't have Guard, as you know—and two types of Reserves. We'll deploy what we call a Selective Marine Corps Reserve Unit, which is a whole-cloth unit, a squadron, a battalion. You know, it's some type of unit. They actually activate 4 months or so before they deploy. They go through the entire training program, the resiliency training, the immersion, all that stuff. So—and when they come back, they do a unit reintegration. So,

it—they have access to the exact same capabilities and helps that a regular unit does.

Where we struggle, and where we have been working hard the last year and a half, are what we call “individual augments.” In other words, that’s that young marine, out of the middle of North Carolina or Oklahoma or someplace, that is pulled out of what we call Individual Ready Reserve. He or she has volunteered, perhaps, and come forward and said, “I’ll go to Afghanistan. I’ll join the staff of General McChrystal.” And that individual then comes on Active Duty individually, doesn’t have access to all these great programs. We do our best, we have a training program for them to get them set; but, when they come home is where we—where I worry the most about. And that’s where, just as General Chandler talked about, the whole idea of the Returning Warrior, or the Yellow Ribbon Program, has been such a huge hit, because we reach out, harvest them in, and then plug them into that program, along with their spouse, and it gets rave reviews. So, that’s how we are trying to accommodate those onesy-twosies.

Senator HAGAN. All right.

Thank you. My time is up.

Senator Lieberman.

Senator LIEBERMAN [presiding]. Thank you. Sorry.

I have no further questions. And I thank all the witnesses for what you’re doing, and also for your responses to our questions.

I know, from Chairman Levin and Senator McCain, this will be—and for all of us—this will be a continuing focus of concern for members of the committee. We are so grateful to our military personnel. They serve with such honor and capability and sacrifice. It’s a part of why, of all the great institutions in our country, I think the military today remains one that still enjoys broad public respect and trust. But, it takes its toll, that service and sacrifice, and I think we’re getting much more in touch with the toll it takes on the minds and spirits of people who serve. And therefore, we want to do everything we can to make sure that we, one, prevent the most serious problems, such as suicide; and, two, we treat problems much before we get to that point.

So, I hope you will understand that we—that you should feel free to advocate to us what you think you need from Congress to fulfill the goals that you have in this regard, which are the goals that we have as well.

I thank you very much. And the hearing is adjourned.

[Whereupon, at 11:40 a.m., the committee adjourned.]