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STATEMENT BY

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VICE CHIEF OF STAFF
UNITED STATES ARMY

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Chairwoman Davis, Ranking Member Wilson, distinguished Members of the Subcommittee; I thank you for the opportunity to appear here today to provide a status on the United States Army's efforts to reduce the number of suicides across our Force. This is my first occasion to appear before this esteemed subcommittee, and I pledge to always provide an honest and forthright assessment.

On behalf of our Secretary, the Honorable Pete Geren and our Chief of Staff, General George Casey, I want to take this opportunity to thank you for your continued, strong support and demonstrated commitment to our Soldiers, Army Civilians, and Family members.

As all of you know, it has been a busy time for our Nation's military. We are at war; we have been at war for nearly eight years. That has undeniably put a strain on our people and equipment. In spite of this, I continue to be amazed by the resiliency of the Force. The men and women serving in the Army today are well-trained, highly-motivated, deeply patriotic, and are doing an outstanding job on behalf of the Nation.

As leaders, we have a responsibility to look out for the physical and mental well-being of our people. The culture of the Army is that of a team; and, in everything that we do – how we train, how we fight – we are guided by the Warrior Ethos, *"No Soldier left behind."* I assure the members of this subcommittee that we are addressing the issue of suicides across the Army with that same attitude.

The Overall Health and Well-Being of the Force

I must address up front what I've learned. Since being given the mission by Secretary Geren and General Casey in January to develop a plan to significantly reduce the high number of suicides across the Army, I have talked

with Soldiers, Non-Commissioned Officers, Spouses, Parents, Commanders, and Chaplains at installations across the Army. I have conducted video-teleconferences with health care providers, therapists, and Commanders of Soldiers who committed suicide. I have met with researchers, scientists, doctors, and practitioners. I have studied the data and analysis that is available on the topic of suicides. What I concluded early on is that the challenge we face cannot and should not be limited to simply reducing the number of suicides.

Suicide is without question the most severe and tragic outcome of a very complex and difficult situation. Fortunately, the vast majority of individuals struggling with behavioral health issues do not choose to end their lives. However, there are many other ways that we are seeing increased stress and anxiety manifested in a much larger segment of the Army's population, to include acts of violence, increased use of alcohol, drug abuse, infidelity, and reckless driving. We recognize that in order to effectively address and improve the overall behavioral health and well being of the force and our Families we must address these types of at-risk behaviors as well.

Therefore, I – and, the Army's other senior leaders – have consciously made the decision to expand our efforts to improving the overall mental health and well-being of the Force. We are confident that by doing so, we will also ultimately reduce the number of suicides in the Army.

That being said, I will provide some specific details on the current status of the Army's ongoing efforts to reduce the number of suicides across our Force, as well as our broader efforts to improve the overall resiliency and mental well-being of Soldiers and their Families.

Calendar Year (CY) 2008 and CY 2009 Army Suicides

During calendar year 2008 there were 140 suicides by Soldiers on active duty; a confirmed rate of 20.2 per 100,000. This is an all-time high for the Army.

And, for the first time in history, the number of suicides in CY 2008 also exceeded the national average (19.0 per 100,000 for a demographically comparable segment of the civilian population). However, it should be noted that the most recent data for civilian suicides reported by the Centers for Disease Control and Prevention (CDC) is from CY 2006.

Unfortunately, this trend has continued into CY 2009. We experienced an alarmingly high number of suicides in January and February with 41 compared to 16 in the same months of CY 2008. This prompted the establishment of the Army's Suicide Prevention Task Force, after which we began to see a reduction. Although I'm not prepared to say that we've "turned the corner" on preventing suicides, I can report that the number of suicides for the months of March through July is lower than the same period last year.

I, and the other senior leaders of our Army, readily acknowledge that these figures are still unacceptable and continue to explore ways to improve the mental wellness of the force.

Suicide is the result of a combination of factors

In this era of what I refer to as "persistent engagement" – Soldiers are required to maintain a heightened state of readiness and operate at an exigent tempo for prolonged periods of time. This undoubtedly contributes to higher levels of stress and anxiety.

However, we all must resist any attempt to generalize or oversimplify the challenges we are facing. Every suicide is as different and as unique as the people themselves. And, the reality is there is no one reason a person decides to commit suicide. That decision reflects a complex combination of factors and events that over time may lead the individual to feel completely hopeless – with no other option than to end his or her life.

Our analysis has shown that there are some common factors among suicide victims which we are working diligently to better understand so we can develop mitigation strategies.

The most common contributing factor in Army suicides is that the nearly three-fourths of Soldiers that have committed suicide had a significant relationship problem or lacked a significant relationship. Over two-thirds of Soldiers that have committed suicide had been deployed, while almost one third of the Soldiers who died by suicide had never deployed. The majority of those who had deployed had participated in one deployment (46%), and the remainder had two or more deployments (21%).

We recognize that behavioral health issues are a significant factor in suicidal behavior. While a very small number of Soldiers who died by suicide had been diagnosed with Post Traumatic Stress Disorder (PTSD) (5.5%), it is clear that other behavioral health issues are involved. Slightly more than 40% of those who died by suicide had received outpatient care for behavioral health treatment. The most common diagnosis is Adjustment Disorder (20.6%), followed by Substance Abuse (16.3%).

Although we have worked hard in the past two years to increase our understanding of suicidal behavior, there is much we still do not know. To help us better understand this complex issue, we have enlisted the aid of the National Institute of Mental Health (NIMH). The Army has funded NIMH to conduct a "Collaborative Study of Suicidality and Mental Health in the U.S. Army", the largest study of behavioral health ever undertaken by the Army. This five-year epidemiological study will examine behavioral health, psychological resilience, suicide risk, suicide-related behaviors, and suicide deaths across the active and reserve components over all phases of a Soldiers career. This groundbreaking study is being carried out by a consortium from the Uniformed Services University of the Health Sciences, Harvard University, the University of Michigan, and

Columbia University. We have very high hopes that this consortium will help illuminate the suicide problem and provide concrete recommendations for service-wide implementation, and potentially even national implementation.

The Army's Approach to the Issue

Today, the Army is in the process of instituting several key initiatives. Most notably, we are adopting a 2-prong approach to transforming the Army's comprehensive care system.

Our goal is to: 1) help Leaders and Soldiers alike better identify those Soldiers who are at-risk and may need extra attention or help; and, 2) increase Soldiers' overall resiliency, while also ensuring individuals who need help are aware of and have access to the resources and support programs that can provide them with the most benefit.

The Army's approach is based on two 'big ideas': the Comprehensive Soldier Fitness (CSF) program and the *Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention*.

The Army's Comprehensive Soldier Fitness program has been designed to raise mental fitness up to the same level of attention as we have historically given to physical health and fitness. We recognize people come into the Army with a very diverse range of experiences, strengths, and vulnerabilities in their mental as well as physical condition. Multiple studies have shown that mental and emotional strength are just as important as physical strength to the safety and well-being of our Soldiers. In fact, a Soldier who is mentally and emotionally fit is better prepared to withstand the challenges and adversity of combat.

In the past, the Army's approach was primarily focused on the right side of the assess, train, intervene, and treat continuum; simply stated, we were reactive. That has changed; today the focus of CSF is to assess, educate, and assist. We

will be proactive in an effort to early and throughout a soldier's career identify and mitigate issues before they become significant concerns.

As part of the CSF effort, the Army has instituted a resilience training program, with modules for essentially every juncture in a Soldier's career – from Basic Training to the Pre-Command Course. There are also pre- and post-deployment modules for both Soldiers and spouses. This resilience training program has already demonstrated the ability to reduce symptoms of post-traumatic stress upon redeployment. People who participated in the resilience training have reported reduced stigma attached to getting mental health care if needed than those who had not participated in the training.

In March 2009, we established the Army Suicide Prevention Task Force which created the *Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention*. The Campaign Plan contains approximately 250 tasks that will optimize existing programs and update policy. By early August, the Task Force will have accomplished almost half of the tasks. Some of the accomplishments to date include:

- Conducting a monthly Senior Review Group world-wide VTC to conduct detailed "After Action Reviews" on recent suicides to gather and disseminate lessons learned.
- Building a data collaboration network among the various Army Stakeholders which will allow the National Institute of Mental Health to conduct their five-year longitudinal study to better understand risk factors associated with suicidal behavior.
- Updating Army regulations and policies to better reflect current Army organization and operational requirements across all components.
- Establishing policies that help guard against accidental overdose and adverse drug interactions.

- Assessing the impact of leadership turn-over in recently redeployed units, stabilizing leadership and medical personnel with units as necessary, and improving access to counseling and behavioral health providers.
- Completing a three-phase suicide "stand-down" and chain teaching program.

A Team Approach

Improving the overall behavioral health and well-being of the Force and thereby effectively addressing the challenge of Soldier suicide is going to require a total team effort across all Army components, jurisdictions, and commands, as well as cooperation with partners outside of our organization, such as the Department of Veterans Affairs and NIMH.

Within the Army, Unit Ministry Teams (UMT) play a critical role in addressing this issue. These teams are comprised of chaplains and chaplain's assistants. Today, there is a unit ministry team assigned to most battalions in the Army. They train and deploy with the units, and work with other supportive agencies and health professionals to assist Soldiers and their Families. UMTs are able to provide a quick and effective response to crises, including suicidal crises, as a result of their integration with the unit, credibility with their Soldiers, and superior pastoral skills and experience. UMTs also provide countless interventions to prevent self-destructive behavior, not only at the point of suicidal crisis, but also in working with distressed Soldiers and Family members prior to a crisis.

Shortage of Health Care Providers

Another challenge we are facing is the insufficient number of health care providers, in particular psychiatrists, psychologists and other behavioral health specialists, including marriage and family therapists and substance abuse counselors, across our Force.

When we grew the Army from a force of 482,000 to a force of 547,400, we did not grow our active duty medical force structure to care for the additional Soldiers and their Family members. This left the Army with a suboptimal ratio of uniformed health care providers to service member which has had a significant impact on the access to care we provide our Soldiers and their Families in a time of war.

I can assure you, figuring out how to address these critical shortfalls continues to be a priority for our Army's senior leaders. U.S. Army Medical Department (AMEDD) is currently working to determine how many doctors, psychiatrists, psychologists, and other mental health care professionals are required to meet the needs of Soldiers and their Families. The reality is there is no precedent for how many health care professionals are needed to care for a Force after nearly eight years of war.

The Army is also educating more primary care providers on the symptoms and courses of action for depression, anxiety, and PTSD. What we discovered is that Soldiers who are unwilling to seek help from a mental health care professional will often go to a primary care physician instead. So, it is important for these doctors to know what to look for and how best to care for these individuals.

Another way that the Army is looking at improving access to counseling or Level 1 treatment for alcohol and substance abuse or other mental or behavioral health problems is through web-based care. *"Web-Care"* would provide online "real-time" counseling via video, email, live chat, or instant messaging. Individuals would be able to log-on in the privacy of their homes at times convenient to their schedules.

Changing the Army Culture

In the past, there has been a stigma associated with seeking help from any kind of mental health professional. Soldiers avoided seeking this type of

assistance for fear that it might adversely affect their careers. However, that is not the case; and, we are taking the necessary steps to change this misperception across the Army.

We recognize that we need to do more, and we are committed to getting the message out to Soldiers that it is okay to get help. We are making progress. In fact, recent mental health assessments conducted in theater have shown a marked increase in the percentage of Soldiers willing to seek mental health care without undue concern that it will be perceived as a sign of weakness or negatively impact their careers.

As an example of this, current Army policy is that even if a Soldier self referred himself or herself into the Army Alcohol and Substance Abuse Program (ASAP) their Commander was informed that they were seeking help. This month, we initiated a pilot program at one installation that allows soldiers to self refer if they think they have a problem and the chain of command is not notified. To date one officer, one NCO and nine Soldiers have self referred into the program. ASAP offices remain open after the duty day and on weekends so Soldiers can make appointments and maintain their anonymity. We will expand it to three installations by the end of August, evaluate and make adjustments to the program, and if successful, change Army policy and allow self referral without chain of command notification throughout the Army.

Closing

Any time a Soldier chooses to end his or her life; the loss affects Family and friends, fellow Soldiers, and the Army. The reality is every suicide is unique, and there is no simple solution. To improve the overall health and well-being of the Force requires a multi-disciplinary approach and a team effort by Leaders and Soldiers at all levels of command and across our Active and Reserve components – together with DoD, Congress, and willing civilian health care providers, research institutes, and care facilities.

Again, I can assure the esteemed Members of this subcommittee that there is no greater priority for the senior leaders of the United States Army than the safety and well-being of our Soldiers. The men and women who wear the uniform of our Nation are the best in the world, and we owe them and their Families a tremendous debt of gratitude for their service and for their many sacrifices.

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