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Subcommittee on Personnel

COMMITTEE ON
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UNITED STATES SENATE

HEARING TO RECEIVE TESTIMONY ON
SUICIDE PREVENTION AND RELATED BEHAVIORAL
HEALTH INTERVENTIONS IN
THE DEPARTMENT OF DEFENSE

Wednesday, April 6, 2022

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U.S. Senate
Subcommittee Personnel
Committee on Armed Services
Washington, D.C.

The committee met, pursuant to notice, at 10:00 a.m. in Room SR-222, Russell Senate Office Building, Hon. Kirsten Gillibrand, chairman of the subcommittee, presiding.

Committee Members Present: Gillibrand [presiding], Tillis, Sullivan, Hawley, and Tuberville.

OPENING STATEMENT OF HON. KIRSTEN GILLIBRAND, U.S. SENATOR FROM NEW YORK

Senator Gillibrand: Good morning, everybody. The Personnel Subcommittee meets today to receive testimony on the Department of Defense's efforts to address and prevent servicemember suicide.

Let me start by welcoming Senator Tillis, our ranking member of the subcommittee. I also want to recognize Senator Tuberville for joining us on the onset. On many issues that have come before the subcommittee, Senator Tillis and I worked well together, and I know the issue of today's hearing is also one that has been top of his mind and a priority of his. I look forward to working with Senator Tillis to investigate and address suicide prevention across the Department and find bipartisan solutions to help support our servicemembers and their families.

Suicide in the military is an epidemic and one we cannot ignore. Last September, in my home state of New York, three servicemembers based at Fort Drum died by suicide in 3 days. What that demonstrated is that no community is immune to the crisis.

After meeting with General Beagle of the 10th Mountain Division last month I was pleased to learn that the programs that their leadership is putting in place to prevent suicide, from providing additional resources to training

individuals at all levels to identify those at risk, and taking a holistic approach to provide supports to servicemembers so they feel better equipped to handle a range of challenges that they may face. I have also believed mental health among our servicemembers is a readiness issue, and in order to foster resilience and build troop fitness our servicemembers need the tools to feel less overwhelmed and stressed, in addition to having access to mental health services as needed.

My goal in holding this hearing today is to better understand what is being done by DoD to prevent suicides in our military and to learn more about what can be done to further eliminate barriers that stand between our servicemembers and access to mental health. We have to end the stigma that is too often associated with requests for help.

In the last annual report on suicide using data from 2020, the Department of Defense noted that suicide rates for the active component increased from 2015 to 2020. During this time, the Department made substantial investments to prevent suicide among the ranks, including training programs for servicemembers, investment in communications and outreach platforms, and increased access to behavioral health screening and resources. Yet suicide rates continue to increase.

While I am cautiously optimistic about the 2021 data, which was just released last week and indicated a 10 percent drop in servicemember suicide, 518 servicemember deaths are still far too high, and the Department still has much work to do to prevent these tragic losses.

I am looking forward to hearing from today's witnesses on this topic. We will have two panels. The first consists of DoD witnesses who will testify about the Department's suicide prevention programs and its related behavioral health interventions, and representatives from the Inspector General's Office and Government Accountability Office to help us understand the efficacy of these programs and any recommendations they have for improvement.

Our second panel will include a military family member who is personally impacted by suicide and experts outside of the Department who have experience in research and outreach in suicide prevention.

Our first panel of witnesses include Dr. Karen A. Orvis, Director, Defense Suicide Prevention Office, Department of Defense; Dr. Richard Mooney, Acting Deputy Assistant Secretary of Defense for Health Services, Policy, and Oversight, DoD; Mr. Michael J. Roark, Deputy Inspector General, Evaluations Component, Department of Defense; Ms. Brenda Farrell, Director, Defense Capabilities and Management, Government Accountability Office.

I will also introduce the second panel after we receive the testimony of the first panel.

Again, I welcome our witnesses today. Thank you for appearing and thank you for your testimony.

Senator Tillis.

STATEMENT OF HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator Tillis: Thank you, Senator Gillibrand, for this hearing on military suicide prevention and mental health care.

It will come as no surprise that we have a mental health care crisis in this nation. The demand for mental health services far exceeds the supply of mental health care providers. The Health Resources and Services Administration estimates by 2025 we will have a shortage of over 250,000 mental health professionals -- psychiatrists, mental health and substance use disorder specialists, and clinical and school psychologists. We do not train enough of them. Their pay is low compared to other health care professionals with similar education and experience, and we place more administrative demands on them, and the pace of their work often burns them out.

While this subcommittee cannot fix these problems, for the nation we can look to improve access to mental health in the military health system.

I look forward to hearing from the witnesses on the first panel about the mental health staffing challenges in DoD and to better understand what this subcommittee may do to help the Department recruit and retain more military and civilian mental health providers. I also want to know the

challenges that patients face when they are referred to care for the TRICARE network. And finally, tell us how DoD will expand the use of tele-behavioral health, especially in remote locations where in-person services are not available.

Now turning to the issue of military suicides, every suicide is a tragedy that could have been prevented with early intervention. From DoD's data we know that most suicides occur in young enlisted males who may have experienced financial problems, failed personal relationships, or legal problems. Leadership up and down the chain of command, from the general officer down to the most junior NCO, must do a better job of developing servicemembers' connectedness to their military unit, to their families, and their supporting community.

Military leaders need to know how to identify servicemembers at higher risk of self-harm. They must eliminate any remaining stigma associated with seeking mental health care, and they must prioritize servicemembers getting health over mission requirements.

I am encouraged by Secretary Austin's recent memo to stand up a Suicide Prevention Response Review Committee, a requirement under Section 738 of the NDAA for fiscal year 2022. I thank him for including Camp Lejeune and the North Carolina National Guard as two of the locations that the committee will review. I want to hear more about that

committee and the work that is going to be done.

Finally, I want to thank the witnesses on Panel 2. I want to thank all the witnesses for being here but especially the witnesses on Panel 2, who are from Durham, North Carolina. Dr. Doraiswamy, who is in the back corner to my right, from Duke University School of Medicine, and Mr. Ford, from a terrific nonprofit organization called Stop Soldier Suicide. I hope the witnesses on Panel 2 can describe some of the innovative best practices in suicide prevention and help us understand how technology can be applied to prevent suicides.

Again, Senator Gillibrand, thank you for holding this important hearing. I look forward to hearing everyone's testimony.

Senator Gillibrand: Thank you. We would now like to hear from our witnesses. Dr. Orvis, we are prepared to hear your opening statement first.

STATEMENT OF KARIN ORVIS, PhD, DIRECTOR, DEFENSE SUICIDE PREVENTION OFFICE, DEPARTMENT OF DEFENSE

Dr. Orvis: Thank you. Madam Chair Gillibrand, Ranking Member Tillis, and distinguished members of the subcommittee, thank you for the opportunity to appear before you today.

Let me start directly first. I am deeply disheartened by the rates of suicide in our military. Every suicide is heartbreaking, resulting in horrifying pain of losing a loved one. This drives us every day to find answers, to ensure those who need help ask for and receive that help, and to be certain that not another son or daughter, brother or sister, or mother or father must also live with the searing pain and emptiness that never goes away after losing a loved one to suicide.

This is a shared challenge. Nationwide suicide rates are alarming, and we continue to observe heightened risk for our young and enlisted servicemembers. My office, the Defense Suicide Prevention Office, works to enhance holistic, data-driven suicide prevention through non-clinical policy oversight and engagement across populations in our armed forces. DoD Health Affairs joins me today to discuss their work with individual servicemembers in health care settings, including clinical suicide prevention efforts and mental health delivery.

Together we are committed to addressing suicide comprehensive through a public health approach. We also leverage best practices from the broader scientific community, including the Centers for Disease Control and Prevention, or CDC. We work closely with the military services. Together we have developed a program evaluation framework that aligns with the CDC's seven evidence-informed strategies for suicide prevention, to track progress and holistically measure our program effectiveness. We are also taking action to ensure all service-level individual programs are assessed for effectiveness, per GAO's recommendation.

Last month, the Secretary of Defense directed the creation of the Suicide Prevention and Response Independent Review Committee to conduct a comprehensive review of the Department's efforts to prevent suicide that will inform long-term progress. He selected nine locations to increase our understanding of the needs of servicemembers across various geographies, including remote and OCONUS areas such as Alaska, as well as across both our active and reserve components. Likewise, we welcome forthcoming insights from GAO regarding our remote and OCONUS communities.

DoD has many ongoing and new efforts underway, including new research and several evidence-informed pilots related to help-seeking, problem-solving, and means safety.

For example, we developed and piloted an interactive training to address servicemembers' most common help-seeking concerns and to encourage help-seeking early on using resources before challenges become overwhelming. We are currently expanding this training to ensure it meets the needs of our remote and OCONUS servicemembers.

Our data tells us that suicide is often a sudden and impulsive act, and that adding time and distance between an individual with suicide risk and the lethal means can be lifesaving. Our suite of evidence-informed tools reinforces the positive impact of safely storing firearms and medications. A concerted DoD-wide implementation of these tools supplements our other efforts, such as training non-medical providers about suicide risk and safe storage of lethal means.

In closing, I thank you for your unwavering dedication and support of the men, women, and their families who defend our great nation. Efforts and insights from the SAS Personnel Subcommittee, GAO, and the DoD IG have been critical to our work. I fully recognize we have more work to do, and I look forward to our discussion today.

[The prepared statement of Dr. Orvis follows:]

Senator Gillibrand: Thank you, Dr. Orvis.

Now I would like to invite Dr. Mooney to give his opening statement.

STATEMENT OF RICHARD MOONEY, MD, ACTING DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH SERVICES, POLICY, AND OVERSIGHT, DEPARTMENT OF DEFENSE

Dr. Mooney: Chairwoman Gillibrand, Ranking Member Tillis, members of the committee, good morning and thank you for the opportunity to testify before you today.

First I would like to thank our GAO and DoD IG colleagues for their ongoing work that fuels improvements across the Department and larger government.

The bottom line is that every suicide is a tragedy that weighs heavily on the Department of Defense and the broader military community. Suicide rates among our servicemembers and our military families are too high. Because DoD is responsible for protecting our servicemembers, just as they are responsible for defending our country, we must do everything possible to prevent suicide in our military community. We are doing this by encouraging help-seeking behaviors, eliminating stigma, and enabling access to mental health clinical services.

We are promoting the utilization of mental health services even as we have a nationwide shortage of mental health providers, which creates challenges in ensuring access to care. The Defense Health Agency is working to developing a staffing model to address these challenges in order to provide timely mental health care with the goal of

treating 100 percent of active-duty servicemembers in the direct care system.

To mitigate challenges in supply we continue to rely on the civilian network, aiming to provide care within our access to care standards. DoD also works to routinely screen servicemembers for mental health concerns throughout their service, from the first visit for new patients, annually during the periodic health assessment, before and after deployments, and prior to separation from military services.

In terms of treatment, the DoD and VA co-developed clinical practice guidelines to address suicide and conditions that increase the risk of suicide, like PTSD, traumatic brain injury, depression, and substance use disorders. We know from research that suicide results from a complex interaction of many factors so while there is no single solution in suicide prevention the clinical practice guidelines reduce unwanted variants in prevention and treatment of those contemplating suicide.

While we remain vigilant in the effort to combat stigma, data suggests we are trending in the right direction. This is suggested by increasing demand for mental health services, which indicates that servicemembers feel less reluctant to get the help they need and deserve. The American Psychological Association reports that

Generation Z, which represents our youngest and future military force, views mental health differently from previous generations. Generation Z is more open about their mental health, more likely to report for mental health, and more likely to seek mental health care. We must continue our clinical and non-clinical stigma reduction efforts to ensure this cultural shift continues and our servicemembers are at ease in seeking mental health care.

We remain grateful for this committee's support for the Department's suicide prevention efforts and the opportunity to discuss the Department's clinically related suicide prevention efforts today. We recognize we have more work to do and much more progress to make to prevent this devastating loss of life. Our efforts will continue to address the many aspects of life that impact suicide, and we are committing to addressing suicide through a comprehensive public health approach.

Thank you.

[The prepared statement of Dr. Mooney follows:]

Senator Gillibrand: Thank you.

I would now like to invite Mr. Roark for your opening statement.

STATEMENT OF MICHAEL ROARK, DEPUTY INSPECTOR GENERAL, EVALUATIONS COMPONENT, DEPARTMENT OF DEFENSE

Mr. Roark: Good morning, Chairwoman Gillibrand, Ranking Member Tillis, and distinguished members of the subcommittee. Today I will discuss three reports: suicide prevention for transitioning servicemembers, access to mental health care, and the impact of the COVID-19 pandemic on military treatment facilities.

First, I will discuss our November 2021, report on suicide prevention for transitioning servicemembers. The objective of this evaluation was to determine whether DoD provided suicide prevention resources for transitioning servicemembers as required by Executive Order 13822. Our report found that the DoD did not consistently screen for suicide risk or arrange for uninterrupted mental health care for transitioning servicemembers as required by the Executive order and DoD policy.

Specifically, the DoD did not establish and implement oversight of mental health assessments and suicide risk screening processes for transitioning servicemembers. Additionally, DoD Instruction 6490.10 lacks a clear definition of a warm handoff, provider training tools, standardized documentation methods, and oversight procedures to ensure compliance.

These challenges occurred because the Defense Health

Agency and the military services did not include a mental health assessment and suicide risk screening as part of the separation history physical exam, which is the medical exam required to be administered to transitioning servicemembers. Additionally, the DoD and the military services relied on expired policy to govern suicide risk screening and referral processes. The inability to identify suicide risk and arrange for uninterrupted mental health care in transitioning servicemembers may result in a lack of mental health care, thus jeopardizing patient safety.

We made five recommends to address the deficiencies we identified. We recommended that the DoD establish consistent policies and procedures to manage suicide risk screening and referral as part of the medical process for transitioning servicemembers. We recommended that the DHA identify the causes for breaks in arranging for continuous mental health care for servicemembers who are transitioning from the MHS to the VHA. We also recommended that the DoD create and implement solutions to increase the number of servicemembers who have continuous care arranged between the MHS and the VHA at the time of transition.

Second, I will discuss our August 2020 report on access to mental health care. We determined that the DoD did not consistently meet outpatient mental health access to care standards for active-duty servicemembers and their families.

Specifically, from December 2018 to June 2019, we found that 7 of the 13 MTFs we visited in the direct care system and their supporting TRICARE network in the purchased care system did not meet the specialty mental health access to care standard each month, and an average of 53 percent of all active-duty servicemembers and their families identified as needing mental health care and referred to the purchased care system did not receive care.

These challenges occurred because the DHA lacked an MHS-wide model to identify appropriate levels of staffing in direct care and purchased care, and published inconsistent policies on access to mental health care. In addition, the DHA did not have visibility over patients who attempted but were unable to obtain mental health appointments in the purchased care system and measured the 28-day specialty access to care standard differently between the direct and purchased care systems. As a result, thousands of active-duty servicemembers and their families may have experienced delays in obtaining mental health care.

We made 14 recommendations to the Assistant Secretary of Defense for Health Affairs and to the DHA to improve access to mental health care in the DoD.

Finally, for our third report, which we issued yesterday, on April 5th, we issued this report discussing the challenges that are facing MTFs at this stage in the

COVID-19 pandemic. Although this report focused on a wide variety of challenges that the MTFs are facing, we asked senior leadership at 30 MTFs, "What is the most serious concern that might be encountered in the future by medical personnel working at your MTF during the COVID-19 pandemic?"

Officials from 25 of the 30 MTFs discussed burnout of medical personnel as a serious challenge. However, officials from 11 of the 30 MTFs stated that staff burnout and fatigue was the most serious concern that might be encountered in the future. MTF officials told us that burnout has caused some staff to quit, further exacerbating staff shortages. In addition, MTF officials stated that burnout has adversely affected staff members' psychological health and caused them to use emergency mental health services for their own behavioral health challenges.

This concludes my statement and I would be happy to answer any questions you may have.

[The prepared statement of Mr. Roark follows:]

Senator Gillibrand: Thank you.

I would now like to invite Ms. Farrell to give her opening remarks.

STATEMENT OF BRENDA FARRELL, DIRECTOR, DEFENSE CAPABILITIES AND MANAGEMENT, GOVERNMENT ACCOUNTABILITY OFFICE

Ms. Farrell: Chairwoman Gillibrand, Ranking Member Tillis, and members of the subcommittee, thank you for the opportunity to be here today to discuss our most recent work related to suicide incidence at remote installations outside the contiguous United States, OCONUS.

Suicide deaths and attempts within the military are devastating events for families. They can also harm unit morale, esprit de corps, and readiness, and increase the risk for suicide among affected servicemembers and their families. Remote OCONUS installations may pose challenges that increase suicide risks. GAO's prior work found that DoD's effort to prevent and respond to suicide deaths and attempts have encountered challenges. Our prior work addressed DoD mental stigma reduction efforts, effectiveness of non-clinical prevention methods, inconsistent use of suicide-related terms.

The NDAA for fiscal year 2021 included a provision for us to review suicide prevention efforts at remote OCONUS installations. My statement today is based on our work being conducted in response to that statutory mandate. Now I will briefly highlight four areas in my written statement.

First, my statement addresses what is known about the

incidence of suicide and related risk factors among servicemembers at remote OCONUS installations. Our preliminary analysis suggested that remote OCONUS installations accounted for a slightly higher proportion for suicide attempts but a lower proportion of suicide deaths relative to the proportion of servicemembers assigned to these locations during 2016 through 2020.

DoD officials told us that the extent of suicide deaths at OCONUS installations may be lower because servicemembers assigned to installations outside the U.S. have limited access to non-military-issued firearms. We found that non-military-issued firearms were involved in over half of reported suicide deaths among members assigned to CONUS installations and were involved in slightly over a quarter or fewer among members assigned to OCONUS installations.

Separately, DoD service and installation officials we interviewed identified risk factors for suicide and related challenges that may be more pronounced at remote OCONUS installation, such as less access to mental health services, increased social isolation, and extreme weather conditions. DoD does not have a process to assess suicide risk at these installations. Establishing such as process could enhance related suicide prevention efforts.

Second, we found that gaps exist in implementing some prevention policies, programs, and activities for those

assigned to remote OCONUS installations. For example, three services have not ensured implementation of some prevention activities such as establishing required prevention teams at installations. These services do not have mechanisms to help ensure implementation. By establishing oversight mechanisms these services may have greater assurance that such activities are implemented across all installations, including OCONUS installations.

Third, we also found that DoD has experienced staffing shortages, as noted earlier today, for behavioral health personnel, in part because it has not developed a strategy to address hiring challenges. By developing such a strategy, DoD may be able to enhance the provision of behavioral health care to servicemembers and their dependents.

Last, DoD has established some suicide response guidance and training for key personnel but gaps exist. For example, DoD has not established statutorily required training for commanders on responding to suicide deaths and attempts. By establishing such training for commanders, DoD can better ensure that commanders are prepared to provide support to suicide attempt survivors and the bereaved.

In summary, on March 1, 2022, we provided DoD with a copy of our draft report along with the recommendations. We will complete the work as soon as we receive DoD's review

and comment of that draft report.

Madam Chairwoman, I am pleased to take questions when you are ready.

[The prepared statement of Ms. Farrell follows:]

Senator Gillibrand: Thank you very much for your testimony. Very challenging and difficult issues, and I appreciate the expertise that you have developed.

I want to first talk about the lack of access to care. Dr. Mooney, in 2020, the DoD inspector general found that as a result of delays in required mental health care access for active-duty servicemembers and their families numerous members were not able to see the right provider at the right time, obtain mental health care, or receive timely follow-up treatment.

What steps is the Department taking to address these barriers accessing needed care, and second, related, how does the DoD track the time between the patient request or referral for mental health care to the time of the mental health assessment? Have you seen long waits, and what steps are you taking to improve that?

Dr. Mooney: Yes, ma'am. Thank you. So to your first question on access to care and how we are approaching that, you know, we have a nationwide shortage of behavioral health providers, as has been mentioned in this hearing already, and so to that end we have worked to build a staffing model that will match supply with demand by provider type, and the goal will be 100 percent of active-duty servicemembers in the direct care system being seen on base. And that staffing model we anticipate to pilot this fall, and it will

impact 100,000 beneficiaries.

With regard to making sure the provider type is matched with the patient, active review and management of appointment schedules, 24 to 72 hours before each appointment to ensure the right patient with the right appointment and the right provider. To increase access to care we are also adding extenders -- PAs, nurse practitioners, licensed mental health counselors -- and also entertaining adding new provider types, credentialing new provider types to include licensed professional counselors and licensed family and marriage therapists.

Additionally to increase access to care we are doing a massive expansion of telehealth. That is one of the top priorities for the Defense Health Agency. Our SMEs suggest that between 50 to 75 percent of behavioral health conditions can be treated virtually, depending on acuity. That would free up time to manage more severe cases in person. This expansion will add 63,500 virtual appointments by the fall of 2022. Those are central appointments that can be used worldwide.

So with regard to access and how that is measured, for a given clinic your access to care, basically in the system there is an appointment-made date and an appointment-seen date, and that, across the clinic for that particular month or period of time you are looking at, that average for all

patients seen there becomes your access to care. The standard for access to care for a routine appointment in behavioral health is 28 days. That means routine. If you have an acute issue you can go and are seen earlier. Usually acutes are within 24 hours. They can be seen in the clinics or in the hospital, in the emergency department. So we want to make sure we have that distinction between a 24-hour acute type of visit versus a routine visit.

Senator Gillibrand: That still seems very long.

You mentioned in the testimony, several of you, about staff shortages. Dr. Orvis, you can start. There has been a great deal of reporting lately on staff shortages of mental health professionals, specifically on and around military bases. What are the biggest challenges military installations are reporting in ensuring access to adequate treatment in a timely manner, and what steps is DoD taking to increase the number of mental health professionals available to provide supports to servicemembers and their family members?

Dr. Orvis: Certainly. I would want to defer to my colleague, Dr. Mooney, in terms of mental health professionals because that falls in the purview of Health Affairs. But what I can offer in terms of non-medical providers, we have other help-seeking resources for our servicemembers, and so we are really looking not only in

terms of behavioral health professionals but encouraging our servicemembers and our family members to seek out help when they need it, from a resource that is right for them. It may be a behavioral health provider. It may be a chaplain. It may be a military one-source counselor or a military family life counselor, or even Veterans and Military Crisis line.

And I will just give one example within that, or an external provider as well. Give an Hour is just one example but we have many wonderful partners in the community that would be potentially a great resource as well.

Within the military community and non-medical providers, military family life counselors are available on installations, and they are also available for surges. So if there are particular locations that need additional support, maybe after a loss of a servicemember due to a suicide, additional personnel can also be brought into that unit or to that installation to provide further support.

And I will defer to Dr. Mooney for mental health.

Dr. Mooney: Yes, ma'am. Thank you. With regard to our ability to recruit and retain, there are pay flexibilities in the 2021 NDAA that have increased special and incentive pays for our uniformed servicemembers, and DHA is working with the military departments to understand how that is impacting the ability to retain that talent, and it

will adjust as indicated.

With regard to being able to hire civilian providers, behavioral health providers, there are some Title 5 pay caps that maybe a way to be more competitive with some of the civilian counterparts. Some of these areas where you have a significant shortage you have a difficult time competing with the civilian sector's ability to pay salaries to behavioral health providers.

Senator Gillibrand: Thank you. Senator Tillis.

Senator Tillis: Thank you, Senator Gillibrand. Again, thank you all for being here.

Dr. Mooney -- and Mr. Roark, you may want to contribute to this -- I know that with our response to the pandemic we saw medical professionals deployed out of the DoD into the civilians sector to help marshal resources for the pandemic. To what extent did that affect the provider population within the DoD?

Dr. Mooney: So with the provider teams that were deployed, that segment of our population that was deployed were more acute care, you know, your pulmonary, critical care specialty, that sort of group. So with regard to behavioral health, I am not sure there was as much of an impact there on staffing. But I think that we are all concerned -- I have read the recent IG report on the impact of pandemic on the services --

Senator Tillis: Certainly increased caseload.

Dr. Mooney: Yes, sir. Yes, sir. And also it led to a referral to our purchased care network, because just as in wartime when your staff deploys, similarly here when the staff deployed to support our civilian hospitals, the TRICARE network was our relief valve.

Senator Tillis: I wanted to talk about, particularly when people experience profound behavioral health challenges maybe for the first time in their life, and you are not able to provide care within the DoD, and you provide a referral, I worry that without a warm handoff -- I want to talk a little bit about the warm handoff to TRICARE. Give me a sense of what we can do better to make sure that when someone gets a referral they actually get the care. Because in my research on this, if you do not have family members or caregivers or other people engaged in that, or the DoD engaged in that, and to know that after a referral is made that they have actually sought the care, how are we doing a better job to make sure that referral has resulted in a positive outcome in terms of getting the care that they have been referred for?

Dr. Mooney: Sure. No, that is a great question. I think that stepping back, with regard to mental health assessments and the warm handoff, we are working a directive type memorandum that will implement a one-separation health

assessment between the DoD and VA. With that directive type memorandum, which will be placed in policy, the 6490.10 that he mentioned, this will ensure the warm handoff. This will connect through the in-transition program to the VA. It also will ensure a mental health screen occurs, and there are flow diagrams in this policy that give instructions to the providers on what to do -- if-then statements -- what to do with the results you have and how you ensure proper care and handoff in the transition process.

Senator Tillis: Mr. Roark, do you have anything to add to that?

Mr. Roark: Yes. As Dr. Mooney said, there is a role for the servicemembers to play in making sure that their care continues as they transition. However, we have tried to recommend solutions to the Department of ways that we could make that as user friendly as possible. And so we have been working with Dr. Mooney and his staff to determine how quickly the implementations that we recommended in our report are being implemented, and I think that the steps that he discussed are the major improvements that we are following, in terms of things that could be done better in the future.

Senator Tillis: Yeah. You know, I agree that there is a role the servicemember has to play, but you also have to understand the conditions that they are operating in. And

if we do not have a greater touch on that, you know, it is my understanding, at least in the literature that I have read, that when you first experience it you may not be behaving rationally to begin with, and now you are asking them to take an added step to get care, which can, by itself, be traumatizing. So it is one thing to expect them to get that care and it is another thing to see whether or not they will follow through with their responsibilities.

And I do have some questions for a second round, but Madam Chair, I will defer for now.

Senator Gillibrand: Senator Tuberville.

Senator Tuberville: Thank you very much. Thank you for being here today on such an important and progressing problem that we have.

I am on the VA Committee, and I have been pushing some non-traditional types of therapy. In my former life of being a football coach I had a lot of brain injuries, and we were fairly successful using hyperbaric therapy with a lot of our football players. I have seen enough of physical drugs in my lifetime to try to cure a lot of these problems that we are having. Sometimes it works; more than not it does not.

Dr. Mooney, what do you think about non-traditional therapies such as hyperbaric therapy, through the DoD?

Dr. Mooney: Sure. I think that, you know, anything

that we do system-wide we need to study and evaluate and understand the impact. And I have had several cases myself, from traumatic brain injury, hyperbaric seemed to make a difference. But I think more study needs to take place before that can be endorsed more broadly.

But no, I am in favor of any of the innovative approaches. I mean, it is a matter of understanding if there are other unintended outcomes from those approaches. So it is the systematic evaluation and then the rollout.

Senator Tuberville: Anybody else have any thoughts about non-traditional therapy? Anybody.

Do you collaborate with the VA on things like this?

Dr. Mooney: Yes, sir. We have an entire organization, the Health Executive Committee, that works with the VA. I am the business line lead for three of the business lines, so there is a lot of work underway collaboratively.

Senator Tuberville: Thank you. Dr. Orvis, University of Alabama is currently conducting a study titled "Operation Deep Dive" to review state death data, cross-reference it against the DoD military service and the VA. I would like to thank you for your involvement in this study and for the wisdom that you share with the students in Alabama. Thank you very much that.

Preliminary data from Operational Deep Dive is showing that members of the National Guard have 10 percent higher

suicide rate, and reservists 45 percent higher suicide rate than their active-duty counterparts. What insight can you share with us on these findings of Operation Deep Dive?

Dr. Orvis: I appreciate the question and I appreciate the work that is going on. A really important study. This and other research, of course, that goes on helps us. It helps us uncover gaps that we may not be aware of or new pieces of information that add to our puzzle and help us identify what do we need to do differently to make a difference. So I very much appreciate the work that is going on.

You know, when we are looking at our Reserve component members, our National Guard members and Reserve members, we really have been looking to understand why there may be differences and it may be different compared to active component servicemembers. And certainly even in terms of thinking about the timing or the manner of death, for our active component servicemembers they are on active duty at the time. For our National Guard and Reserve members, the majority of individuals are dying by suicide when they are on non-active-duty status, about 75 percent both in the Reserve and the National Guard, and we see that pretty consistently.

So we know it is perhaps even more complicated for our National Guard and Reserve members, two lives that they are

traversing, their military life and their civilian life, and the military role and their civilian job. But we also know that there are commonalities across our servicemembers and across individuals throughout the U.S. in terms of causes of suicide. We know financial challenges, when coupled with other things, can influence risk for suicide.

Do we have a protective environment for the individuals? We are really focused in at the DoD, particularly right now, on safe storage of lethal means -- firearms, medications, other lethal means. And data from our broader U.S. populations, of our U.S. civilians, does indicate that there are certain regions within the U.S. that have higher access to personal firearms, other lethal means, and that may also be a contributing factor.

Senator Tuberville: It has got to be a pretty good shock to be a National Guardist or reservist. One day you have got a job and the next day you are in harm's way, and on their family too. So thank you for that.

I have got a couple more questions. I will wait on the second round.

Senator Gillibrand: Thank you. I want to talk a little bit about reducing stigma. You mentioned in some of your opening statements. [Inaudible] servicemembers to speak up confidentially and if needed outside the chain of command.

Dr. Orvis and Dr. Mooney, can you talk about DoD's planned implementation of that policy and what, if any, impact you have seen or expect to see in assuring needed treatment is sought out. And Ms. Farrell, in the 2016 GAO report, what additional actions were needed to enhance DoD's efforts to address mental health care stigma. Has anything been done to de-stigmatize mental health care treatment since that time, and what additional steps would you recommend?

Dr. Mooney: Yes, ma'am. So the Brandon Act, Section 704 of NDAA 2022 will make a big difference, I believe, in reducing stigma and enabling our servicemembers to feel comfortable in discussing and triggering a referral with their commander to get medical care.

We are in the midst of socializing the directive type memorandum that will launch this program, and we anticipating that directive type memorandum into coordination in May of 2022. And the current medical policies covering referrals include DoD 6490.08, command notification requirements to dispel stigma and providing mental health care to servicemembers, and 6490.04, mental health evaluations of members in military operations.

Senator Gillibrand: Dr. Orvis?

Dr. Orvis: Yes. We are in support of Health Affairs in terms of their implementation of this important new

provision. As I mentioned before, we are really looking to identify how can we encourage, in any way, help-seeking and to reduce the stigma that we know is associated with seeking help, whether it is mental health care or other types of help-seeking, not only in the military but also more broadly.

I would just offer, as a few other things that we are doing which is outside of this provision. From the highest levels of our leadership, from Secretary Austin to Deputy Hicks, we are really trying to look at different ways in which to help to reduce the stigma among our servicemembers and families. You had referenced outreach and efforts that we are doing and ramping those up, and most certainly we are.

We also, recently Deputy Hicks directed a stand-up of a new interdisciplinary working group that is an intersection of suicide, mental health, and the intelligence and security expertise within the Department. We know that our servicemembers have concerns about career impacts associated with help-seeking, and we know that -- and this is very complex -- there is data that suggests that at least in terms of security clearances, for instance, that really is a very small, less than 1 percent, likelihood that someone seeking mental health treatment that it would have an impact on their security clearance. But yet that kind of

misconception exists, so how do we get after that, and how do we understand the various assignments or deployment requirements that might be associated with mental health and concerns about not seeking help because of impacts on assignments that an individual might have.

So there is a new working group that was just recently stood up that is really looking at this, making recommendations of what do we need to do in terms of changing policy and/or changing training for commanders for the workforce, for our servicemembers and family members, to get after that one piece of stigma of the larger stigma puzzle.

Senator Gillibrand: Ms. Farrell?

Ms. Farrell: Thank you for mentioning the 2016 GAO report. I am happy to say that all of the seven recommendations in that report have been implemented as of last year. It is hard to believe but in 2016 there was not a consistent definition of what are these barriers that prevent people from seeking health care that is generally referred to as stigma. So that was a huge step for DoD to look at those barriers and define them.

They have done other actions such as destigmatizing policies -- one was mentioned about security clearances -- that the policies could have wording that could also present barriers. So they revisited those policies and taken

action. They have established a coordinating entity to collaborate with others and oversee the destigmatizing efforts. They are now in a good place in terms of establishing goals and measures, which we know they have done, to actually measure the effect of their efforts to address stigma. So that will be the next focus, is to look at what they are doing and see what is working and what is not working, and refocus if necessary.

Senator Gillibrand: Thank you. Senator Tillis.

Senator Tillis: Thank you, Senator Gillibrand. Dr. Orvis, the Suicide Prevention and Response Independent Review Committee is going to focus on nine military installations as a part of the process. Can you give me an idea of how they went about choosing the nine military installations that would be a part of the review?

Dr. Orvis: Sure. Absolutely. The nine locations were selected using data-driven methodology, which I can speak a little bit more, and we also ensured that we coordinated with the military departments to gather their insights as well.

We wanted to make sure that -- and per the Secretary's direction -- that we were addressing various needs of our servicemembers, so looking at various geographies, to include remote and OCONUS areas. In terms of the data-driven methodology, we looked at both suicide data as well

as command climate data to identify installations that were higher in terms of risk factors for suicide and lower in terms of protective factors. And so that drove the recommendations for those nine installations, as well as we wanted to ensure that we were representing all of the military departments and representing both active and reserve components of our servicemembers.

Senator Tillis: Your comment about command climate, when was the last time, if ever, that we have done a command climate survey on issues related to eliminating the stigma, of providing more access to care? Has that ever occurred? What made me think about it is we just recently were briefed on military sexual assault command climate survey. There were a lot of action items coming out of that, and it would just seem to me that this would be a natural part of building on the recommendations from the GAO report. And I was just curious, has that been done before?

Dr. Orvis: I would have to take for the record if that occurred and when those particular items might have been included in a systematic way. Within the current redesigned command climate survey it is looking at various risk and protective factors that contribute to healthy and unhealthy climates. And then there is also an opportunity within the survey to be able to have commanders ask specific questions that they are interested in being able to gather more

information on. So that may have occurred in individual surveys for particular commanders.

What I would also offer is we have the status of forces survey that is an annual survey, and consistent items within that status of forces each year is asking about barriers to care, stigma. So we do have robust data from our servicemembers in understanding their perceptions on what is holding them back from seeking care, if they would seek care who would they be willing to -- you know, which source would they be willing to seek out care from.

Senator Tillis: Well thank you for that. I think it would be helpful. One of the findings that I took away in the review for military sexual assault is it tends to have more to do with the climate created by current command rather than a continuity of culture, and we have got to get that cultural foundation in place.

Before I go to Dr. Mooney, Mr. Roark, you had talked about some of the challenges have to do with transition and post-transition stickiness. I feel like this is an area where we have so much work to do in our Transition Assistance Program, and making sure that is not just being well-informed when someone is transitioning. But it is very similar to what I was talking about with the warm handoff for referrals. When we know that there is a serious or potentially serious challenge out there we have to do a

better job, on an interagency basis, of tracking and determining whether or not they are actually getting care that we suspect that they need at the point of transition.

Did your report point out any recommendations or actions that the Department should take?

Mr. Roark: Yes, and an important point about our suicide prevention report was that we developed the concept for that evaluation in concert with the Veterans Affairs OIG. And so working collaboratively we determined that transition period, one year prior to transition and then one-year post-transition, is such a critical time for suicide and mental health continuity of care and suicide prevention. So that was kind of the overall umbrella under which this work was done by our agency.

Two points that we mentioned in our report, which I think are really important, are the mental health screening that was required by the Executive order. In 2020, only 34 percent of transitioning servicemembers received that. And then secondarily, on the separation health, physical exam, only about 70 percent in 2020 completed that exam. So in terms of items that would put the VA in the best possible position, if the DoD can --

Senator Tillis: They do not know what they do not know.

Mr. Roark: Exactly. If the DoD can put both the

servicemember and the VA in kind of the best possible situation as they leave the Department, then that is the goal. And we made recommendations to the Department, and that is what Dr. Mooney was discussing earlier, in terms of some of the changes that they have in the works to try to improve that.

Dr. Mooney: Yes, sir. The one Separation Health Assessment between the DoD-VA has a lot of protections. It ensures understanding of the requirement for the behavioral health evaluation. It also has a linkage to the in-transition program so that the warm handoff can occur to ensure care.

One piece, though, is that not every servicemember who retires or separates seeks care at the VA. They go off to other providers. So that is another area for concern and for work.

Senator Tillis: Thank you.

Senator Gillibrand: Senator Tuberville.

Senator Tuberville: I am just curious, and there might not have been enough time. But has there been an uptick in suicides since the fall of Afghanistan last August? Does anybody have any data on that?

Dr. Orvis: Thus far our data does not support that, but we are looking to see what may occur. I am working closely with the Department of Veterans Affairs as well, as

it may be impacting our veterans.

Senator Tuberville: Okay. Thank you.

You know, our military is a tool of national power and we, as lawmakers, sometimes have the ability to send people in harm's way. What resources does the DoD, Dr. Mooney, make known and available to the servicemembers, to their families, and their friends, you know, marriage counseling? Is there anything that we offer to our men and women? Or anybody can answer this. I am just looking for answers.

Dr. Mooney: Sure. Most of that is probably in Karen's lane, but I can tell you, as a person who has deployed in the past there are deployment lines, there are chaplains, there are other folks there that coordinate and provide resources for the servicemember and for the family.

Senator Tuberville: Okay. Thank you. Anybody else?

Dr. Orvis: Sure. I will add to that as well. Absolutely, both in terms of our servicemembers and family members. We have a host of resources in terms of helping with kind of everyday life and life challenges, so have strong financial supports in terms of not only financial education across the military lifecycle but also free resources available both on installation and virtually, online, for assisting with financial health and challenges.

We also have, as I had mentioned earlier, Military OneSource and the military family life counselors. They are

really designed to be able to help with those everyday life challenges as well. It could be finances. It could be relationship challenges, whether that is in significant partner relationships, parenting challenges. They support with relocation or with deployment challenges and reintegration challenges coming back, and offer free resources to our servicemembers there.

And then, of course, there are community resources available as well that we have partnerships with, just as a few examples.

Senator Tuberville: Ms. Farrell, do you have anything to add to that?

Ms. Farrell: I do. Thank you. There is no doubt that DoD has a management framework in place that is very comprehensive, with a governance structure, part of the governance structure sitting at this table as well as collecting the relevant data and assessing it and putting forth strategies.

But our work looking at remote OCONUS locations found that sometimes the implementation was not what it should be, and there were gaps in the policies and the programs and the activities at those remote OCONUS locations. I do not know about all the CONUS locations, but, you know, it comes down to actually having the boots on the ground implementing those activities that are prevention activities or specific

key personnel that should be assigned at those locations that coordinate the clinical and the non-clinical, for example. So that is an area that we have made recommendations for DoD to oversight mechanisms in place, among other things.

Senator Tuberville: Thank you. Thank you, Madam Chair.

Senator Gillibrand: Mr. Roark.

Mr. Roark: Yes. So in our suicide prevention report we did identify and review some of the programs that are available to some individuals who are transitioning, such as members who have a disability and are going through the board process to be separated from the military. Also the in-transition program for folks that have prior mental health care in the last year.

However, although there were good things occurring in those particular programs, the overall population of active-duty servicemembers transitioning was at least 160,000 per year. So although there are some programs that are effective in certain populations, it is important to think about the larger population as well, and to make sure that some of those lessons learned can be spread to the larger population.

Senator Gillibrand: Any other recommendations that the panel would like to give before we close out the panel, on

any questions that have been asked so far?

Senator Tillis: Madam Chair, before we close. I mean, there is no question in my mind that the DoD would like to end suicide. We have challenges. The OIG has pointed out some. The GAO has made recommendations. What would be very helpful for this committee is the extent to which, as we move into the NDA, any authorities or focus that we should place on this to give you more enablers to do the job I know you want to do.

And then I do have several questions for the record that I would appreciate your attention to.

Senator Gillibrand: And please be specific in your recommendations. I mean, we have heard a lot of challenges -- not enough staff, not enough staff where they are needed, very long wait times. Having a normal wait time of 28 days is fine if you are not in trauma or in distress, but if these individuals cannot self-identify that then it is a failure. They need that intervention.

So please take the time to make specific recommendations for money that you need, personnel that you need, support for programs that already exist, additional research. Whatever it is, I would like a direct recommendation of things you would like in this year's NDAA to address the problems that we still have. Given all the good work that we have already done, given all the things we

have put in place, we need direct recommendations and requests to guide us in writing this personnel markup. So thank you.

Any other questions from the Senators?

Thank you very much.

[Pause.]

Senator Gillibrand: While the next panel gets settled I will just introduce everyone. We will have Dr. Beth Zimmer Carter joining us, as well as Mr. Chris Ford, Chief Executive Officer, Stop Soldier Suicide; Dr. P. Murali Doraiswamy, Professor of Psychiatry and Medicine, Duke University School of Medicine; Dr. Craig J. Bryan, Director, Division of Recovery and Resilience and Science Prevention Program, the Ohio State University College of Medicine.

So we would like to hear first from Dr. Carter.

STATEMENT OF DR. BETH ZIMMER CARTER

Dr. Carter: Chairwoman Gillibrand, Ranking Member Tillis, and distinguished subcommittee members, thank you for this opportunity to testify.

I am Dr. Beth Zimmer Carter, and I come to you with a unique perspective. I am a family physician, retired Army lieutenant colonel with command experience, and proud mother of Special Forces Army Ranger Christopher Carter, who died by suicide at age 22.

Chris, my only child, was vivacious, bright, funny, handsome, and fulfilled his lifelong dream of being an Army Ranger. He was well-liked, well-decorated, and deployed four times to Afghanistan with almost 100 Special Operations missions. On his first deployment, he witnessed the grotesque deaths of his buddy, his interpreter, and a female Special Forces member. Chris sustained two close-range concussive blasts in that encounter, as well as numerous training blast exposures.

During his transition period at the end of his Army commitment Chris was self-medicating with marijuana, legal in his state, to control anxiety and insomnia after medical and mental health treatments failed. He self-admitted this to his new command, who later stated to me they "felt the need to make an example of Chris," as he was in a leadership position, and many others in the unit were also using

marijuana. He was demoted, sacrificed a month's pay, made to do humiliating work, confined to the compound, and they initiated "other-than honorable" discharge proceedings. Chris was already anxious, dealing with PTSD symptoms, and now humiliated and devastated. He attempted suicide for the first time.

My husband and I flew across the country to confer with Chris' battalion commander. Despite a commendable record, we were told to our face that they "really didn't believe Chris was suicidal" and thought he was just trying to get out of his disciplinary proceedings. Even after a hospitalization for the suicide attempt, they resumed restrictions, prohibiting him from leaving the compound, forbid any socialization, canceled his Christmas leave, and continued discharge proceedings. Chris was required to re-enlist for another year as there was a several-months wait for his medical board determination. He was isolated in the supply room, cleaned latrines, and called "pot-head." Unbelievably, they did all of this just after losing another battalion member to suicide.

The morning of his death, I knew Chris was severely struggling while on duty, and I attempted to contact his superiors to notify them and request their assistance. Even though I am a retired Army commander, I was told, "The command speaks to soldiers, not moms." Chris proved his

suicide sincerity that afternoon on Feb 12, 2015. We buried him on his 23rd birthday.

There were multiple opportunities for the military to recognize the risks and invoke alternate lifesaving approaches, as Chris had several blast concussive exposures known to cause traumatic brain injury; been diagnosed with multiple high-risk mental health conditions; felt trapped and hopeless, having to re-enlist in another year in a toxic environment; had humiliation, financial consequences, and legal ramifications due to his help-seeking, self-acknowledgement of his marijuana use; survivor guilt after losing his buddy and teammates; and recent exposure to the suicide of someone he identified. Instead, many of the military's actions are known to increase suicidal risks.

Commanders need to courage, support, and reward self-help. Those that stigmatize, isolate, and punish should be held accountable; require mandatory group or personal mental health intervention after a traumatic event, especially one with personnel loss; embed mental health providers in units, to normalize mental health and ease of access, just as with physical health medics and sick bays. Commanders need to communicate to distant-dwelling families how to enlist support when concerned.

Military medicine should get upstream in prevention. Require mandatory annual mental check-ups just like physical

check-ups; better recognize symptoms and use evidence-based treatments for PTSD and suicide care; improve substance abuse treatment options; expedite the Medical Board process, to a 30-day maximum wait.

Military institutions must destigmatize, normalize, and improve access to and use of mental health care; avoid compromising careers for those seeking help; ensure eligible service members are referred to the Warrior Care Programs; continue investigating TBI blast exposure risks and improve prevention, identification, and care; advance TRICARE coverage of evidence-based care methods.

Sadly, 7 years later, I know from my charity, government, and survivor contacts many of the same deficiencies continue and some issues have tragically reversed progress.

I am grateful to organizations such as TAPS, the world leader in assisting those who have lost a military loved one. TAPS has been instrumental in support of me and the tens of thousands of military suicide loss survivors.

I appreciate the opportunity to share Chris's story. He was an extraordinary young man with a bright future and will be forever loved and missed.

Thank you for considering these insights and recommendations to reduce the preventable devastation caused by a death from suicide.

[The prepared statement of Dr. Carter follows:]

Senator Gillibrand: Thank you very much.

Mr. Ford?

STATEMENT OF CHRIS FORD, CHIEF EXECUTIVE OFFICER, STOP SOLDIER SUICIDE

Mr. Ford: Chairwoman Gillibrand, Ranking Member Tillis, and distinguished members of the subcommittee, on behalf of my time at Stop Soldier Suicide and the clients we serve thank you for the humbling opportunity to share our experiences and perspectives on this critical readiness issue. I am especially honored to sit alongside Dr. Craig Bryan, a fellow Air Force veteran and an esteemed member of Stop Soldier Suicide's Scientific Advisory Committee.

To Dr. Zimmer Carter, please accept my deepest condolences in the loss of your son.

To be clear, I am neither a psychologist nor a suicide prevention researcher, but I am a 20-year Air Force veteran with combat tours supporting Operations Enduring and Iraqi Freedom, with two additional tours at the Pentagon where I retired from the Joint Staff leading efforts to improve servicemember transition and integration via community-based approaches. I have experienced firsthand the challenges of military service, combat, transition into society, and in the worst moments, the challenges and grief surrounding untimely deaths.

Most recently, I am honored to serve as the CEO of Stop Soldier Suicide, the nation's largest nonprofit organization exclusively focused on reducing military suicide rates to

match national parity by 2030. In this role, I have not only seen the complexity of suicide and grief it causes but also the hope and joy that comes from helping servicemembers and veterans move from struggling to thriving as a direct result of our work.

Sadly, since 2001, more than 120,000 servicemembers and veterans have died by suicide, enough to empty Washington Nationals Park three times. Leading research indicates each suicide affects 135 lives, meaning these untimely deaths have affected more than 16 million Americans in the last two decades, two times the population of New York City.

Statistically, we know these tragic deaths are most common amongst young men, often ages 18 to 34, and likely experiencing a combination of factors such as intimate partner problems, substance use, financial strain, and more. It is easy at this level to focus on this problem in terms of numbers and percentages but these are real people who had friends, family, and loved ones. We must do better.

We need to ensure DoD leaders at all levels view mental fitness on par with marksmanship, physical fitness, and warfighting skills. Leaders embrace, if not evangelize, the need for strength, endurance, and expertise in fighting and winning our nation's wars. Likewise, leaders must embrace mental fitness as the last spoke on the wheel required for military readiness.

I fear our society views suicide as an intractable part of the human condition instead of viewing it as a complex problem we can collectively solve and possibly eliminate. Just like our aspirations to rid this planet of cancer, so too should we aspire to eliminate suicide from the U.S. military.

My team at Stop Soldier Suicide works tirelessly every day aiming towards that lofty goal. Since 2010, Stop Soldier Suicide has served more than 3,500 clients with an average duration of care of 8.5 months. Last year alone, we served more than 1,000 clients, delivering more than 17,000 man-hours of care and ultimately saving 147 lives. To date, zero active clients have died by suicide. We do this by providing free, confidential, trauma-informed care using leading treatments that reduce suicidal thoughts and behaviors via telehealth solutions in all 50 states.

Using suicide-specific modalities, our clinicians can effectively save lives as evidenced by our recent program evaluation finding that 97 percent of our program graduates experience reduced and stable risk.

Take Emily, for example. Emily, age 22, served in the Army for 4 years and was medically separated in 2021, after a military sexual trauma. When she told her chain of command about her trauma, leaders tried to talk her out of reporting the crime, stating the perpetrator was a "good

soldier." She separated from the Army and quickly found herself homeless and disenfranchised from her family. Since working with our team, we have helped reduce Emily's suicide risk, improved her family relationships, helped her secure a job, and we are connecting her to her VA benefits. Emily has a long road ahead, but we have reversed her course from heading towards suicide to a life worth living. She is just one of the 520 active clients we are working with today.

Based on this case and others over the last 11 years I offer the following recommendations to the DoD and to this committee:

(1) Increase access to suicide-specific care;

(2) Eliminate mandatory reporting requirements for care providers;

(3) Better understand trauma and risks in servicemembers that occur prior to military experience;

(4) Conduct annual behavioral health checkups;

(5) Destigmatize help-seeking behaviors and protection servicemembers from negative career implications for having the courage to ask for help;

(6) Re-examine the timing of screening;

(7) Place increased emphasis on lethal means safety; and

(8) Improve transition experiences for separating and retiring servicemembers.

I thank you for this opportunity and I look forward to your questions.

[The prepared statement of Mr. Ford follows:]

Senator Gillibrand: Thank you.

Dr. Doraiswamy.

STATEMENT OF P. MURALI DORAISWAMY, MD, PROFESSOR OF PSYCHIATRY AND MEDICINE, DUKE UNIVERSITY SCHOOL OF MEDICINE

Dr. Doraiswamy: Chairwoman Gillibrand, Ranking Member Tillis, and members of the Personnel Subcommittee, thank you for inviting me to testify on this very important topic. As mentioned, I am a Professor of Psychiatry and Duke, but I am here testifying in my personal capacity.

I do not work directly in military mental health. My views are informed by my experience as a leading expert in evidence generation, in deploying technology, and as a physician caring for patients. I share all of your concerns over the problems of rising suicide rates, especially amongst young enlisted servicemembers.

One metric that has not been mentioned today is suicidal ideation, or suicidal thoughts. At the peak of the pandemic, the CDC estimated that nearly 1 in 4 young adults were experiencing suicidal thoughts. That is roughly 30 million Americans. If those thoughts do not abate and persist or increase over time, then we can expect to see a further increase in suicide rates in coming years.

Over half of those who commit or attempt suicide have never sought professional help, and this is the group that I feel we have not really paid attention to. Young men are the least likely of any group to seek help through traditional pathways. Some of the key reasons have already

been discussed -- stigma, career impacts, and a fear of being seen as falling short of cultural standards. Further, interventions or questionnaires that servicemembers perceive as having punitive consequences may discourage correct answers or further care-seeking, especially during transitions or enlistment.

I am pleased to hear of the many steps that the Department of Defense has already put in place or is considering, but I want to highlight one modality that is particularly well-suited for young adults, namely digital health, the use of smartphone and Web-based tools for mental health which I feel has not been scaled for maximum impact yet.

We are in the midst of a technology revolution, where the smartphone is at the core of not only our social connections and entertainment but also where we go to seek health care knowledge. Surveys show young adults are much more comfortable with text messaging on WhatsApp or Instagram than making or receiving phone calls. They are more willing to reveal mental health information on digital surveys or even to a chatbot than to a human clinician.

In 2019, prior to the pandemic, I co-led a report to spotlight, through expert knowledge and case studies, the most promising technologies available today to meet gaps in mental health care as well as forthcoming innovations that

may transform future mental health care. I have made this report available to the subcommittee.

The pandemic resolved a two-decade debate about the value of virtual medical visits. Once regulations were relaxed, almost overnight telehealth became essential and proved it could improve no-show rates in some cases by 50 percent without any adverse consequences, either in terms of data breach or patient harm.

There are many other digital health tools that have equal or higher potential to be scaled. These include smartphone-based symptom rating scales, chatbots, clinical decision support software, better use of data, apps for psychological or peer support, text messaging-based counseling services, and digital therapeutics.

I want to highlight one such success story, which is Crisis Text Line -- the number is 741741, which is the easiest numbers you can find on your smartphone -- which is a U.S.-based nonprofit, which provides free, 24/7 counseling to young people in crisis throughout the United States via text messages or WhatsApp. It has facilitated over 100 million messages over 5 years, and trained some 20,000 crisis counselors. Over half of its users had never spoken to any other mental health professional.

The top areas users seek help for are relationship issues, sadness, suicide, and loneliness, many of the same

issues confronting our young enlisted men. Users under 25 most frequently seek help late at night, which this system facilitates.

Although there are hundreds of other promising technologies and commercial apps in the mental health field, the incentives and regulations are not aligned for them to generate high-quality evidence. Remarkably, only four mental health apps have generated the evidence needed to be cleared by the FDA to date to treat mental health disorders.

I am not suggesting that technologies replace face-to-face or the human touch, but they can serve as a bridge between what we have and what we need to have so that people can get the care, anytime, anywhere.

I recommend that the DoD take a leadership role to evaluate the performance of digital tools to better understand where they contribute the most, what factors correlated with success, as well as which patients were not served well by digital approaches. Likewise, they can take a leadership role to see how we can better use big data analytics to help our enlisted servicemen. Any implementation pilot should be intentional about not causing harm. Such data would also benefit millions of civilians.

Today most of us cannot think of life without the internet, digital cameras, or GPS, all innovations pioneered and implemented by the military first. I believe the DoD is

similarly uniquely positioned to bring human values and the digital revolution together to save lives.

I want to thank the chair and the ranking member for the opportunity to share these thoughts with you and your subcommittee, and I look forward to answering your questions.

[The prepared statement of Dr. Doraiswamy follows:]

Senator Gillibrand: Thank you.

Dr. Bryan?

STATEMENT OF CRAIG BRYAN, PsyD, DIRECTOR, DIVISION OF RECOVERY AND RESILIENCE AND SUICIDE PREVENTION PROGRAM, THE OHIO STATE UNIVERSITY COLLEGE OF MEDICINE

Dr. Bryan: Thank you for the invitation to join you today to talk about this important issue. I am a clinical psychologist and veteran of the U.S. military who deployed to Iraq in 2009, and has spent the years since devoted to understanding and preventing suicide amongst my fellow servicemembers. This work has afforded me the opportunity to visit and collaborate with military leaders and servicemembers around the world.

During one recent visit to a military installation at Fort Drum a senior NCO shared with me an important story about a junior enlisted soldier who asked him for help several years before. This soldier's mother had recently called to tell him that her basement was flooded and she did not know what to do. The soldier could not afford an out-of-state flight to visit her, and his supervisor would not authorize enough leave for him to drive home to help.

Increasingly frustrated and despairing, he exclaimed to his senior NCO, "I can't take this anymore. I just want to kill myself." The senior NCO listened to the soldier's problems and helped him develop a plan to assist his mother, one piece of which was convincing the supervisor to approve the leave request. A solution and plan now in place, the

soldier expressed relief and gratitude and the problem and crisis was solved.

When the senior NCO notified his chain of command about the situation, however, he was told the soldier needed to be transported to a local hospital for a mental health evaluation. The senior NCO argued against that. It seemed unnecessary. "It is policy, though," he was told.

Emergency services were called and the soldier was transported against his will to a local emergency department to be evaluated. No longer in crisis, the soldier was nonetheless coerced into starting mental health treatment out of concern that he was concealing or under-reporting the full extent of his crisis and possible depression. The soldier was not allowed to go on leave until he was cleared by a mental health professional. This delayed the soldier's ability to help his mother. Understandably, this increased his stress and frustration and created a new suicidal crisis that counteracted the good work achieved by the senior NCO.

Luckily, a military mental health professional provided the clearance needed for the soldier to go on leave, and in the end it all worked out, but at what cost?

The experience left a very negative impression on both the senior NCO and the soldier. The soldier's experience was bad enough that he expressed the intent to never ask for help again. The impact on the other soldiers in the unit

cannot be measured as well.

I want to emphasize that this story is not unique to any particular installation. In the past decade and a half, I found stories like this coming up more and more often. I shared this story because it uniquely highlights how the military can effectively prevent suicide and also fail at the same time.

The senior NCO's actions serve as an exemplar of how to effectively intervene in the right way, at the right time, for the right person. He listened; he quickly developed a plan of action that directly solved the problem. The senior NCO correctly recognized that this soldier's crisis could best be resolved through pragmatic problem-solving, not mental health treatment.

The larger organization response, by contrast, demonstrate how institutional policy and cultural norms can make things worse. I suspect the policy sided to justify the coercive transport for involuntary mental health care was not a formal policy per se but rather was an unwritten rule or an organizational norm that had emerged over time, due to growing fear and anxiety about liability. Better-safe-than-sorry rules, though well intentioned, can paradoxically make things worse. These rules fail because they prioritize liability management at the expense of individual servicemembers' well-being.

In my written testimony submitted for today's hearing I outlined three evidence-based strategies that could improve suicide prevention efforts within the DoD and propose several possible policy actions that align with each strategy. All three strategies involve system-level reforms and change.

We do not need more awareness curriculum, more resilience trainings, more suicide prevention briefings, or more suicide risk screening. We need to eliminate or remove policies, procedures, and unwritten rules of thumb that degrade quality of life, that strain the mental health care system, and increase the use of coercive and potentially harmful practices.

Suicide prevention does not mean that everyone needs to be conducting suicide risk screenings and repeatedly imploring servicemembers to go get mental health care. Rather, it means we should be working every day to create lives that are worth living.

Thank you, and I look forward to your questions.

[The prepared statement of Dr. Bryan follows:]

Senator Gillibrand: Thank you, Mr. Bryan.

Dr. Carter, thank you for sharing your family's experience, and I offer my deepest condolences for the loss of your son. I cannot imagine the horror you have had to go through.

Could you talk a little bit more about the barriers that your son faced? It sounded fundamentally like a grave injustice. The right people did not talk to him at the right time. And I have heard that marijuana is extremely effective for PTSD and for pain management.

So can you talk a little bit about what barriers he had, that he had to seek self-medication, that he could not find any other means medically to alleviate his depression, anxiety, and what barriers you had as a parent trying to get him the care he needed?

Dr. Carter: Yes. Thank you very much, and I really want to thank all of the subcommittee's insight into this and these questions, and both the first committee and this have been very heartening, as well as many of the responses from the first committee, as things hopefully have improved in some merits.

Chris was first having some mental health anxiety issues after his third deployment. When he sought care first through his local sick bay he was told to keep it quiet or he would not be able to deploy on his fourth

deployment. And as a gung-ho leader he did not let his unit, and they were his team, down.

He was tried on various medications for depression, which actually sometimes made his anxiety worse. He also was attempting and did seek mental health care. They did have an embedded mental health provider, who I highly recommended, because it really worked well for their accessibility. But follow-up was difficult while training, and again, his care was not necessarily ever addressed from a suicide standpoint. It was addressed for his anxiety, his insomnia, his PTSD symptoms, but not actually looking at the suicidal.

And no care plan was ever made that I ever found in his record, things that we now know are just basic evidence-based treatments. So even though he was getting a knowledgeable mental health provider, they were not addressing suicide care, and that was one of the things that I was hearing on the first, is that we need to make sure all our mental care providers, those civilian as well as military, are working better at understanding suicide treatment, not just mental health general treatment.

There was the access. There was the stigma. After the suicide death of one of his cohorts -- and he told me that he identified, and I actually happened to be on base and went to that funeral for that young soldier. I went to the

memorial service given on the base. It was very much almost a blame type of service. The commander -- and it was a new commander -- but the commander pretty much said, "You know, you do not need to do this, guys. If you do this, you are weak," you know, kind of statement, instead of again seeking that self-help and support.

They did have a meeting and they brought someone in, and again, they literally called him -- and I will not say the word, but a negative word, for pulling the trigger. So again, instead of looking at this as a method to help and support and find, it actually made the fellow soldiers quiet down and not want to look like they were the weak one in the unit.

He was in his transition period, and therefore he was not deployable, so he had kind of lost some of his -- he had no real work level so he was somewhat lost. And they also, because of this, were putting him extremely humiliating positions. He was cleaning latrines and picking up leaves off the parking lot by hand, were the jobs that he was put in. Some of this was because of his disciplinary status because he had self-admitted the marijuana use and they were actually going through with this potential for other-than-honorable discharge, but also some of it was to protect him, to keep him safe. They would lock him in the supply room to count supplies, so that he could not hurt himself. They

also were making him sleep on a private's floor at night, in his barracks, because they again were watching him to make sure that he was being safe to himself, all things that we know increase his burdensomeness feelings, increase his humiliation, increase the suicidal risk.

I was aware of a lot of this. I came forward and I was able to convince them, convince command to let him move off-post with me, and he did live with me the last few months, in an apartment off-post. But again, I had the means to fly across the country, pick up an apartment, and try to help support with that.

The day he actually died he was working to get into a Warrior Transition Program that was being set up for transitioning servicemembers to help with this kind of getting job placement and support. And he applied, he was accepted, he had a job lined up as a draftsman, and he was looking at an architectural future, so that would kind of work all out. And his command told him that he would be unable to do this because of his disciplinary proceedings that were pending. So that was the last of the last straws, and we know there are multi reasons why people die by suicide. It is not just one reason, but that was the majority of the conflicts. And even though I was a military person myself, I was a doctor, it was very difficult for me to get through. Even some of the NCOs were standing there,

literally saying to my face, "We do not believe you. We do not believe he is suicidal." And again, this kind of was astonishing. I mean, I would not believe this story if it was not true for me, but it was. And all these factors continued to add until the final demise.

Senator Gillibrand: Thank you so much, Dr. Carter. Senator Tillis.

Senator Tillis: Thank you all for being here, and Dr. Carter, you made a comment in your opening statement and you alluded to it in your final comments there that you had a commander say they talked the soldiers, not moms.

Dr. Carter: Yes. That was the last day. I was trying to get through to his command. Now in their defense the commander and the majority of the battalion had just deployed over, again, to Afghanistan, and so it was kind of a backup command that was left behind. But when I left a message and I said, you know, "Why can't I talk to someone? I need to talk to someone," that was what was stated to me.

Senator Tillis: Well, it raises a question whether or not we need to make it clear through the NDA process if the person who is in crisis is comfortable with a provider or a caregiver talking to the command that they should, in fact, be required to do that, and we will look into that as a matter of policy.

Dr. Doraiswamy, thank you for the time in my office

this morning. You have a unique blend of medical practice and the discipline and a focus on technology. You and I talked about maybe being able to accelerate. The biggest challenge we have right now with so many options being available -- I did write down that number of the Crisis Text Line and I looked it up after you gave it to me, 741741. It looks like an impressive, easy-to-use platform, particularly for ideation it would seem to me it is going to be the most effective tool to get out there if somebody is just experiencing that.

But what I would like to do is, we may have a second round and I hope we do, but I do want to discuss how we can potentially get a group effort to come up -- you and I talked about the Hackathon in the office -- specifically on maybe coming up with some best practices or ideas to better serve the broader community, particularly the community that is really untouched now who are going through ideation.

I am also very interested in just stating for the record, I think COVID has solved the argument over whether or not telehealth has efficacy. I do not believe anyone who has been here for the last 2 years can honestly believe that it does not. We had a successful pilot in the VA for behavioral health triaging that makes me believe that we can make a lot of progress there.

So I guess just a quick question on the barriers that

we are even seeing in the private sector. What should we look at or put our foot on the accelerator for, for making sure that we codify or expand the use of telehealth for behavioral health and general health needs?

Dr. Doraiswamy: Thank you, Senator, for this very important question. I totally agree with you that telehealth is now essential infrastructure for the country.

So it was the relaxation of HIPAA standards, as you know, that sort of literally overnight transformed telehealth into something that was practical and widely used. If those authorization are revoked then insurance companies will piecemeal determine what is necessary and not necessary and set different pricing standards. Currently it is reimbursed at the same rate as face-to-face, in-person visits. I think it is very, very important to continue telehealth the way it is, because otherwise you do not want it to go back to where it was before the pandemic.

And then the second issue is there is still a substantial portion, perhaps 10 percent, of individuals who may not have access to broadband, who may not even have access to smartphones or computers. I think it is really very important to see how we can reach out to those individuals to reduce health disparities.

The third is I do agree with you that telehealth has not produced significant harms. The real question is, has

it actually produced substantial gains over conventional treatment because it has reduced dropout rates? And if it reduces dropout rates then you would expect the outcomes to be better. I have not seen randomized studies or big data analytics from telehealth to look at actual outcomes compared to face-to-face, historical face-to-face outcomes.

The last is it has been very difficult to implement rating scales, because as you know, you cannot manage what you cannot measure. There are more than 500 different outcome measures that can be used in mental health. It has been very difficult to implement and integrate them into telehealth for a variety of reasons, but I think we need to do that in order to be able to, 2 years down the road, to see how effective we are, what the gaps are, and how we can remedy those gaps.

Senator Tillis: And Dr. Carter, Mr. Ford, and Dr. Bryan, thank you for your past service.

Mr. Ford, thank you for the work you are doing. I know you are down in Durham. How do you connect to your clients? How do they know about you? How do they come to you?

Mr. Ford: That is a great question. We use proprietary information about the behaviors of servicemembers and veterans that indicate they are expressing mental distress and maybe headed towards suicide. So it is a very multi-touch marketing effort, much like you

would have in commercial enterprises. If you are shopping for a new pair of shoes on a website, you are going to see ads for those types of shoes everywhere thereafter.

So we use a lot of keyword identifiers and demographic information to push advertisements digitally to people we know that they are exhibiting the behaviors of concern that would benefit from our service. Whereas fixed facility models would say "we are here if you need us," we are knocking on people's digital doors saying "we are here because we know you need us."

Senator Tillis: Thank you.

Senator Gillibrand: Senator Hawley.

Senator Hawley: Thank you, Madam Chair. Thanks to all of you for being here.

Dr. Carter, I want to start by thanking you for being willing to be here and to share your story and your son's story, Corporal Carter. It is always good to see somebody from Missouri, so thank you for being here for that reason. I understand that Chris was laid to rest in St. Charles, I think it was. Is that right, your son?

Dr. Carter: Actually he is in Jefferson Barracks.

Senator Hawley: Okay. In Jefferson Barracks. Got it. Well, thank you for being willing to share. And I just -- I am now a father myself and when I was your son's age I lost my best friend, who was the same age I was, to suicide, and

that has been 20 years ago now. But I saw what his family went through, and as a father -- of course, I was a young man then -- as a father now myself of three small children I just cannot begin to imagine what it was like. So thank you for being willing to talk about it and share about it in the end, and allow your heartbreak and devastation to help other families. That is just incredible. So thank you for being willing to do that.

I just want to ask you, in that regard, in your experience you talked about some of the stigma that your son encountered. What have you seen in terms of best practices that are effective at reducing stigma, in being willing to say, "Hey, I am struggling," being willing to say, "I need to get some help"? I mean, have you seen anything that you would recommend or you could share with us?

Dr. Carter: Yes. Best practices is a hard word because that means evidence-based usually, and so this is going to be my personal.

Senator Hawley: Fair enough.

Dr. Carter: The one factor I think that seems to have the most credence and seems to get the most effect from those that I have talked to -- and I still keep contact with many of my son's military buddies who are still active duty -- is those in higher-ranking status who come forward and speak on the fact that they have sought mental health care,

that they have suffered problems, and that their career has not been jeopardized by that process. And that being passed down, as well as those that then speak out. When we hear of group treatment where here we are in a post-suicide, mental health program and somebody is calling this servicemember, you know, a demeaning name, those folks come forward and put their foot down. Tell it like it is. State how it is not a weakness that they are getting help or that they would come forward for help, but it is a positive.

And I loved the way you stated it with having it part of those five members of readiness is mental health readiness, so being supportive on that line.

Senator Hawley: That is good. That is very helpful. Thank you.

Here is a broader question for anybody on the panel. Just looking at the Department, DoD's own Annual Suicide Report from 2015 to 2020, that report determined a significant increase -- significant increase -- in suicide across all the services, among their active component. What is your views -- and theories are fine. I mean, I am not going to hold you to this, but I am just curious, what do we think is driving this very significant increase? Because it is not 1 year, it is not 2 years. It is now, over time. And I realize it is a society-wide problem, maybe especially with men, maybe especially with young men. But putting the

larger society issue to one side, looking at active-duty servicemembers, does anybody have a view as to what is driving this? We are reaching sort of epidemic levels here.

Dr. Bryan: I suspect the honest answer is no one really knows. I think what we understand about suicide, though, is that it is caused by many different things, so there are probably actually multiple factors driving it.

One issue that I have become increasingly conscious of is that we have almost pigeon-holed our perspective of suicide as a symptom of mental illness or as a mental health outcome, when we know that the majority of servicemembers who die by suicide do not have a mental health condition. This tracks on U.S. general population rates as a whole. And this is where I think a lot of the work that we have been doing is focusing more on things like needs restriction as well as quality of life issues. Because I think for decades we have doubled down on the "get help, get help, mental health, mental health," and that is just one piece of the puzzle.

Senator Hawley: You mentioned that just a second ago, Dr. Bryan, in your opening statement, and it caught my attention when you said it then, when you talked about quality of life and about how it is important to promote -- this is my gloss on it now -- but it is important to promote a sense of purposefulness and meaningful, as opposed to

saying, "Well, it is just a mental health issue and we will fix that." But it is really about how you see your whole life. Can you just expound on that?

Dr. Bryan: Yes, and I provide a little bit more in detail in my written testimony. But what we are starting to recognize now as suicide researchers is that suicide can more usefully be understood as a behavior that is independent of mental wellness, mental health conditions. And there is neural research, there is no psychological research showing that in the moment of sort of the decision it is sort of "Do I live? Do I die?" There is this ambivalence or this mulling that happens. And we see that the parts of the brain that are most closely associated with the decision to act or not act involve reward centers, perceptions of reward versus punishment. And if life is not rewarding, if life is punishing, if the idea of staying alive means dealing with toxic work environments, strain, stress, then the value of suicide as an escape from that suffering increases and the probability begins.

So that is where mental health treatment, now we are starting to understand part of the reason suicide-focused therapies are effective, is because we teach people how to change that decision process. But I think we need to move beyond that, because the majority of servicemembers dying by suicide do not have mental health conditions and are not

coming for treatment. And so if life is worth living it adjusts that balance and that decision.

Senator Hawley: Thank you.

Senator Gillibrand: I would like to continue that line of questioning for all the panelists. I have also heard of a problem with overprescribing medication, so that if somebody is identified as having suicide ideation the first response is medication. And in many instances, overprescribing and poor prescription management, not dealing with the more holistic approach to how do you create wellness, and in your words, quality of life, Dr. Bryan.

But for each of the panelists, can you talk a little bit about how we should be looking at the whole of the patient, not just the clinical diagnosis and the medication given, to make sure that they are being supported? Dr. Carter, in your son's case, they instigated shame. I cannot believe the punishments they were giving to somebody with suicidal ideations. Everything that Dr. Bryan just said would make life not worth living, undermining all of his connections to family, friends, mission, purpose. And then the belittling is just inexcusable. I mean, it is not acceptable.

So I would like to talk a little bit about the interventions that work, this notion of holistic approach, what is working, what is not working, what have you seen in

practice, and what recommendations specifically would you like us to look at for the NDAA?

Mr. Ford, why don't you start, and then Dr. Carter, and then Dr. Doraiswamy, and then Dr. Bryan.

Mr. Ford: Thank you so much. I think in our work over the last 11 years, and more specifically in the last few years, we find that suicide-specific treatments work. Again, 3,500 clients, no active client dying by suicide, 97 percent of them with reduced and stable risk -- all via telehealth, mind you -- shows that there are ways to help people who have the courage to raise their hand. These modalities that we use, some of which pioneered by Dr. Bryan and Dr. Rudd, BCBT, in particular, focus on more than just the mental health of the person. They focus on social determinants of health, relationships, support networks, financial stability.

So we find that in our care for our clients, as we try to resolve underlying comorbid conditions, that having a healthy environment with improved relationships, more financial stability, less external strain on their mental health really reduces the suicide risks, which can be short-lived and acute but severe at time.

I think a really important component of our model as well is contingency planning, especially around lethal means safety. We know that when firearms are used in suicide they

are 83 percent better in being lethal. We need to create more time and distance between people who are at high-risk states for suicide so they have time to manage those risks and prevent them from making a permanent decision to a temporary problem.

Senator Gillibrand: Thank you. Anyone else? Go ahead, Dr. Carter.

Dr. Carter: Yes. I would like to piggyback on that. The combination of what you two just stated so eloquently is perfect, is that we need to find the environment and support the environment that is a positive support. And that means all of us, probably, could use better training on what to do and how to help our fellow man, and as well as continue to outreach to each other and look for questions and responses that might make us more concerned and push a little harder. But that environment needs to be a norm for us all.

The other, and this kind of goes back to your question too, Senator Hawley, about why now. You know, there was a lot more, I think, stress on redeployment, is what I am hearing, especially -- well, I know the special forces especially.

And then another area that I think we have not really touched a lot on is traumatic brain injury. A lot more concussive exposures in these more recent wars, and we now know that that can cause biological changes that we are

discovering that can make some differences.

So other methods or things that might be outside the box -- and sometimes I have to take off my doctor hat when I talk about the outside-the-box things -- but we know ketamine, although it is a drug, does have some immediate decrease in suicidal tendencies for those who experience it. SGB, stellate ganglion blocks, is a new and upcoming method of looking at methods to interact with the biological manner of reducing some of the extreme, especially in PTSD, effects for soldiers or anyone who has PTSD. It can reduce and has a calming effect so that, therefore, they can address some of the other psychological issues more comfortably.

There are new methods looking at MRI types of therapies, which we know in depression has some effect. I had a recent ex-servicemember who we helped support in a float chamber, and again, these seem like strange things, but in this case it was very helpful for him, and a calming effect, I guess much like meditation and yoga would be.

So again, methods that we use that could become just the norm of our treatment. I mean, yes, football players can do yoga and so can servicemembers, and things that will help all of us feel healthier and happier.

Senator Gillibrand: And Dr. Doraiswamy and Dr. Bryan. Be brief because I am out of time.

Dr. Doraiswamy: Sure. Thank you. This is a really

important area. I often make a comment, "Citibank can predict suicides better than clinicians can." That is because they are probably multifactorial -- economic crises, it could be criminal issues, it could be relationship issues, alienation, loneliness. Many of those are not captured fully by the medical system.

I believe we need to find ways to track those in a way that is not threatening to the individual and address them. I think otherwise we will never be able to fully address the suicide risk, especially in the impulsive, last-minute suicides.

Dr. Bryan: I think with your question regarding medication, a meta-analysis published by Katrina Fox published a couple of years ago showed that the amount of therapy medication has a very small benefit for suicide risk, not nearly as pronounced as like cognitive behavioral therapy for suicide prevention.

I think one of the reasons why we see high rates of medication is because, as we mentioned in the previous panel, the mental health care system is overwhelmed in the DoD, and so prescribing medication where you can have a 15-minute appointment and meet with someone every 6 to 8 weeks to monitor becomes much more sort of practical within an overwhelmed system than meeting with someone every single week for an hour. And so I think that is a major factor

contributing to higher rates of medication.

The second thing, and the last thing I will say is that these treatments that we have been talking about, these suicide-focused treatments, many of those have been tested in the DoD. They reduce suicide attempts amongst active-duty personnel by 60 to 76 percent. They are astronomically better than traditional mental health treatments.

What we are finding now is that there is no sort of systematic training or implementation program to help push this out into DoD MTFs, but secondly, there are, again, some other sort of institutional, bureaucratic burdens to implementing those treatments. Clinicians do not have enough time to schedule appointments on a regular basis, and the paperwork and administrative and bureaucratic demands are crushing the will and the soul of our mental health professionals, and it detracts, it eats into face-to-face clinical time because they are having to fill out more forms and they are having to fill out more paperwork to meet regulatory requirements.

Senator Gillibrand: Senator Tillis?

Senator Tillis: Thank you all. On BCBT, I think that particular treatment has efficacy of about 60 percent on avoiding suicides. To what extent is that implemented in practice in the DoD now?

Dr. Bryan: So it is not widely used, and part of it is

for the reasons I just mentioned. And right now, you know, we conduct trainings for different MTFs periodically, but it is largely just based on if they have money left over at the end of the fiscal year.

Senator Tillis: I see Senator Sullivan has arrived and we are going to have a vote shortly. But I am particularly interested, as a follow-up, we can have a broader discussion about general health care systems and paperwork burdens, but to the extent that we can identify procedural requirements that are not adding value but putting care further away, I would be very interested in getting that for the purposes of any considerations that we should have for either pilots or just policy decisions with respect to the DoD and DHA.

Thank you all.

Senator Gillibrand: Senator Sullivan.

Senator Sullivan: Thank you, Madam Chair. Thank you for holding this hearing, and thank you to the witnesses.

You know, my state, Alaska, has a wonderful veteran and military population. We also have a huge suicide problem. And Madam Chair, I would like to submit for the record a recent USA Today article, very extensive, on the problems that we have had in the Alaska military. I would like to submit that for the record.

Senator Gillibrand: No objection.

[The information follows:]

[SUBCOMMITTEE INSERT]

Senator Sullivan: So we have had about, I think the number is 38 in the last 4 years, in one state. That is more members of the whole U.S. military that were killed in Afghanistan during the same time, killed in Alaska. And it is everybody from enlisted to even sergeant majors, so it is a big problem.

One of the things that article highlights is -- and I know the subcommittee here has been talking about resources, and this big issue of, hey, when a soldier actually has the courage to say, "Hey, I need help," a lot of times the answer is like, "All right. You have got to wait for 60 days." Well, as you guys know more than most, a lot of times these people, these great young Americans, do not have 60 days.

So from my perspective, what do we do? I will just give you one example of something I am thinking about. One of the military's answers is, well, it is hard to find mental health professionals, civilians, who can do that kind of work in a remote area in Fairbanks, Alaska. My view is it should be a priority of the military. So you actually bring the active-duty forces to do this on a regular basis, to be with the troops, and not have to wait 60 days. What do you guys think on that issue, and how often do you see that as a problem?

Mr. Ford: I am 100 percent aligned, Senator, that

bringing more resources to bear immediately should be a priority. I can tell you that when we became aware of this issue and talked with leadership at the command, they asked for help from us.

Senator Sullivan: You mean in Alaska?

Mr. Ford: In Alaska. And on March 22nd, we launched a digital ad campaign to let servicemembers and their families know that we are a trusted, confidential, evidence-based resources for their care. And we have already had 24,000 impressions on those advertisements, 78 people have visited our site, and we already have 1 new client. That is just starting to scratch the surface.

But we are going to keep pouring our efforts and money into doing that. We are relocating one of our clinicians from Colorado to Alaska as we speak --

Senator Sullivan: Oh, good.

Mr. Ford: -- to provide that care. We are a telehealth solution but also having that person in-state will improve our efficacy and delivery.

But it is a tough environment. I cannot solve all that through telehealth -- the darkness, the long days, the frigidity -- but we are doing everything we can as a community-based provider to offer care, and we would welcome the opportunity with the DoD to improve access to our lifesaving care.

Senator Sullivan: Good. Let me ask another question. I know you have already touched on it. It is the stigma. And I want to hit this in two ways. So I am a marine. I have been in 28 years. I was in a recon unit for a number of years. The SF community, special forces, recon community in particular, has a toughness to it, and yet they have seen a lot.

I went to one of the hospitals here with Vice President Pence and Senator Manchin about 4 years ago, and all the discussions we had was how hard it was for these warriors who have seen a lot to finally raise their hand and say, "Hey, I need help." Because the culture in the military, particularly the SOF community, is you never ask for help, and if you are asking for help, you are weak. And to be honest, if you are asking for help in certain units they actually get rid of you. That is bad.

But let me give you a flip-side one, that I am working on legislation right now and I would love to work with this subcommittee on. I have constituents -- we have a great military ethos in Alaska, more veterans per capita than any state in the country -- I have constituents whose lifelong dream is to join the Air Force, the Army, the Marines. And when they have gone to OCS or when they have applied and they are asked, "Have you taken medicine, prescribed medicine, for depression?" and they say yes, guess what the

rules are in the U.S. military? You are not qualified to be an officer in the U.S. Marine Corps. You are not qualified to be an officer in the U.S. Air Force.

So we are telling the young teenagers of America -- and you guys know there is a teenage suicide crisis, a lot of factors, COVID -- but we are telling young Americans right now, if your dream is to be an Air Force pilot, and you have depression, as a 16-year-old young girl, teenage girl, you either need to not go get help, or if you did go get help and were prescribed drugs, and then you applied to be an Air Force pilot, you have got to lie. I think that is so wrong. That is happening right now.

What do you guys think of both of those issues? Sorry, Madam Chair. I went a little long. And we are working on legislation right now on that because I just think it is wrong. That 16-year-old girl who wants to be an Air Force pilot, A, if she has got a problem with depression and she is 16, she should go seek treatment, but that should not disqualify her when she is 22 to be an F-35 pilot. But right now that is the rule. I have examples of this. I do not want to embarrass any of my constituents, but it is happening.

Dr. Bryan: Yeah, this is a great example of another sort of policy institutional barrier to the intended outcome and goal. We want, on the one hand, for people to seek out

help, and at the same time we, in essence, punish them when they do so.

Senator Sullivan: In the active force --

Dr. Bryan: Correct.

Senator Sullivan: -- but people who want to be pilots or officers --

Dr. Bryan: Exactly.

Senator Sullivan: -- or enlisted.

Dr. Bryan: So this is where I think, you know, there is no amount of therapy and medication that is going to solve that problem. This is where looking at systemic change and reform, institutional policies and practice, that is where we would need to be able to target in order to open up the pathway for these other ideal, potentially lifesaving interventions.

Dr. Doraiswamy: I agree, 100 percent. This is probably the only institution where such a practice exists that I know of. We have more than three decades of experience now with antidepressants. There is no evidence whatsoever to indicate that it impairs performance or --

Senator Sullivan: Or they make you unreliable or --

Dr. Doraiswamy: -- exactly, or, in fact, if anything, they reverse.

Dr. Carter: Thank you for your service. Thank you for that question. Amen, exactly. That is all I can say. That

is exactly my story with my son, and I just appreciate the fact that you understand. And as far as back to your question of stigma and what else can we do, that is another stigma-builder from the very get-go. Yep.

Senator Gillibrand: Well, Senator Sullivan [inaudible] and they are going to write a letter each to the committee. I would like you to put this in writing, of your five recommendations for laws we should change. So the structural stuff you are talking about, Dr. Bryan, we want to do. We are the Personnel Subcommittee. This is our job. And Dr. Doraiswamy, using not only apps -- some of this was so helpful, Senator Sullivan, about the way they are treating current patients effectively to allow these risk factors to be identified quicker. Like I broke up with my girlfriend, I have massive debt, parents just separated -- all these stressors. And if you have a checklist of are you undergoing any of these stressors, and there are 15 of them, and you have checked them all, that is going to create an opportunity for someone, hopefully the right person, to then get them the kind of support they need, without undermining their career, without undermining their deployability, without, you know, as what happened in Dr. Carter's son's case, enormous, absolutely outrageous response of demeaning this individual and giving him the kinds of work and demotions because he came forward asking for help.

So it is shocking how badly we are structured today.

This panel has a lot of really good ideas that they will submit to us in writing. If you have any other follow-ups, please.

Senator Sullivan: I will just mention one thing. I think the risk factor issue is really important, and I track every one of the suicides in Alaska. But my first experience with all of this was horrible, right. I was a Marine recon officer. I had a young Alaska Native marine who was -- we were a reserve unit. He called me because he broke up with his girlfriend. He was very distraught. And I said, "Hey, I am going to see you in 4 days. Do not worry. I will take care of it. You are going to be fine. You are going to be with your brothers." He did not have 4 days.

So those indicators -- and I did not know that, right. So those indicators that you can give to commanders I think would be really helpful. And by the way, a lot of it, especially with the young ones -- in Alaska I review every case -- a lot of it is, you know, we do not look at, oh well, you broke up with your girlfriend, or you are having problems with your spouse. That is a big issue, a big issue.

Senator Gillibrand: Especially for young servicemembers far away from family. They have no support

systems. If their commander berates them or demeans them, that is as good as your father berating you or demeaning you. It is so undermining. And for the commanders not to be trained to know the basic things that you did not know -- no one trained you on this -- it is not fair for the military because they do not have the tools they need to protect these servicemembers.

And I think the stigmatization of asking for help has to be addressed, and I think you are right to start early. Start it in even for the service academies, even for enlisted, just start a process that is better.

Senator Hawley?

Senator Hawley: I just wanted to piggyback on that. Since it sounds like Senator Gillibrand has you writing recommendations, I want to suggest one more thing to add to that, and it is on the commander training piece. I just wonder, so anecdotally -- and this is pure anecdote, so this is why I would like your expertise on this -- anecdotally, as someone who has taught -- I used to be a professor, and I have worked with young people, young men in particular, that I taught -- what my anecdotal experience has been is that young men, in particular, if you say to them, you know, "Will you see a counselor?" Oh, no. Big stigma. "A mental health professional?" Oh, no, no, no, no. "A doctor?" No, no, no.

"Will you get mentored?" Oh yeah, sure. Mentoring, yes. "Leadership training?" Oh, absolutely. Leadership training, yes, absolutely.

So I am just wondering, my question to you is, when we think about the commanders, is there something we could do or we could help give them training where they recognize these signs, they can intervene, and they know how to say that, listen, we can be the first line here, and it is not about triggering all the different stigmas but it is about us recognizing that this guy or this gal is in crisis, and we can approach them as the leader and help them, nudge them, help them get the help that they need.

You know, is there something we can do in the training component for our commanders that can help that, where we avoid some of those stigmas that for a lot of folks I think are tripwires, where they just check out, like, no, I am not going to do that.

Senator Gillibrand: It is almost like it is resiliency training. And it was interesting. Mr. Ford said that we should be looking at mental health as a readiness issue. So if you saying we want everyone to be ready, it is a readiness issue and it is a resiliency training issue. And giving more access to this analysis, the commanders and to the servicemembers and veterans themselves, I think is necessary.

Just even the awareness, Dr. Doraiswamy, when you have a handheld app, and you can even self-diagnose, like go through a program that the DoD can develop to say, "Oh, my God, I have got so many risk factors. I need some resiliency training." You know, some kind of like you need resiliency training, and that is not a negative thing to sign up for immediately. Something as simple as that, where you are not seeing a shrink, you are not getting medicated, but you are doing something positive that is supported.

Because Dr. Carter's son -- you were not here, but he self-medicated. He was trying to manage his PTSD, trying to manage his anxiety, because that is what servicemembers do. They try to fix it themselves. They do not want to go to help. And he was punished for that. So that is the problem I see in all your testimonies.

Please submit the letters. We are here to work hard to lift up these stories and this advice in a very productive way.

Thank you. Meeting adjourned.

[Whereupon, at 12:13 p.m., the subcommittee was adjourned.]