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ARMED SERVICES COMMITTEE**

STATEMENT OF

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BEFORE THE

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Chairman Levin, Senator McCain, and distinguished members of this committee, I would like to thank you for this opportunity to discuss our efforts to prevent suicides and the treatment of Traumatic Brain Injury and Post Traumatic Stress.

Suicide loss destroys families, devastates communities, and unravels the cohesive social fabric and morale inside our commands. Navy has worked at multiple levels to understand and appreciate the unique factors that contribute to each loss, and at the same time recognize and foster the common factors of the organization and environment that help keep people on a path to life.

What we know

In calendar year 2009, 46 Active Duty Sailors and 6 Selected Reserve Sailors took their lives. This translates to an annual suicide rate of 13.3 per 100K. From January through May 2010, there have been 13 suspected Active Duty suicides, compared to 20 through May in 2009; there are 3 suspected Selected Reserve suicides, compared to 2 through May in 2009.

Since 1993, Navy suicide rates per 100K have ranged from 17.3 in 1995, to 9.7 in 2005, with an average of 11.6.

Numbers and rates alone do not describe the entire situation nor reveal all the lessons learned to save lives. Each suicide and each suicide attempt is investigated. Further a DOD Suicide Event Report, and other documents, provides the means to gather case data for qualitative and quantitative analysis. Lessons learned are integrated into the education and training continuum, communications plans and policy changes.

Demographic factors, such as age, time-in-service, pay grade, and ethnic background have thus far revealed little regarding suicide risk; Navy's demographic distribution of

suicides largely mirrors population demographics. Analyses conducted on deployment cycle status, recent deployments, boots-on-ground deployment, and “individual augmentee” status are a relatively proportional to suicides among Sailors who had deployed (Center for Naval Analysis May 2010, CNO Executive Panel (CEP) 2010). A deployment experience may influence the sequence of events to suicide in some individual cases. But, as a whole, deployment history does not appear to affect suicide risk.

Consistent with the last ten years of analysis, Sailors who commit suicide tend to have multiple stressors (DONSIR Technical Report, DODSER). Recent analysis suggests that as many as half of those who committed suicide had transition-related factors, such as: change of duty station, deployments, temporary duty or an upcoming separation from active duty or retirement (CEP Study: 2010). Periods of duty station transition introduce stress, may interrupt social support systems, and could result in leadership and organizational systems being less available to see some signs of change in a Sailor. Coincident with their decision to act, many Sailors who commit suicide had factors or were in situations that affected their judgment: including alcohol, anger, high emotion and/or sleep disruption. We are working closely to analyze and understand how work load, operational tempo and organizational (unit) factors may contribute to sleep deficit and how sleep deficit may link to suicide.

The 2008 DOD Health Related Behaviors Survey reported that ~5% of Sailors surveyed had seriously considered suicide in the past 12 months. Although that might be a generalization, using the force level at that time (340, 000), this translates to as many as 17,000 Sailors contemplating suicide in a year. Since the long term annual average of

Sailors who have died of suicide is 40, it is clear that the vast majority of Sailors who consider suicide ultimately chose a path to life. Factors such as resilience, leadership, peer engagement, family bonds, support services, and a sense of purpose can compel Sailors to not choose suicide.

Our Approach

Potential solutions to suicide must enhance our ability, as a community, to influence one to choose a path of life. That includes the ability to recover from traumatic change or misfortune and regain physical and emotional stamina. The center of gravity of our policy and practice is the combination of resilience of Sailors and their families, the command's awareness and intervention. We consider it a core responsibility to educate, build a resilient force, and provide an environment in which Sailors and families can thrive in the face of dynamic and demanding operations. It is incumbent on every leader to build trust and unit cohesion at the command level, and provide a clear sense of mission and meaning to what our Sailors do. Additionally, leaders must identify and assist those faced with significant outside stressors, to include relationships, financial and legal matters, health and mental health issues, and depression. All of these are similar to issues that affect suicide rates in the general U.S. population.

What we've done

Navy's suicide prevention efforts focus on leadership, education, and awareness. Prevention efforts in the past year have provided policy guidance, training, tools, and communication to enable local command suicide prevention programs, and strengthen a network of command suicide prevention coordinators. Chief of Naval Operations

instruction (OPNAVINST) 1720.4A, published 4 August 2009, provides updated policy for Navy suicide prevention programs centered on local command programs supported by a designated suicide prevention coordinator, responsible for support of training, intervention, reporting, and response. In fiscal year 2010, training workshops for leaders, first responders, and suicide prevention coordinators have been conducted at 20 locations in five countries, with five more planned by the end of the fiscal year. A new training video, "Suicide Prevention: A Message from Survivors" was distributed in April 2010. Interactive training options such as "Front Line Supervisor Training" and "Peer-to-Peer Training" which include skill-building exercises, based on scenarios and role play, have further enhanced the command toolkit. Community-specific outreach workshops and leadership briefs were provided, upon request, to Reserve, Recruiter, and Supply Corps audiences.

Navy continues a robust communications plan about suicide awareness, promoting the core message: "Life Counts!" A dedicated website (www.suicide.navy.mil), poster series, brochures, videos, leadership messages and newsletters communicate Navy's message on suicide prevention. Expanded communications have included quarterly update messages, public service announcements, and efforts to engage Sailors in creating innovative options such as our poster contest, in which Sailors designed the entries and chose the winner with on-line voting. Providing families with information about risk factors, warning signs, and support resources has also been a top priority since families are the most likely the first to observe Sailor distress.

Our program, “Operational Stress Control (OSC)”, is an increasingly integrated structure of promoting health, family preparedness/resilience, and stress prevention. It is aimed at building resilience and proactively addressing chronic problems before they become acute. OSC¹ addresses the psychological health needs of Sailors and their families; it is implemented by operational leadership and supported by the Naval medical community. OSC provides practical decision-making tools for Sailors, leaders and families, developing their abilities to identify stress responses and mitigate tension. By addressing problems early, most individuals should be able to mitigate the effects of personal turmoil and acquire the necessary help when professional counseling or treatment warrants. The Stress Continuum² is an evidence-informed model that highlights the shared responsibility of Sailors, families, leadership and caregivers for maintaining optimum psychological health. This model has been integrated into our behavioral health communications to the Fleet. It includes suicide awareness, substance abuse, navigating stress, and leader skills. This past year has seen the introduction of a formal OSC curriculum for Sailors “from boot camp through War College”, as well as for their families. Within a few months, a one-day, facilitated, skills-based course will be available.

Recognition of stress related behavior must be followed by effective action. We have developed a stress first-aid intervention to recognize when a Shipmate is in trouble, called Combat and Operational Stress First Aid (COSFA). It is being taught to all Sailors,

¹NAVADMIN 332/08 dated 21November 08 established the Navy’s Operational Stress Control program.

² The Navy and Marine Corps utilize the Stress Continuum Model. Historically, Navy viewed those under stress as either fit or unfit whereas now we understand four distinct stages of stress responses: Ready (Green), Reacting (Yellow), Injured (Orange) or Ill (Red). This model is used to recognize and intervene when early indicators of stress reactions or injuries are present before an individual develops a stress illness, such as PTSD or depression.

to intervene and engage that Shipmate, and to connect that Shipmate to the next level of leader and caregiver support. The advantage of this integrated approach is that we are training our Sailors to look beyond stereotypical warning signs, and to recognize changes in behavior and initiate helpful actions to save lives, preclude further injury, and promote personal growth.

The Chief of Naval Operations (CNO) directed the establishment of the Navy Preparedness Alliance (NPA), represented by Chief of Navy Personnel, Commander US Fleet Forces, Surgeon General, Commander Navy Installations Command, and Chief of Navy Reserve, Chief of Chaplains, and Master Chief Petty Officer of the Navy to address a continuum of care covering all aspects of individual medical, physical, psychological, spiritual and family readiness across the Navy. The “alliance” has proven valuable in examining the tough readiness issues that cross stakeholder boundaries and making informed decisions on identified issues. For example, acting on the advice of the “alliance”, Navy placed a limitation on tour lengths for personnel assigned to overseas detainee operations, based upon a review of the results of the Behavioral Health Needs Assessment Survey (BHNAS) (a battery of anonymous self-reports to evaluate psychological well-being). The Chief of Naval Personnel chairs the NPA and routinely reports its findings directly to the CNO. Navy’s integrated approach continues to rely on leadership monitoring a variety of indicators of the “tone of the force”, including a comprehensive quarterly review of personal and family readiness/preparedness metrics and trends, various family readiness polls, and focus groups.

Support structures and intervention mechanisms initiated in the last few years have become more integrated and effective. “Navy Safe Harbor”³ continues its mission to provide non-medical support for all seriously wounded, ill, and injured Sailors, and their families, with Recovery Care Coordinators and Non-medical Care Managers covering 17 locations. The Navy Reserve Psychological Health Outreach (RPHO) Program, implemented in Fiscal Year 2008, provides two RPHO Coordinators and three Outreach team members (all licensed clinical social workers) to each Navy Reserve Region (5 regions) for mental health support. The RPHO teams engage in active outreach, clinical assessment, referral to care, and follow-up services to ensure the mental health and well-being of Reserve Sailors and have been actively involved in extending tracking and intervention for suicide related behaviors in our reserve community.

What is working

The 2009 Behavioral Health Quick Poll provided a baseline assessment of our suicide prevention and Operational Stress Control awareness and attitudes. This annual poll will be repeated over the next few months to examine changes over time. The 2009 poll indicated that 83% of Sailors polled reported receiving required annual training, and 86% of Sailors polled expressed confidence that they know what to do if someone talks about suicide or shows warning signs. Over 84% of Enlisted Sailors polled and 94% of officers polled believed an at-risk Sailor would get needed help. However, several perceived that pursuing treatment would result in some negative impact to their careers such as loss of security clearance, or that the individual would be treated differently by

³ Safe Harbor is a Navy program, established in 2005, for the non-medical care management of severely wounded, ill, or injured Sailors and their families. Safe Harbor Sailors have had no suicides.

their peers in the unit. These polls have shaped our actions to foster new attitudes and habits, to encourage early use of support resources and to provide viable paths to unit reintegration and continued Navy service.

What we've learned

There is no conclusive evidence that suicide awareness efforts alone reduce suicide rates. Evidence does support the effectiveness of comprehensive approaches that include stress reduction, suicide awareness, intervention skills, community building, leadership engagement, and access to quality treatment. Communities engaged in workshop training in 2008-2009 experienced relatively stable or declining suicide numbers during this period. A rise in Navy's suicide rate in 2009 was, in part, attributable to shore and training units that were not systematically included in or utilizing comprehensive training workshops, until 2010.

Where we're going

Initiatives and areas of expanded focus for fiscal year 2011 include: providing one-day training workshops for Navy mental health providers to improve skills in assessing and managing suicide risk; articulation of policies and best-practices regarding communication between commands and medical providers related to suicide assessments and follow-up care; better communication processes for access to support services for civilian personnel; continuing to implement Operational Stress Control; assessing tangible effectiveness of training efforts; expanding post-intervention support for those affected by suicide loss; and researching the means to measure organizational strain in

terms of the ratio of mission demands to end-strength resources, and how to reduce or mitigate strain effects.

Post Traumatic Stress (PTS)

What we know

Combat stress affects each Sailor uniquely, falling along a physical and emotional stress continuum ranging from stress reactions to stress injuries and disorders, to include Acute Stress Disorder and Post-Traumatic Stress Disorder. Early identification of symptoms enables supervisors and unit leaders to aggressively intervene to preclude stress reactions and injuries from becoming stress disorders. Navy has channeled our psychological health-related efforts within the domains of: reducing stigma through culture change, psychological health promotion, surveillance, and clinical care.

What we've done

Culture Change: Using a partnership of Navy line officers and clinicians/caregivers, Department of the Navy embarked on developing a Maritime Combat and Operational Stress Control doctrine that creates a new way of thinking and talking about the effects of psychological demands on our Sailors, Marines, and their families. This joint leader and caregiver effort created the stress continuum model that provides a color-coded paradigm for recognizing and communicating about stress injury behaviors. This model has been integrated into our behavioral health communications that include: suicide awareness, substance abuse, stress management, and leader skills.

Psychological Health Promotion: Psychological health promotion efforts are based on the Institutes of Medicine three levels of prevention: universal, selected, and indicated. Selected prevention efforts includes stress resilience training in operational training, suicide and substance use awareness training and leader after action reviews following critical events. Project FOCUS (Families Over-Coming Under Stress) is an example of a selected intervention for families responding to the challenges of deployment. Indicated prevention efforts are those that provide critical interventions for those who show stress injury behaviors. The combat and operational stress first aid training is designed to guide Sailors, leaders, and caregivers to provide early non-stigmatizing support.

Surveillance: Navy Medicine implemented an aggressive in-theater surveillance program combining on-site mental health leadership consultation and care through the Mobile Care Teams (MCT) - a small team of industrial/organizational psychologists supported by a clinical mental health provider. In conjunction with the consultation and care services, the MCT executed the 4th installment of BHNAS. The BHNAS is the most comprehensive in-theater mental health assessment conducted by the U.S. Navy and provides data relative to critical mental health indices (PTS, Depression, Anxiety, Morale, Suicide-Risk, & TBI) as well as organizational variables (e.g., living conditions, leadership, unit cohesion, family relationships). Data collection for BHNAS IV recently concluded in Afghanistan and Kuwait and consisted of over 1,000 Sailor Surveys. Analysis is ongoing.

Post-Deployment Health Assessments (PDHA) and Post-Deployment Health Reassessments (PDHRA) are also utilized to assess the mental health of our

Sailors. Current efforts are underway to expand the Mental Health Assessment aspect of these tools to continue surveillance for two years after re-deployment.

Clinical Care: Beginning in 2007, Navy Medicine established Deployment Health Centers (DHCs) as non-stigmatizing portals of care for service members staffed with primary care and psychological health providers. We now have 17 DHCs operational. Our health care delivery model supports early recognition and treatment of deployment-related stress reactions and injuries within the primary care setting, enabling early and effective interventions to reduce occurrence of Post Traumatic Stress Disorder and other mental health conditions.

Navy Medicine emphasizes the importance of Evidence Based Treatments when caring for our wounded Sailors and Marines with Post Traumatic Stress Disorder. The Navy Center for Combat Operational Stress Control (NCCOSC) has developed the Psychological Health Pathways program and is currently pilot testing this program at Naval Medical Center San Diego, Naval Hospital Camp Pendleton, and Naval Hospital Twenty-nine Palms. The program is designed to track all patients diagnosed with PTSD to ensure that clinical practice guidelines are followed and evidence-based care is provided to each patient. It involves aggressive mental health case management, standardized measures, provider training and comprehensive data tracking.

What we've learned

Command and Shipmate intervention can help prevent stress reactions and injuries from developing into stress disorders such as Post Traumatic Stress Disorder, Depression, and other mental health conditions that could potentially lead to suicidal behavior. Navy's broad array of prevention, early intervention, and treatment programs

serves to empower Shipmates, supervisors, and leaders to identify stress symptoms early in the reintegration process and get them the level of support they need.

Where we're going

Navy is constantly assessing the effectiveness of current programs, with a priority on increasing access to evidence-based programs with proven outcomes. Research efforts are underway to build on the rapidly growing body of knowledge regarding the innovative prevention and treatment of stress disorders in military populations.

Navy Medicine is actively engaged in ongoing efforts with the Department of Veterans Affairs (VA) and the other Services to implement the Integrated Strategy for Mental Health. The goal of this effort is to collaborate and coordinate across departments to develop a population based continuum of care.

Traumatic Brain Injury

What we know

While there are many significant injury patterns in theater, an important focus area remains Traumatic Brain Injury (TBI). Blast is the signature source of injury of OEF and OIF, and blast injury often causes TBI. Sailors are deployed in support of operations in Iraq and Afghanistan and, accordingly, treatment of TBI is a priority for Navy. The majority of TBI injuries are categorized as mild -- a concussion. There is much we do not know about these injuries and their long-term impacts on the lives of our service members.

What we've done

Education of Sailors and medical personnel about the early identification and treatment of TBI is critical to the successful recovery. Navy Medicine is addressing this issue by providing TBI training to health care providers from multiple disciplines throughout the fleet. This training is designed to educate personnel about TBI/concussion, ensure all medical personnel are familiar with tools used to assist in diagnosis of TBI, and to review guidelines for the treatment of TBI.

Navy Medicine, in partnership with the Center for Deployment Psychology at the Uniformed Services University, is providing hands-on training on TBI/Concussion management and the Military Acute Concussion Evaluation (MACE), an in-theater screening test for possible TBI. Initial training has been provided to 688 medical officers, physician assistants, and Hospital Corpsmen. Plans are underway to expand this training.

Surveillance for injuries across the pre and post deployment continuum is essential to early identification of TBI. Pre-deployment screening with the Automated Neurological Assessment Metrics (ANAM) establishes a baseline, and enables identification of individuals with conditions that should preclude deployment. Navy has implemented ANAM testing with targeted testing of the highest risk communities, including: Navy Military Construction Battalions, Explosive Ordnance Detachments and Weapons Intelligence Units.

The Navy is standardizing a model for treatment of injured service members with Traumatic Brain Injury/Concussion and will implement it across the Navy Medicine enterprise. The multidisciplinary model will be primary care based with active case

management to ensure coordination of care. Experts in treatment of TBI are available to all individuals with TBI that need care beyond what can be provided in Navy Primary Care.

We are employing a strategy that is both collaborative and integrative by actively partnering with the other Services, Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, Defense and Veterans Brain Injury Center (DVBIC), the VA, and leading academic medical and research centers to make the best care available to our wounded, ill and injured afflicted with TBI.

What we've learned

In order to detect TBI cases earlier, event-based reporting is required to ensure that all at risk individuals receive proper evaluation. Additionally, we have learned that there are other tools available to help diagnose TBI that may be more effective than the ANAM. Navy will continue to explore new ways to identify individuals with TBI so that they can receive the care they need.

Where we are going

Navy Medicine is working with the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury and the DVBIC, as well as the other Services, to ensure we have a comprehensive TBI surveillance program in place for the identification and early management of TBI cases in theater. This process again emphasizes the importance of collaboration between line and medical leaders. The new in-theater TBI surveillance process will be based upon incident event tracking and will require that leaders send all service members with suspected concussions and those

exposed within a set radius of an explosive blast to medical for evaluation. This process will cast a wider net to further ensure individuals with TBI are identified early.

Navy Medicine is also working to establish TBI Restoration Centers in theater, where service members can receive assessment and short-term treatment from a team consisting of a psychologist, physical therapist, occupational therapist, and a sports medicine trained family physician.

Conclusion

On behalf of the men and women of the United States Navy, I thank you for your attention and commitment to the critical issue of suicide prevention and in your interest in the best possible care for the silent injuries of war: PTS and TBI. By teaching Sailors to navigate stress, Navy will make our force more resilient. By assisting and treating those with TBI and PTS, we could eliminate a potential cause of depression and suicidal behavior. Navy is committed to a culture that fosters individual, family and command resilience and well-being. We honor the service and sacrifice 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.