

RECORD VERSION

STATEMENT BY

**GENERAL PETER W. CHIARELLI
VICE CHIEF OF STAFF
UNITED STATES ARMY**

BEFORE THE

SENATE ARMED SERVICES COMMITTEE

SECOND SESSION, 111TH CONGRESS

**TO EXAMINE PROGRESS IN PREVENTING MILITARY SUICIDE AND CHALLENGES
IN DETECTING AND CARE FOR THE INVISIBLE WOUNDS OF WAR**

JUNE 22, 2010

**NOT FOR PUBLICATION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

**STATEMENT BY
GENERAL PETER W. CHIARELLI
VICE CHIEF OF STAFF
UNITED STATES ARMY**

Chairman Levin, Senator McCain, distinguished Members of the Senate Armed Services Committee; I thank you for the opportunity to appear here today to provide a status on the United States 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.

On behalf of our Secretary, the Honorable John McHugh and Chief of Staff, General George Casey, I would like to take this opportunity to thank you for your continued, strong support and demonstrated commitment to our Soldiers, Army Civilians, and Family Members.

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

I will tell you, the men and women serving in the Army today are doing an absolutely outstanding job on behalf of our Nation. They are well-trained, highly-motivated, and deeply patriotic. Our nation has asked a lot of our Soldiers and they have exceeded expectations by a long shot.

However, the prolonged demand on them – *and on their families* – continues to put a significant strain on our Force. Many individuals have deployed multiple times. They are tired. A significant number of them suffer physical injuries, such as musculo-skeletal damage, amputations, bullet or shrapnel wounds, or burns. Many more suffer from behavioral health issues, such as depression, anxiety, traumatic brain injury and post-traumatic stress – often referred to as the “invisible wounds of war.” The Army is

continuing to work very, very hard to identify ways to address these behavioral health issues by alleviating some of the stress on our Force while also improving our ability to detect, prevent, and treat these and other injuries.

Our overarching goals are to improve individuals' resiliency; eliminate the long-standing, negative stigma associated with seeking and receiving help; and, ensure Soldiers, Army Civilians and Family Members who may be struggling get the help that they need.

Calendar Year (CY) 2009 and CY 2010 Army Suicide Reports

Suicides in the United States Army have been on the rise since 2004. In CY 2009, we had 162 active duty suicide deaths (including activated members of the National Guard and U.S. Army Reserves), with 244 across the total Army. During this same period, we had 1,679 known attempted suicides.

However, so far this year, we've seen a fairly significant reduction in suicides among active-duty Soldiers. As of 10 June 2010, there have been 62 suicides (includes 3 activated USAR Soldiers and 3 activated ARNG Soldiers); for the same time period last year there were 89.

Unfortunately, we have seen an increase in suicides among reserve component Soldiers not on active duty [2010 total (as of 10 June)—53 (43 ARNG; 10 USAR); 2009 total—42 (same time period)].

The decrease in active duty suicides would seem to indicate the refocused efforts by our Army are beginning to work. Conversely, the increase in suicides among reserve component Soldiers not on active duty may reflect the Army's more limited ability to influence these Soldiers once they return home.

We also track suicides among Department of the Army Civilians [2010 total (as of 10 June) for DA Civilians—13; 2009 total—21] and Family Members [2010 total (as of 10 June) for Family Members—4; 2009 total—11].

The loss of any Soldier, Army Civilian or Family Member to suicide is tragic, incomprehensible, and unacceptable. Each of these suicides represents an individual and a family that has suffered an irreparable loss. Army leadership is working to better understand the causes of the disturbing rise in Soldier suicides and we've instituted prevention measures that recognize everyone in the Army must be part of the solution. You have my word that we will continue to work diligently to further reduce suicides across our Force.

Soldiers engaging in high-risk behavior

Equally alarming to the increase in Army suicides is the growing population of Soldiers engaging in high-risk behavior. Illicit drug use, alcohol abuse, disciplinary infractions, misdemeanors and felony crimes are all on the rise. There is a known spike in these behaviors as Soldiers return from deployments. A so-called "star burst" effect has been recognized at about the 90 day mark, where an increase in these and other high-risk behaviors has been noted. Meanwhile, there is a clear link between suicides and these and other high-risk behaviors.

Of the 160 active duty suicide deaths in Fiscal Year (FY) 2009, 146 were related to high-risk behavior (e.g., self-harm, illicit drug use, binge drinking and criminal activity); including 74 drug overdoses. Data collected since 2005 consistently show that approximately 33 percent of suicides included either drug or alcohol use. In addition 32 percent had some form of closed or pending misdemeanor or felony investigation.

Prescription drug abuse

Meanwhile, recent estimates show that 14 percent – or approximately 106,000 Soldiers – are prescribed some form of pain, depression or anxiety medication. This ranges from Percocet for a simple tooth extraction to powerful anti-psychotic

medications prescribed to an individual experiencing a true psychiatric crisis. The potential for abuse (or misuse) is obvious. We are working with the legal and medical communities to improve transfer of information between commanders, medical professionals, and program and service providers, while ensuring we protect the privacy rights of patients.

The office of the Army Surgeon General is also drafting a new policy to provide guidance on the prevention and management of polypharmacy with psychotropic medications and central nervous system depressants. This new policy will assist in reducing adverse clinical outcomes among patients receiving care in the military medical system.

This is one of the major risks associated with suicide: polypharmacy, post-concussive syndrome and pain. I have mentioned the first two; to address pain management, our medical department recently led a task force consisting of subject matter experts from all services and Department of Veterans Affairs (DVA). This task force has developed a number of recommendations to improve pain management for our patients; and, we are currently developing a campaign plan to address this important issue. These efforts will improve care for all patients, both in & out of uniform.

The Army is also continuing to conduct and evaluate programs for substance abuse self-referral, pre-deployment and post-deployment behavioral health screening, and the use of virtual communication technology to provide more accessible behavioral health counseling.

The nationwide shortage of behavioral health care providers and substance abuse counselors continues to present a significant challenge. The Army is working hard to recruit more in order to meet the increased need for these services across our Force.

For example, one hundred more Medical Corps officers were recruited in FY 2009 as compared to FY 2007. One hundred and twenty more civilian Behavioral Healthcare personnel were hired in FY 2008 compared to FY 2007. Meanwhile, the Army has increased funding for use of “3R” bonuses (recruiting, relocation and retention) in order to hire more substance abuse and family advocacy program counselors. The Army has also expanded its civilian force structure to include supportive specialties such as Licensed Professional Counselors, Licensed Marriage and Family Therapists (LMFTs) and Military Family Life Counselors (MFLC).

Army Suicide Prevention Task Force

After the all-time high of 20 suicides in a single month, January 2009, the Army mandated an unprecedented Army-wide stand-down followed by a deliberate chain teaching program focused on suicide prevention. The Secretary of the Army, at that time, the Honorable Pete Geren and Chief of Staff of the Army, General George Casey appointed me to lead the effort to reduce the trend of suicides in the Army.

I ordered the immediate activation of the Army Suicide Prevention Task Force (ASPTF) – a group of multi-disciplinary representatives from across the Army staff – in March 2009 to dedicate focused energies and resources to tackle all aspects of suicide.

Over the past year, the ASPTF examined the complexity of suicide, taking into account national suicide trends, individual Soldier risk factors and the Army’s institutional approach to suicide prevention. The task force identified risk factors and indicators that help potentially illuminate correlations to high-risk and suicidal behavior in the Army. The task force continues to review over 70 existing Army-wide programs, identifying those that work, while strengthening the most effective programs and streamlining efforts where it makes sense.

The unique governance, policy, structure and process of the task force, together with the Army Suicide Prevention Council (an interim HQDA-level organization chartered under my authority and mandated to expedite solutions from HQDA through

appropriate commands) greatly expedited implementation of many strategic changes over the past 12 months, including:

- June 2009, reduced accessions waivers for adult felony (major misconduct) convictions; and DAT (positive drug and alcohol tests at MEPS); misconduct (misdemeanor)/major misconduct for drug use; possession; or drug paraphernalia, to include marijuana. This translated to nearly 4,300 fewer applicants accepted into the Army as compared to 2008.
- Revised legacy protocols for investigating and reporting suicide.
- Rewrote DA PAM 600-24, *Health Promotion, Risk Reduction, and Suicide Prevention (HP/RR/SP)* for synchronization of HP/RR/SP Program Portfolio. This policy integrates HP/RR/SP programs and services at the installation level.

VCSA Suicide Senior Review Group

In an effort to learn as much as possible from every suicide, in March 2009 I also established the monthly VCSA Suicide Senior Review Group (SRG). The SRG involves senior commanders from affected commands across the Army. We meet in person or via video tele-conference and review approximately 15 to 20 suicide cases each month. The cases are discussed to glean lessons learned and identify trends and themes in an effort to help prevent future suicides. The SRG is the most intense two and a half hours I spend each month.

Also, to aid in gain as much information as possible from every suicide, the task force developed a suicide event collection report, comprised of data fields to be filled in by the Field Army. The report provides me and Army leadership with instant, actionable information on each individual Army suicide within approximately 72 hours of the Criminal Investigation Command's initial response.

Army Campaign Plan for HP/RR/SP Report

The ASPTF is responsible for the development and publication of the Army Campaign Plan for HP/RR/SP, a comprehensive plan outlining unprecedented changes

in Army doctrine, policy and resource allocation. This holistic approach accounts for the many challenges our Soldiers, Army Civilians and Families face. These challenges include, but are not limited to: substance abuse; financial and relationship problems; and, post-traumatic stress and traumatic brain injury.

The content of the Campaign Plan was informed and developed by three concurrent efforts – (1) the collection of suicide data and research, (2) the comprehensive review of existing policy, doctrine and all known HP/RR/SP related documents from HQDA and across DoD, and (3) the VCSA-led installation level assessment, which obtained input from commanders, Soldiers and Family Members and reviewed programs and processes at the installation level.

I also chartered a multi-disciplinary team of experts led by a General Officer that is writing a comprehensive report on the Army's HP/RR/SP past and future efforts. The team is preparing to release its full report as soon as it is completed and reviewed.

The report represents over a year's worth of work at the direction of the Army's Senior Leadership to provide a "directed telescope" on the alarming rate of suicides in the Army. The report is based on the ASPTF's experience, ongoing research; and, presents new concepts and modeling for HP/RR/SP governance, policy, structure, and process. It represents the most comprehensive HQDA report of its kind, capturing both the initial findings of the ASPTF and informing the future of suicide prevention within the Army.

In an effort not to prematurely reveal out of context details on findings, I will mention very few in this statement. Prior to the formal roll-out, I and the Army's other senior leaders will come back and brief the Members and their staffs on the full contents of the report.

Bottom line: this report indicates there is a confluence of stressors that cause suicides, but no single panacea to prevent them. As I have said many times over the past year, there is no one solution to this problem.

Last year, shortly after Secretary Geren and General Casey appointed me as lead of this ongoing effort, I visited six installations with a team for the sole purpose of looking at suicide prevention efforts in the Force. By the time we reached the third installation, it was readily apparent to all of us that this challenge was not limited specifically to suicides; but, to the overall health and well-being of the Force after eight-plus years of war. In other words, we quickly determined that suicide is merely a symptom – *albeit the most severe* – of a much larger problem. The focus on suicide prevention was too narrow and the aperture needed to widen to a more comprehensive review of all Soldier and family risk reduction and wellness programs.

That initial eye-opening experience led to the holistic approach we have since adopted to achieve Soldier wellness (promoting the physical, mental and spiritual health of the force). 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.

A Team Approach

As I emphasized previously, effectively addressing the challenge of Soldier suicides will require a team effort across all Army components, jurisdictions, and commands, as well as continued cooperation with partners outside of our organization, to include DVA (has joined the Army Suicide Prevention Council) and the National Institute of Mental Health (NIMH).

In October 2008, the Army entered into a 5-year, \$50 million joint study with NIMH, the *Army Study to Assess Risk and Resilience in Service Members* (Army STARRS). This study represents the largest DoD longitudinal epidemiologic study of

mental health, psychological resilience, suicide risk, suicide-related behaviors, and suicide deaths in the Army. The goal is to help identify those Soldiers most at risk, as well as develop intervention and mitigation strategies that will help decrease the number of suicides across the Army.

This is the largest single study on the subject of suicide that NIMH has ever undertaken. It includes Soldiers from every component of the Force – Active Army, Army National Guard, and Army Reserve. The study will follow willing Soldiers as they enter the training base and periodically thereafter for the next five years. The researchers will conduct a variety of interviews, surveys, psychological evaluations, etc.

Intermediate data and emerging results are reported quarterly to inform the Army's ongoing intervention strategies. Initial findings from preliminary analyses of suicide deaths include:

- Suicide risk is highest for currently deployed Soldiers, next highest for previously deployed, and lowest (in relative terms) for never-deployed Soldiers
- Since 2004, suicide risk has been elevated among Soldiers with < 1 year of service
- Most (about 53%) Soldiers who die by suicide do not have a record of an encounter with a behavioral health diagnosis in the military healthcare system
- Mental disorders, particularly depression, anxiety, and post-traumatic stress are among the most potent risk factors for suicidal behavior
- The average period between onset of PTS and an individual seeking help is 12 years; during that period, symptoms can manifest in a variety of ways, including spousal abuse, anger management issues, divorce, drug/alcohol abuse, loss of employment.

We are confident this study's findings will eventually lead to predictive algorithms. Ultimately, we are trying to develop a predictive model that accounts for the cumulative effect of transitions of all types (accession, PCS, death of family member, TCS, retirement, etc.) and stressors across a Soldier's entire career. Ideally, this would

lead to tailored interventions based on known or predictive levels of stress. The results will benefit the Army, the other military Services, as well as the U.S. population overall, and may lead to more effective interventions for both Soldiers and civilians.

Traumatic Brain Injury and Post-traumatic Stress

One of the challenges in preventing suicide is recognizing that an individual – even someone as close as a family member or good friend – is considering taking his or her own life and may need help. Too often individuals will suffer in silence. They may be dealing with severe depression or anxiety and choose to hide their concerns from family members or friends.

Post-traumatic stress (PTS), traumatic brain injury (TBI), and other behavioral health issues can present similar significant challenges. I consider these “invisible injuries” to be among the most common result of the “signature weapon” of this war: blast. In fact, the majority (60%) of the Soldiers enrolled in the Army’s Wounded Warrior program have PTS (43%) and/or TBI (17%) as a primary service disqualifying injury of 30% or greater.

These injuries pose unique challenges, especially as compared to easily-detectable wounds such as amputations and burns. PTS and TBI are among the most difficult and debilitating in terms of accurate diagnosis, treatment, and recovery. The study of the human brain is an emerging science; and, there is still much to be learned about these and other highly-complex injuries involving the brain. This pertains not just within the military community, but throughout the entire medical community as a whole, worldwide.

We are making progress, both in theater and at medical facilities around the world. In a concerted effort to minimize the number and severity of injuries, the Army implemented a new TBI management strategy across the force aimed at prevention, early detection and effective treatment of injuries. Additionally, the Army is instituting a revised program of instruction for medics and other behavioral health providers that

includes training specific to TBI and PTS injuries. We're also incorporating instruction on this important issue into training programs at the National Training Center, Joint Readiness Training Center and other locations.

The new TBI management strategy, "*Educate, Train, Treat & Track,*" is also being successfully implemented downrange. Deploying Soldiers receive training prior to their arrival in theater; in fact, I personally have briefed several units. Last week, I briefed a deploying Brigade Combat Team via VTC. This emphasizes to Leaders and Soldiers just how serious I, and the Army's other senior leaders, are when it comes to these very serious injuries.

The new TBI management strategy also includes strict "event-based" protocols that govern exactly what Leaders and Soldiers must do if involved in any type of concussive event. At a minimum, every Soldier must undergo a medical evaluation followed by a mandatory 24-hour downtime period and a second exam before returning to duty. We cannot permit the proud "Warrior Spirit" of our Soldiers, which leads many of them to ignore their concussions and remain in the fight, to dominate the competing need to protect them against another injury during the vulnerable period of healing.

Meanwhile, back at home, since 2002, the Department of Defense has opened 52 TBI treatment centers across the country. These centers are staffed with multidisciplinary teams of medical providers capable of treating the full range of TBI, from mild to severe. The National Intrepid Center of Excellence, dedicated to research and treatment of military personnel and veterans suffering from TBI and other behavioral health issues will open this summer. It is built on the Bethesda, Maryland campus of what will become the new Walter Reed National Military Medical Center, the DoD's largest and most advanced medical complex, and across from the National Institute of Health—a key partner in advancing the science and treatment of these injuries and illnesses.

We are making progress, but it remains an incredibly challenging endeavor. The reality is some of these neurological injuries or conditions cannot be fully healed or repaired even with the most advanced medical treatment available. Unlike an amputation, for example, there is no standard procedure or prognosis for care for moderate or severe TBI. This can understandably add to the frustration felt by affected Soldiers and family members.

In the past, individuals suffering from TBI, PTS, or what was previously referred to as “battle fatigue,” were often told there was nothing further that could be done for them. They were discharged from the military and left to suffer in silence. This is absolutely unacceptable. Next to the prosecution of current and future conflicts, our highest priority remains caring for the brave men and women who serve and sacrifice on behalf of our Nation.

In 2007, the Army established Warrior Transition Units (WTU) to facilitate the treatment and rehabilitation of Soldiers determined to require complex medical care for six months or longer. Today, there are 29 WTUs and nine Community-based WTUs located around the world. Approximately, 9,300 wounded or injured Soldiers are receiving treatment at these facilities. Teams comprised of nurse case managers, health care providers, and cadre members assist them and their families through the full recovery process. The feedback has consistently been very positive. And, we are continually making improvements to the care and services provided at these facilities based on lessons learned.

The Army activated the Warrior Transition Command to oversee the WTUs and to guide the ongoing execution and development of the Warrior Care and Transition Program. This included accomplishing a paradigm shift from simply treating and discharging Soldiers to a comprehensive program that includes holistically preparing Veterans for a successful and productive future in the Army or as a private citizen. The overarching goal is to help Soldiers and Veterans to heal physically and mentally while building bridges to positive opportunities that lie ahead for them in the future.

I, and the Army's other senior leaders, are absolutely committed to doing anything and everything possible to help these Soldiers at all stages of care, even after they leave military service.

Changing the Army Culture

Today, there is a wide range of programs and services available to Soldiers, Veterans, Army Civilians and Family Members who need assistance. However, individuals are frequently reluctant to seek help. We must change the culture of our Army. In the past, there has been a stigma associated with seeking help from any kind of mental health professional. Soldiers avoided seeking this type of assistance for fear that it might adversely affect their careers. However, that is not the case; and, we are taking the necessary steps to change this misperception across the Army.

Web-based Behavioral Health Care Services

Today, Soldiers and Family Members can access behavioral health care services on-line through the TRICARE Assistance Program (TRIAP). The program is open to:

- Active duty service members
- Members eligible for the Transition Assistance Management Program (TAMP) for 6 months after demobilization
- Members enrolled in TRICARE Reserve Select, as well as spouses and family members 18+ years

Soldiers and Family Members can access unlimited short-term, problem-solving counseling 24/7 with a licensed counselor from home or any location with a computer, Internet, required software download, and webcam. If more specialized medical care is deemed necessary, an immediate warm handoff can/will be made to a medical provider.

In conjunction with TRIAP, the Army is working to build a network of locations and on-line providers for telemental health services, using medically-supervised, secure

audio-visual conferencing to link beneficiaries with offsite providers. Once in place, this Network will be able to provide the full-range of behavioral health care services, including psychotherapy and medication management. Our long-term goal is to create a network of counselors and certified mental health care providers that encompasses the entire U.S. Then, when a Brigade redeploys, for example, a gymnasium full of stations/computers could be put in place allowing every Leader and Soldier to participate in a behavioral health evaluation on-line upon redeploying.

From 28 Oct 09 to 18 Nov 09, Tripler Army Medical Center (TAMC), Schofield Barracks, Hawaii, conducted a Behavioral Health (BH) virtual pilot study with Soldiers returning from combat duty to determine clinical efficiency of BH screening, comparing face-to-face versus webcam versus VTC. A total of 450 Soldiers from 25th Infantry Division were screened. The results were very positive. Young Soldiers indicated an overwhelming preference for on-line counseling versus face-to-face.

The pilot conducted at TAMC validated the use of virtual BH counseling for our returning/redeploying Soldiers. In March 2010, we conducted a similar pilot for an entire returning Brigade Combat Team (4-25 IBCT) at Fort Richardson, AK. Similar satisfaction and increased BH referral rates were appreciated; and, we are now implementing this virtual BH technology at other locations anticipating returning units. These previous efforts will allow us to enhance collaboration with the DVA and hopefully expand this capability in the future to include TRICARE network BH providers.

Behavioral Health Care

The good news is that Soldiers are seeking behavioral health care in record numbers with over 236,000 behavioral health contacts in FY 2009, indicating that our efforts to emphasize the importance of behavioral health are working. In particular, recent mental health assessments conducted in theater have shown a marked increase in the percentage of Soldiers willing to seek mental health care without undue concern that it will be perceived as a sign of weakness or negatively impact their careers. This is

because Soldiers recognize the importance of individual help-seeking behavior and commanders realize the importance of intervention.

That said, we recognize that we must do more. We must eliminate the long-standing, negative stigma associated with seeking and receiving help. There is absolutely no reason for an individual to suffer when help is available simply because he or she is afraid of how others will react.

Closing

In my 38-year career in the Army, I have never dealt with a more difficult or critical mission than the current charge to reduce the number of Soldier suicides and properly diagnose and treat individuals suffering from TBI, PTS and other behavioral health issues.

Over the past year, our commitment to health 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, 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, program managers and service providers.

This is a holistic problem with holistic solutions, and that's how we are going to continue to approach it with this campaign.

Again, I can assure the esteemed Members of this committee that there is no greater priority for me and the other senior leaders of the United States Army than the safety and well-being of our Soldiers. 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 for their many sacrifices.

Chairman, Members of the Committee, I thank you again for your continued and generous support of the outstanding men and women of the United States Army and their families. I look forward to your questions.