

UNITED STATES DEPARTMENT OF DEFENSE

TASK FORCE ON THE PREVENTION OF SUICIDE  
BY MEMBERS OF THE ARMED FORCES

Washington, D.C.

Tuesday, November 10, 2009

ANDERSON COURT REPORTING

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- 7 MS. BONNIE CARROLL
- 8 CDR AARON WERBEL
- 9 CDR EDMOND FEEKS
- 10 DR. RICHARD MCKEON
- 11 LTC UEOKA
- 12 COL JOHN C. BRADLEY
- 13 DR. DAVID JOBES
- 14 DR. DAVID LITTS
- 15 DR. LANNY BERMAN
- 16 MGY SGT PETER PROIETTO
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1 PROCEEDINGS

2

3 OPEN SESSION:

4 MG VOLPE: Okay, if everybody could take  
5 your seats. Welcome, everybody. I'd like to  
6 begin today's session for the DoD Task Force on  
7 the Prevention of Suicide By Members of the Armed  
8 Forces. I'm Major General Phil Volpe. I'm a  
9 co-chair along with Ms. Bonnie Carroll of this  
10 esteemed Task Force that is functioning for a  
11 year's time in order to make recommendations to  
12 the Department of Defense on how to reduce or  
13 eliminate suicides amongst members of the Armed  
14 Forces. That is our goal, and we are very focused  
15 on that.

16 We've had a number of sessions already,  
17 and we have a number of sessions today and a  
18 number planned in the near future. We have  
19 several important topics for today, so I'd like to  
20 begin with some administrative announcements by  
21 CDR Feeks. CDR Feeks, could you take charge?

22 CDR FEEKS: Thank you, Major General

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1 Volpe. As an Alternate Designated Federal Officer  
2 for the Defense Health Board, which is a Federal  
3 Advisory Committee and a continuing independent  
4 scientific advisory body to the Secretary of  
5 Defense via the Assistant Secretary of Defense for  
6 Health Affairs and the Surgeons General for the  
7 Military Departments, I hereby call this meeting  
8 of the DoD Task Force on the Prevention of Suicide  
9 By Members of the Armed Forces, a subcommittee of  
10 the Defense Health Board, to order.

11 MG VOLPE: Thank you, CDR Feeks. And  
12 now carrying on the traditions of the Board, I'd  
13 like to have everyone stand and have a moment of  
14 silence for our men and women who are serving in  
15 the Armed Forces, their families, and especially  
16 on the horizon of having Veterans Day this week.  
17 Please join me.

18 Thank you. Please be seated.

19 CDR FEEKS: General Volpe, sir, we would  
20 be remiss if we fail to wish every Marine a happy  
21 birthday today.

22 MG VOLPE: Let's make that official.

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1 Happy birthday, Marine Corps! I've heard you've  
2 served in every single year of the Marine Corps.  
3 Is that true? No, I'm just kidding.  
4 Since this is an open session, I'd like  
5 to begin by going around the table and have each  
6 member of the Task Force introduce themselves --  
7 name, where you're located, and what you bring to  
8 this Task Force. So we'll start over at this end.

9 DR. LITTS: Hi. I'm David Litts. I'm  
10 the Director of Science and Policy at the National  
11 Suicide Prevention Resource Center. I got my  
12 start in suicide prevention in the Air Force when  
13 it inaugurated a program in the mid '90s that was  
14 fairly successful at the time in lowering the  
15 suicide rate, and I work with the Surgeon General  
16 in the developing of the national strategy and  
17 releasing that from '99 to 2002. Pleasure to be  
18 here.

19 MGY SGT PROIETTO: MGY SGT Pete  
20 Proietto. I'm an 0369 Infantry Unit Leader. I  
21 work with CDR Werbel on the Marine Corps Suicide  
22 Prevention Program and help with the development

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1 and implementation of the NCO program that we just  
2 rolled out. So I'm real happy to be here and look  
3 forward to hopefully getting this problem under  
4 control.

5 MG VOLPE: Welcome back from  
6 Afghanistan.

7 MGY SGT PROIETTO: Thank you, sir.

8 DR. HOLLOWAY: Good morning. My name is  
9 Marjan Holloway. I am a clinical psychologist and  
10 a faculty member working at Uniformed Services  
11 University of the Health Sciences in the  
12 Department of Medical and Clinical Psychology as  
13 well as Psychiatry. Most of my clinical and  
14 research work focuses on the treatment of  
15 individuals following a suicide attempt.

16 CDR WERBEL: Good morning. I'm Aaron  
17 Werbel. I'm a Navy clinical psychologist. I'm  
18 the Manager of the Marine Corps Suicide Prevention  
19 Program and co-chair with Dr. McKeon the Federal  
20 Working Group on Suicide Prevention.

21 MS. CARROLL: I'm Bonnie Carroll. I'm  
22 the Director of the Tragedy Assistance Program for

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1 Survivors. The national organization brings  
2 support to all families who have lost a loved one  
3 serving in the Armed Forces, including those who  
4 have died by suicide. I'm an Air Force Reserve  
5 Officer and the widow of an Army Officer.

6 MG VOLPE: I'm Phil Volpe, Army Flag  
7 Officer and current co-chair along with Ms. Bonnie  
8 Carroll here on the Suicide Prevention Task Force.

9 CDR FEEKS: CDR Ed Feeks, Executive  
10 Secretary of the Defense Health Board.

11 DR. BERMAN: Good morning. I'm Lanny  
12 Berman. I'm a clinical psychologist here in  
13 Washington, D.C. I am Executive Director of the  
14 American Association of Suicidology and currently  
15 the President of the International Association for  
16 Suicide Prevention.

17 DR. MCKEON: I'm Richard McKeon with the  
18 Substance Abuse and Mental Health Services  
19 Administration where I serve as the Lead Public  
20 Health Advisor in the Suicide Prevention Branch  
21 and also the co-chair of the Federal Working Group  
22 on Suicide Prevention with CDR Werbel.

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1 COL BRADLEY: Good morning. I'm John  
2 Bradley. I'm Chief of the Integrated Department  
3 of Psychiatry at Walter Reed Army Medical Center  
4 and National Naval Medical Center; also Vice Chair  
5 of the Department of Psychiatry at Uniform  
6 Services University as well as a member of the  
7 Army's Scientific Review Board for Suicide  
8 Prevention.

9 DR. JOBES: I'm David Jobes. I'm a  
10 Professor of Psychology at Catholic University  
11 here in Washington. I'm co-director of the  
12 Clinical Training Program there as well. I'm a  
13 clinical psychologist by training and have been  
14 working in suicide prevention many years; been a  
15 consultant to the VA and various branches in the  
16 Department of Defense and Suicide Prevention. My  
17 major expertise in research is in assessment and  
18 treatment of suicidal states. Thanks.

19 MG VOLPE: Let me introduce at the end  
20 of the table here someone that we skipped a moment  
21 ago because I wanted to introduce her. That's --  
22 this is COL JoAnne McPherson. And on behalf of

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1 Ms. Bonnie Carroll and myself and all the members  
2 of the Task Force, I'd like to welcome JoAnne to  
3 the Task Force. She's just been selected as the  
4 new Executive Secretary. The Acting Executive  
5 Secretary has been CDR Feeks. He's been doing  
6 double the work for the Defense Health Board and  
7 our Task Force, and now we have -- we are thrilled  
8 and happy to have JoAnne onboard and get spun up  
9 here to be our Executive Secretary. So she was  
10 just hired last week and without even -- we're  
11 ready to have her just dive into it. So, go  
12 ahead, JoAnne, it's all yours.

13 COL MCPHERSON: Thank you very much,  
14 sir. Thank you. Good morning, everyone.  
15 Welcome. I'd like to thank the speakers who have  
16 come today and have worked hard to prepare  
17 briefings to help us further understand the topic  
18 that we're addressing in this Task Force.

19 For those in attendance today, we'd  
20 appreciate it if you would please sign the general  
21 attendance roster that's located on the table just  
22 outside this room if you haven't done so already.

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1 This includes members of the public and media  
2 representatives who may be here today.  
3 For those who are not seated at the  
4 tables, handouts are provided at the table at the  
5 Registration Desk as well. Restrooms, if you  
6 haven't found them yet, are just down the hall in  
7 the far corner -- so out the doors and to your  
8 right, and they're on your immediate left. For  
9 telephone, fax, copies, messages, please see Ms.  
10 Severine Bennett. Sev -- she just stepped out --  
11 or Mr. Mike Tate who's standing here in the corner  
12 with the strange tie.

13 Because the opening session is being  
14 transcribed, please make sure you state your name  
15 before speaking and use the microphones so that  
16 our transcriber can accurately report your  
17 questions, as has been pointed out to us in this  
18 modern technology. The information is actually  
19 being recorded, so he will not be the one who's  
20 actually typing it up. So the person who types it  
21 will not know who speaks and will not know our  
22 voices by the end of the day. So please, again,

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1 make sure you say your name before making any  
2 comments.

3 Refreshments are available for both  
4 morning and afternoon sessions for the Task Force  
5 members, the speakers, and distinguished guests.  
6 We will also have a catered working lunch here at  
7 the Marriott for the Task Force members. Folks of  
8 the public attendees may wish to consider the Agio  
9 restaurant here or further down Wisconsin Avenue  
10 are many restaurants.

11 I would like to request that no flash  
12 photography be taken at the Task Force meeting.  
13 This may be distracting to both the speakers and  
14 observers. Also, please turn off your electronic  
15 devices so that the speakers are not disturbed.

16 If time allows, we will take questions  
17 and statements from the public at the end of the  
18 Panel Discussion this afternoon. We ask that you  
19 register to speak at the desk outside the room.  
20 Everyone has the opportunity to submit written  
21 statements to the Task Force as well. They may be  
22 submitted today at the Registration Desk or by

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1 e-mail to defensehealthboard@ha.osd.mil. We do  
2 have that address available outside for you as  
3 well. Or they may be mailed to the Defense Health  
4 Board office, and again, that information is  
5 available at the Registration Desk.

6 Finally, the next meeting of the Task  
7 Force will be held on Tuesday, December 15, here  
8 in the same venue, the Marriott Bethesda, and the  
9 Defense Health Board Website will have further  
10 information as we get closer.

11 I'd like to start now with our first  
12 speaker for this morning. Our speaker is COL  
13 (Ret) Charles Hoge. COL(RET) HOGE received his BA from  
14 Sarah Lawrence College in 1980 and his medical  
15 degree from the University of Maryland in 1984.  
16 He specialized in internal medicine and infectious  
17 diseases. From 1989-1991 he served in the U.S.  
18 Public Health Service as an Epidemiology  
19 Intelligence Service Officer at the Centers for  
20 Disease Control where he was lead investigator for  
21 outbreak investigations.

22 He left the Public Health Service to

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1 join the Army in 1991 and spent the next six  
2 years, including four years in Thailand,  
3 conducting field studies on the treatment and  
4 prevention of enteric infections that affect U.S.  
5 soldiers deployed to developing countries.

6 Between 1997 and 2000, he changed  
7 careers and completed a residency in psychiatry at  
8 the Walter Reed Army Medical Center. He is board  
9 certified in internal medicine, infectious  
10 diseases, and psychiatry.

11 Between 2000 and 2009, Dr. Hoge directed  
12 a prominent research program focused on mitigating  
13 the mental health impact of the wars in Iraq and  
14 Afghanistan at the Walter Reed Army Institute of  
15 Research. He served as the Director of the  
16 Division of Psychiatry and Neurosciences from 2004  
17 until 2009 where he supervised 100 professionals  
18 involved in behavioral health, traumatic brain  
19 injury, and sleep deprivation research efforts.

20 Dr. Hoge retired from active duty in  
21 August 2009 and is now serving as the Army Office  
22 of the Surgeon General Neuropsychiatry Research

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1 Consultant. He is an attending psychiatrist at  
2 Walter Reed Army Medical Center where he  
3 supervises residents and treats Service members,  
4 veterans, and their families. Thank you.

5 REVEREND CERTAIN: Excuse me, hello?  
6 Hello? Can you hear me?

7 COL MCPHERSON: Hello?

8 REVEREND CERTAIN: Hi. It's Robert  
9 Certain. I will be on the telephone with you  
10 folks most of the day. So just by way of  
11 introduction, I'm Robert Certain. I'm an  
12 Episcopal priest and Vietnam veteran. I'm retired  
13 Army -- a retired Air Force Chaplain, living in  
14 Atlanta and a member of the Defense Health Board  
15 and this committee.

16 COL MCPHERSON: Thank you very much.

17 MG VOLPE: Reverend, thanks for chiming  
18 in. Appreciate it.

19 COL(RET) HOGE: Good morning. Thanks for  
20 inviting me. It's a great honor to be here. And  
21 I thought I'd take the time to sort of give a bit  
22 of a broader perspective, public health

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1 perspective. My background in public health and  
2 epidemiology sort of always leads me to think more  
3 on a population level. And I want to present just  
4 some basic hypotheses for the increase in the  
5 suicide rates, talk a little bit about general  
6 categories of the strategies that are used to  
7 prevent suicide. And rather than get in the  
8 weeds, I know you've heard briefs already about  
9 the specific programs that are going on, and we'll  
10 hear more on that. So this is more of a broader  
11 perspective.

12 Just to start my presentation, I want to  
13 put things in context a little bit. This is from  
14 a paper we published three years ago in Suicide  
15 and Life Threatening Behavior that looked at the  
16 1990-2000 rates of suicide, military-wide, in all  
17 four Services. And what you see is that during  
18 that time period, the crude rate of suicide varied  
19 from 10.7 to 14.1, depending on the Service. When  
20 we adjusted this demographically -- age, gender,  
21 and race -- we found that things leveled out in  
22 the Army, Marines, and Air Force, but the Navy

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1 rate was substantially lower than the other  
2 Services. So demographic adjustment and over this  
3 11 year period demographic adjustment resulted in  
4 bringing things closer -- the comparison -- but  
5 for the Navy, not so much. When we added in the  
6 undetermined cases, then you see things -- and  
7 this is the crude rate -- so crude rate of  
8 suicides plus undetermined looks sort of like  
9 this, but the adjusted -- once you adjust that  
10 with suicides plus undetermined, you see the rates  
11 are virtually identical. And I think what's  
12 happening here for the Navy is the over-boards,  
13 which are counted -- there's a higher rate of  
14 counting over-boards as undetermined, but if you  
15 put them in with the suicides, essentially you see  
16 an absolutely identical rate.

17 This is another -- this has to do with,  
18 you know -- why is the Air Force rate, for  
19 instance, lower here, somewhat lower than the  
20 Army. This has primarily to do with the  
21 demographics of the Air Force compared with the,  
22 you know -- why is the Air Force, for instance,

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1 lower than the Army and Marines? This has to do  
2 primarily with demographics.  
3 This is just another way of presenting  
4 the data. Essentially it's the same data. If you  
5 look at the variability in suicide rates --  
6 because suicides are rare events, even still  
7 they're rare events, and particularly rare event  
8 for individual Services where you may have, you  
9 know, anywhere from 200,000 up to 550,000 I think  
10 now for the Army, you know, a few suicides can  
11 make an enormous difference in changes in rates.  
12 So you see this sort of variability year to year.  
13 You see wide fluctuations. The blue line, for  
14 instance, is the Air Force rate. This period was  
15 the period that was -- there was a high amount of  
16 focus on this period based on the interventions  
17 that were done and I think the conclusion was  
18 reached that this was -- that there was maybe some  
19 efficacy of the interventions that were  
20 implemented. But in comparison with the other  
21 Services, for instance, here's -- there's a sharp  
22 drop in Marine Corps rate. This may have been

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1 largely due to year-to-year variability. But  
2 there's a lot of factors that go into, you know,  
3 demographics, how cases are ascertained, what the  
4 -- how cases are categorized. So undetermined  
5 pendings, et cetera, can change rates and a lot of  
6 expected variability year to year. When we  
7 calculated the rate of variability, 25 percent to  
8 40 percent, depending on the Service, was within  
9 statistical variation. Okay?

10 Now what's happening now? Clearly we're  
11 out -- we've seen a statistically significant  
12 increase in rates, but not in all Services. We're  
13 only seeing that in the Army and Marine Corps as  
14 far as I could tell from presentations from last  
15 time. So I think we need to -- we need to -- you  
16 know, it's fairly obvious that we need to pay  
17 attention to the fact that those -- the two forces  
18 that are engaged in the highest amount of ground  
19 operations are those that are -- in which we're  
20 seeing the biggest increases in rates. There have  
21 been some statistically significant clusters at  
22 some posts. I think Mike Bell has done some of

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1 that investigation. He'll be talking later on and  
2 there's reports that are available on some of  
3 those clusters. And although there's a limited  
4 amount of high- quality epidemiologic data with  
5 denominators, you can gather a lot of information  
6 from numerator data. And the most consistent  
7 factors identified in the reports I think you all  
8 are aware of -- deployment length, multiple  
9 deployments, relationship problems, financial and  
10 legal problems, increased use of alcohol and  
11 drugs, increased family violence, access to  
12 weapons, and behavioral problems. And there's a  
13 substantial proportion of suicides have actually  
14 involved individuals who have touched mental  
15 health in one form or another within the Army --  
16 and I'm focusing now on Army suicides -- this  
17 graph I think you've seen. The increase and I  
18 think it's projected to be higher this year. And  
19 we're now, for the first time in a number of  
20 years, above the civilian rate, demographically  
21 adjusted.

22 This is data from the CHPPM report,

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1 which I think Mike Bell's going to speak more to  
2 later on that was just recently released -- 45  
3 percent of the Army suicides between 2003 and July  
4 of 2009 had one or more behavioral health  
5 diagnoses, 15 percent had in-patient treatment, 7  
6 percent had a history of a prior attempt. So  
7 again, this is not -- this is probably -- well,  
8 this is not inconsistent with civilian data in  
9 that there is a relationship, clear relationship,  
10 between mental health problems or mental disorders  
11 and suicides.

12 So what are the key hypotheses for an  
13 increased suicide rate? There may be an increase  
14 population prevalence of mental disorders because  
15 of the association of mental disorders with the  
16 suicide due to the high levels of combat exposure.  
17 And I think we're -- and I'll show a little bit of  
18 data pertaining to that. Multiple deployments  
19 involving ground combat operations with relatively  
20 short dwell time, obviously a major focus right  
21 now, increased use of SSRIs and other psychotropic  
22 medications. There's the FDA black box warning, a

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1 lot of attention, that's been in the news quite a  
2 bit, so that's a hypothesis. Perhaps stigmas and  
3 barriers have increased. I don't think we have  
4 any evidence for that, but that has to be on the  
5 table as far as hypotheses. In other words, maybe  
6 there are increased barriers that have, you know,  
7 led to people being less inclined to seek  
8 treatment. Again, I don't think there's evidence  
9 for that.

10 And then finally has the resiliency of  
11 the population changed? This has also been in the  
12 news. There's been, you know, reports of  
13 increased waivers over the last several years, and  
14 so that, you know, is a potential hypothesis.  
15 Just a very quick look at a little bit of data.

16 What is the evidence for increased  
17 population prevalence for mental disorders? We've  
18 been tracking cross-sectionally and Brigade Combat  
19 Teams' rates of PTSD, depression, and generalized  
20 anxiety since the beginning of the war. We  
21 started with a rate of PTSD of around 5 percent in  
22 our baseline pre-deployment sample before OIF,

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1 just before OIF kicked off. The Millennium Cohort  
2 Team out in San Diego -- who would be probably  
3 very wise to bring in and give you all a  
4 presentation -- they're doing a 20-year  
5 longitudinal study of 100,000 military Service  
6 members, and they're following them into the  
7 civilian sector afterwards. They're linking it  
8 with National Death Registry data and they've done  
9 some fabulous publications on PTSD, depression,  
10 alcohol abuse, and the baseline prevalence rate of  
11 PTSD is around 3 to 4 percent. What we've seen  
12 since the beginning of the war is that in our  
13 Brigade Combat Teams, there's a much higher  
14 proportion of previous deployers, and you see  
15 rates now that are in the 10 to 15 percent rate  
16 among those deployers. So I think that there's --  
17 it's probably safe to say that by and large in the  
18 population, there's probably been an increase  
19 because of the much higher proportion of the  
20 population are deployed, but it hasn't been  
21 systematically looked at maybe in the way that it  
22 should be.

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1           There's a strong relationship of PTSD,  
2 depression, and suicide and frequency in intensity  
3 of combat, we've demonstrated in a number of  
4 studies is the single most important predictor of  
5 PTSD and depression in our Brigade Combat Teams,  
6 regimental combat teams, Service members. And  
7 then Mike Bell I know will show some data later on  
8 occupation, but in his report -- from the recent  
9 report there's indication that combat arms  
10 individuals have higher rates of suicide. So  
11 again, I think that speaks to the potential for  
12 increased exposure in the combat environment, high  
13 intensity combat exposure being important.

14           What's the data for multiple  
15 deployments? We don't have any direct -- I don't  
16 think there's direct data on multiple deployment  
17 and suicide as yet, but I know that's being  
18 actively looked at. But there's certainly some  
19 indirect evidence from MHATs, and we've shown for  
20 several years now that there's a direct multiple  
21 deployment effect from our cross-sectional surveys  
22 that we've collected repeatedly in combat. MHAT

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1 IV, MHAT V, and now MHAT VI will be released  
2 shortly and is consistent with the prior reports  
3 in that regard.

4       There's been a lot of discussion on  
5 what's sufficient, what do you need for dwell  
6 time? What's the necessary dwell time? We've  
7 clearly shown and published data that the 12-month  
8 reset is not sufficient, and in fact what we see  
9 in our Brigade Combat Teams is an increase in PTSD  
10 and depression prevalence between the 3-month time  
11 point and the 12-month time point, not a decrease.  
12 Now there are individuals who resolve their  
13 symptoms, but there's other individuals who become  
14 more symptomatic during that period of time. And  
15 it's -- the difference between 3 months and 12  
16 months is not great. It's like 12 percent and 15  
17 percent, but it doesn't go 12 percent and 6  
18 percent. In MHAT IV there was -- it was  
19 recommended that the dwell time should be 18 to 36  
20 months, and I know there'll be more on that coming  
21 in MHAT VI. Actually General Casey, in his  
22 interview on Sunday with CNN, indicated that based

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1 on an Army report, that the dwell time -- the  
2 optimal dwell time -- needed to be 2 years in  
3 order to get people back down to, you know, more  
4 or less baseline rates of PTSD and depression.  
5 And he was referring to the MHAT report which is  
6 coming out.

7 Attrition -- one of the issues with  
8 looking at the evidence for multiple deployments  
9 and reset is that as individuals move throughout  
10 their lifecycle, there is a relationship of  
11 deploying to a combat zone and attrition. We  
12 demonstrated this in the JAMA publication a few  
13 years ago that the infantry soldiers who had --  
14 Army Service members who had -- deployed to  
15 non-combat locations had a much higher rate of  
16 staying -- or had a significantly higher rate of  
17 staying in the military than individuals who'd  
18 deployed to a combat location. We demonstrated  
19 that in our 2006 JAMA publication. And that was,  
20 for instance, comparing, you know, rotations into  
21 Bosnia or Kosovo or other locations compared with  
22 -- and we were only looking at Army Service

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1 members then. So what happens is that there's a  
2 segment of the population that attrits in -- the  
3 combat probably -- in combat and deployment and  
4 multiple deployment, there's a segment of the  
5 population that will leave military service, and  
6 therefore leaving the healthier segment of the  
7 population. And so you might actually not see a  
8 deployment-related factor or maybe you even see an  
9 inverse relationship, depending on how you're  
10 looking at the data. So attrition is one of the  
11 things that needs to be factored into the  
12 analysis.

13       These are just a little data from MHAT  
14 IV, MHAT V, showing that overall, depression,  
15 acute stresses, the PTSD scale, you get somewhere  
16 between 18 and 20 percent, 17 and 20 percent for  
17 depression or PTSD. That's in-theater and our  
18 Brigade Combat Teams, that's very similar to what  
19 we see in post-deployment as well. We've seen an  
20 increase in OEF -- this was from last year's MHAT  
21 report -- 9 percent was what we saw back in 2005.  
22 In 2007 it was 17 percent, again bringing it up in

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1 line with what we've seen in Iraq and  
2 post-deployment.

3 This is the data looking at the  
4 relationship between the level of exposure to  
5 combat and the risk of reporting high levels of  
6 PTSD symptoms in Brigade Combat Teams, so a linear  
7 relationship up to a certain point.

8 This is the relationship of multiple  
9 deployments reported in last year's MHAT report.  
10 Again, it's very similar to this graph. Okay?

11 So I think that's just a little bit of  
12 the evidence, and there's quite a bit more  
13 supporting the first two hypotheses. What about  
14 the other hypotheses? The third, looking at SSRI  
15 use, the FDA black box warning has clearly raised  
16 a lot of concern. Maybe the use of SSRIs  
17 in-theater or the use of SSRIs in Service members  
18 are related to suicides. I think we don't -- we  
19 certainly do not have any evidence to support  
20 that. And if you really look at what's the basis  
21 for the black box warning, it was not suicides,  
22 completed suicides, it was suicide behavior,

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1 primarily suicidal ideation and not involving  
2 adults. This was involving adolescents. So this  
3 is not a -- it does not appear to be relevant data  
4 to our population. It's not data that we can  
5 necessarily ignore, but it's not data that is  
6 necessarily relevant either. And what is the --  
7 there's evidence now from some med analyses and  
8 some public health assessments that have actually  
9 shown that since the black box warning,  
10 prescribing of SSRIs has gone down and suicide  
11 rates have gone up in certain populations. And  
12 that's happened both in the Netherlands and in the  
13 U.S. where a similar warning -- in the Netherlands  
14 there was a similar warning issued. There was a  
15 nice study from the VA that showed that SSRIs had  
16 a protective effect. The overall consensus of the  
17 experts in the field and from the latest  
18 literature that I've seen, the latest reviews that  
19 I've seen, is that the benefits of SSRIs in  
20 treating depression, treating anxiety disorders  
21 including PTSD, the benefits of SSRIs -- and that,  
22 and one of, you know, one of the benefits of

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1 treating depression is that depression is  
2 associated with suicide -- the benefits outweigh  
3 the risks.

4 What about stigma and barriers? There's  
5 certainly no evidence that stigma and barriers  
6 have increased. There's multiple stigma reduction  
7 efforts underway. And I don't think there's much  
8 evidence that we've been successful in reducing  
9 stigma through a variety of programs, and I don't  
10 think that indicates a failure of the programs. I  
11 think that indicates the pervasive nature of  
12 stigma in the population at large, not just the  
13 military population, but in the general civilian  
14 population as well. What's unique about the  
15 military primarily is it's a mostly male  
16 organization, and men simply do not seek treatment  
17 anywhere near the frequency that women do.

18 Is there evidence that the resilience of  
19 the population is changing? I think there's very  
20 little or no evidence. There's some information  
21 on waivers that may be pertinent, but if you look  
22 at the data on waivers and compare it to, for

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1 instance, ASFAB scores or, you know, AFQT scores  
2 or high school diplomas, really the force looks  
3 just the same as it has, you know, for the last 20  
4 years. There's very consistent levels of high  
5 school diplomas and ASFAB scores and really no  
6 evidence that the -- we have a very healthy  
7 population compared to demographically adjusted  
8 population in the civilian community because of  
9 the rigorous medical evaluation that Service  
10 members undergo to come into the military, the  
11 qualifications that are required. We have a  
12 healthier segment of the population, and I think  
13 there's really no evidence, or not sufficient  
14 evidence, to suggest that resilience is changing  
15 in the population that would explain the suicide  
16 rate.

17 In terms of prevention and intervention  
18 strategies, there are four main categories, and  
19 I'm sure this is, you know, very familiar to you,  
20 but -- education stigma reduction, resilience, and  
21 training -- and there's certainly a huge amount of  
22 effort and, you know, a lot of the, you know,

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1 descriptions of military programs that you're  
2 being presented with fit into this category. A  
3 big part of the public health intervention  
4 strategy in DoD is the PDHA and PDHRA,  
5 post-deployment health assessments, which is a  
6 standardized, routine, process for all Service  
7 members returning from deployment. Then there's  
8 surveillance efforts such as the work by Mike Bell  
9 that you'll see later and treatment efforts.

10 Just very briefly, we don't -- I don't,  
11 in my opinion -- we really don't have any  
12 education efforts that's been proven to be  
13 effective in reducing suicidal behaviors. But  
14 there are -- there's some outstanding efforts by a  
15 number of different organizations using consensus  
16 processes to codify best practices -- the CDC,  
17 American Foundation for Suicide Prevention,  
18 SAMHSA, American Association of Suicidology and  
19 other organizations -- and they're working  
20 together in a cohesive manner, and there's some  
21 outstanding information on what is considered best  
22 practices now that are very relevant to consider.

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1           What about the PDHA/PDHRA process? I  
2 think that because of the changes in the screening  
3 process, the increase in the length of the form,  
4 the addition of a lot of different items, it's a  
5 very confusing process right now. And clinicians  
6 don't necessarily know exactly how to use the  
7 information that's collected by the Service member  
8 when they come back from deployment in a  
9 systematic manner. I think that still, despite  
10 the number of years that we've been doing the  
11 PDHA/PDHRA, the benefits are uncertain and there's  
12 little or no evidence that it's reduced stigma.  
13 There are also risks to the PDHA/PDHRA process,  
14 such as labeling and stigma of individuals who  
15 don't have a mental disorder because they --  
16 because it's essentially we're medicalizing  
17 readjustment problems. And what's the data for  
18 that? This is from an article that we published  
19 in JAMA in 2007. We looked at the Army Service  
20 members who had undergone the PDHA process, and we  
21 looked -- we had a cohort of 56,000 -- it was  
22 essentially the first cohort of Army Service

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1 members underwent the PDHA process -- out of those  
2 56,000, about 6 percent screened positive for  
3 PTSD. And out of the 6 percent that screened  
4 positive, 20 percent were referred for a mental  
5 health problem, were referred to mental health, or  
6 referred to a behavioral health practitioner. And  
7 the other 80 percent -- now the first question you  
8 can ask is, "Why was only 20 percent of  
9 individuals who screened positive referred?" And  
10 the reason for that is because there's a lot of  
11 false positives, a lot of the reactions that  
12 individuals have after coming back from combat are  
13 normal. A lot of the Service members are not  
14 interested in receiving mental health treatment,  
15 and unless they have a condition that is  
16 associated with suicidality, homicidality, or  
17 behavior that impairs their occupational  
18 functioning, they're not under any obligation to  
19 seek treatment. It's a voluntary process whether  
20 they seek treatment. And so they sit down with  
21 the primary care professional, and the primary  
22 care professional says, "I see you marked three of

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1 the four questions on PTSD positive; let's talk  
2 about that." And then a decision is made whether  
3 the person wants or desires or needs referral to  
4 mental health. And a lot of individuals at that  
5 point will receive education, but not necessarily  
6 receive a referral. And I think that's  
7 appropriate. So 20 percent -- about a 20 percent  
8 referral rate.

9 Now then you look at this group -- out  
10 of the group that got referred, how many actually  
11 went in and received their follow-up? How many  
12 followed up? And it turns out that 43 percent of  
13 the individuals who were referred did not  
14 follow-up with their appointment; so even after  
15 they received the referral, they didn't follow-up  
16 with an appointment and the remainder went to  
17 their appointment. Then you look at the six-month  
18 time point, three to six months later when they  
19 receive the PDHRA, at what proportion of  
20 individuals had resolution of their symptoms? And  
21 you actually find that those who failed to show up  
22 for their appointment had higher resolution of

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1 symptoms. Okay, at a higher rate of resolution of  
2 symptoms. Now that's not necessarily, again,  
3 reflecting a failure of the PDHA/PDHRA process.  
4 This is essentially a basic program evaluation  
5 study, which is typical of most program evaluation  
6 studies. It's not a randomized control trial.  
7 It's not an experimental design. It's confounded  
8 by things like severity. It's very likely that  
9 the individuals who followed up with their  
10 appointment had more severe symptoms or more  
11 pervasive symptoms, and so they would be less  
12 likely to resolve their symptoms six months later.  
13 But this is -- it raises a number of issues with  
14 regard to how we evaluate and test some of our  
15 assumptions that we have. We assume that being  
16 screened and seeing a mental health professional  
17 is going to be helpful, and that assumption is not  
18 necessarily correct in all cases.

19 There's also false positives. If you  
20 take any diagnostic test -- let's say PTSD screen  
21 -- here's a thousand soldiers who returned from  
22 deployment to Iraq -- from an Iraq or Afghanistan

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1 deployment. Let's say 15 percent of them actually  
2 have post traumatic stress disorder, so 150 out of  
3 the thousand have the disorder. And we screen  
4 them with a test that has an 80 percent  
5 sensitivity and an 80 percent specificity, which  
6 is very typical of what we consider a highly  
7 efficient test. The most efficient test of mental  
8 health usually falls in the 80 percent specificity  
9 range. So 80 percent sensitivity will mean that  
10 120 out of the 150 individuals with PTSD will be  
11 identified by our screening test. That's good.  
12 We're only missing 30 of them. Okay? However,  
13 the screening test will also identify 170  
14 individuals who do not have PTSD. The screening  
15 test will say they do, and we'll have 290 people  
16 -- almost 30 percent of the population -- will  
17 screen positive on this test. Okay? And that  
18 means the majority of people coming into the  
19 mental health clinic from that screening  
20 evaluation in fact do not have the condition.  
21 Okay? They sit down with a mental health  
22 professional who has the perspective that they may

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1 have the condition, and then there are labels  
2 applied, there are treatments applied, those  
3 things carry risks. I'm not saying this is  
4 necessarily a bad thing, but I'm pointing out that  
5 there are negative things that can happen with the  
6 screening processes as well. So that was the  
7 second sort of pillar of our strategy  
8 post-deployment health assessment. There are some  
9 questions regarding that.

10       What about the treatment -- surveillance  
11 and treatment? There's excellent surveillance  
12 efforts going on. I think it's important to point  
13 out that the epidemiology of completed suicides is  
14 not the same as the epidemiology of behaviors and  
15 attempts, and we can't necessarily apply knowledge  
16 gained from one to assume that it's going to be  
17 useful in developing a strategy for completed  
18 suicides.

19       There are reporting -- there is always  
20 some biases inherent in the classification of  
21 deaths and in the accurate reporting of suicides.  
22 This has been very well documented in civilian and

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1 we had a study that we published a few years ago  
2 on misclassification in the DoD system as well.  
3 So there are misclassifications. Suicides  
4 sometimes get classified as accidents. Sometimes  
5 they get, you know, if they're undetermined, et  
6 cetera, and we have to -- there may be utility in  
7 merging groups like "pending," "undetermined," and  
8 "suicides" together for certain types of analyses  
9 so as to try to reduce that variability. And it's  
10 also important to point out that our surveillance  
11 effort, the DoD -- the DODSER -- is what would be  
12 considered in public health circles as "a passive  
13 surveillance system." It's not an active  
14 surveillance system. We can't guarantee that  
15 every case is identified because it relies on the  
16 reporting. It relies on clinicians to report the  
17 cases. Now by and large we can assume that the  
18 majority of serious suicide attempts -- those  
19 involving hospitalization and so forth -- will be  
20 reported, but it's still a passive surveillance  
21 system.

22 And then in terms of treatment, I don't

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1 want to focus -- obviously there's a lot on mental  
2 health treatment, which is very relevant to the  
3 prevention of suicide, including SSRIs for  
4 instance, but I think that some of the key areas  
5 that are very important in further efforts include  
6 the CBT efforts. There have been some randomized  
7 trials on CBT for suicide ideation and behaviors.  
8 Dr. Jobes has been involved in that in the VA and  
9 there's been others that have shown a lot of  
10 promise. And I think that dissemination of those  
11 efforts is going to be, you know, it has the  
12 potential to be worthwhile because I think that  
13 it's fair to say that these are not routinely used  
14 now by mental health professionals throughout the  
15 DoD and VA or the civilian community.

16 Primary care intervention such as  
17 RESPECT-Mil -- I think that if we're going to make  
18 a dent in stigma, it's not going to be through  
19 screening and it's not going to be through  
20 education efforts. We can do education efforts  
21 till the cows come home; I don't think that's  
22 going to change the way people perceive mental

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1 health problems. I think we need to make mental  
2 health treatment more routine in primary care. So  
3 the soldiers and Marines when they come in for  
4 sick call, they can see a mental health  
5 professional just as easily as they see a primary  
6 care professional.

7       And then case management and continuity  
8 of care -- I think from the literature on best  
9 practices and primary care and for, you know,  
10 post-war health conditions for -- a lot of these  
11 conditions interrelate and overlap, but there's a  
12 lot of excellent work on collaborative care models  
13 based in primary care that involve case and care  
14 management.

15       So just in terms of recommendations, I  
16 -- this is kind of part of my, you know, I'm on  
17 the bandwagon to really relook at what we're doing  
18 with our post-deployment screening processes. But  
19 is it going to reduce suicide? I don't know if  
20 any of these things will reduce completed suicides  
21 per se, but it certainly will, I think, help to  
22 improve the mental health of the force which

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1 hopefully will have an effect on the tip of the  
2 iceberg. So the PDHA/PDHRA process I think is  
3 worth relooking at, and I've written quite a bit  
4 on the problems, for instance, with MTBI  
5 screening. That's not necessarily relevant as per  
6 se to this discussion, but it's -- we sort of end  
7 up lumping these things quite a bit.

8       Program and evaluation -- program  
9 evaluation and research and evidence should guide  
10 interventions. I think that it's fair to say that  
11 we roll out interventions without building in  
12 effectiveness measures, true effectiveness  
13 measures. We are always playing catch up. We're  
14 always doing post-hoc analyses like what I showed  
15 you with the PDHA/PDHRA. And as a just a -- from  
16 my public health background, it would be nice if  
17 we sometimes put -- didn't rush to create the  
18 programs and took some time to and understood that  
19 these problems aren't going to be fixed overnight,  
20 that it may take a number of years, and really sat  
21 down and rolled up our sleeves and figured out  
22 well, what is the evidence point to? What's the

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1 most -- what are the key strategies that are going  
2 to be most important, based on what we know now,  
3 based on the existing knowledge now? I think that  
4 the money is in primary care interventions in  
5 terms of reducing stigma. The analysis of risk  
6 factors, there's a lot of numerator data being  
7 tossed around. I'm very -- I'm in great  
8 admiration of the work that CHPPM's doing because  
9 now we have an epidemiological focus to the  
10 analysis of suicide. And I encourage continuing  
11 those kinds of analyses, and particularly with  
12 adjustment for demographics -- age, race, and  
13 gender -- because you can't even look at a figure  
14 like combat arms. Does combat arms have higher  
15 rate than non-combat arms? Well, the answer's,  
16 "Yes," in our simple, you know, cross-sectional  
17 two-by-two look, but we don't know because unless  
18 we actually do the demographic adjustment of that  
19 comparison. And so -- and I think that we also  
20 need to factor in attrition because if we find --  
21 we may find some, you know, if we can document,  
22 for instance, dwell time effects and multiple

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1 deployment effects with our in-theater samples,  
2 but once they get home, you have the problem is  
3 confounded by attrition. And so post-deployment  
4 analyses or population analyses of individuals  
5 after deployment may not show us what we're  
6 looking for. And, in fact, we see very consistent  
7 multiple deployment and dwell time effects  
8 in-theater, but I don't know if we're going to  
9 consistently see that post deployment because of  
10 attrition issues.

11 And then, of course, existing programs  
12 will not likely address the ongoing effects of  
13 high deployment frequency, duration, or short  
14 dwell time. Thank you very much. Appreciate your  
15 time and attention.

16 MG VOLPE: We have -- this is Phil Volpe  
17 -- we have time for -- if any Task Force members  
18 have a question now. We will have a Panel later  
19 on -- you'll be --

20 COL(RET) HOGE: I was not going to be here,  
21 but I could if you want me to be.

22 MG VOLPE: Well, we'll talk later, but

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1 let's ask for questions now.

2 DR. MCKEON: Let me weigh in, I think.

3 Thank you, Colonel, for your, I think, very  
4 informative presentation. I think it would be  
5 great if you could be here later on. This is  
6 Richard McKeon by the way, thanks.

7 One of the hypotheses that you did not  
8 include -- and let me ask you whether you think  
9 this is a viable hypothesis -- is that the  
10 increase in suicide rates in the military reflects  
11 a national increase that we do not yet potentially  
12 know about because our national figures lag  
13 behind. Is that -- and you can speculate why that  
14 could be, with the most common speculation  
15 currently has to do with the impact of the economy  
16 -- in your judgment is that something that should  
17 be included as a possible hypothesis?

18 COL(RET) HOGE: I don't -- I mean, it's -- I  
19 suppose it could be concluded as a possible  
20 hypothesis, but I think it's very, very unlikely.  
21 And the, you know, the economic situation  
22 certainly does not affect military Service

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1 members. I mean, it's a uniformly employed  
2 population without standing access to healthcare  
3 and benefits. So that's part of what makes it  
4 healthier than the civilian segment of the  
5 population.

6 I don't think this reflects -- and  
7 particularly we would see it rise in the Air Force  
8 and the Marine Corps also. I mean, there's no  
9 reason to -- the fact that we see this only in the  
10 Army, I mean -- I'm sorry, the Air Force and the  
11 Navy -- the fact that we only see the increase in  
12 Army and Marine Corps I think means that whatever  
13 it is that the Army and Marine Corps is doing is  
14 different than what the Air Force and the Navy is  
15 doing now, you know, with regard to what's  
16 happening in the war. And it's fairly obvious to  
17 me, having studied, coming from, you know,  
18 multiple studies of Brigade Combat Teams what that  
19 is and regimental combat teams as well. I mean,  
20 that's fairly obvious, you know, to, you know,  
21 from my perspective. But I -- so no, I don't  
22 think so.

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1 MG VOLPE: This is Phil Volpe. Dr.  
2 Hoge, one of the takeaway points I got -- and I  
3 just want to make sure I have this correct -- but  
4 you appear to indicate to me that the evidence and  
5 information we have is more supportive that dwell  
6 time and reset is more important than deployment  
7 length and multiple deployments from what we know  
8 today.

9 COL(RET) HOGE: I, sir, I'm -- the MHAT VI  
10 report I think will speak directly to that, and  
11 that's going to be released -- my understanding is  
12 that it's going to be released at the end of this  
13 week. So I'd rather defer my answer to that for a  
14 few days just because I'm, you know, I'm not the  
15 MHAT VI person. But you're on the right track,  
16 sir.

17 MG VOLPE: Okay.

18 DR. BERMAN: This is Lanny Berman.  
19 Thank you first of all for an excellent  
20 presentation.

21 COL(RET) HOGE: My pleasure.

22 DR. BERMAN: I'm struck by a couple of

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1 things. One that overall the reported rate of  
2 mental disorders is quite low relative to the  
3 general population rates derived from  
4 psychological autopsy studies. So I'm curious  
5 whether you feel comfortable with the quality of  
6 surveillance relative to the depth of the data or  
7 the standardization of data collection relative to  
8 completed suicides or relative to potential mental  
9 disorders? And within that framework, whether you  
10 suspect that there are -- particularly with your  
11 hypothesis of increased rates of mental disorder  
12 -- that most of these are undiagnosed and  
13 obviously they were untreated.

14 COL(RET) HOGE: Yeah, I think -- yes, sir --  
15 I think there's probably -- it's fair to say that  
16 there's undiagnosed mental health problems or  
17 mental disorders in individuals who are suicidal  
18 and we just don't know about. But it's startling  
19 to me that nearly half of the -- given the stigma  
20 and barriers in the military in the predominantly  
21 male population and the fact that we know that  
22 less than half of individuals who meet very high

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1 thresholds for symptoms -- individuals who have,  
2 you know -- out of the group of individuals who  
3 have very high symptoms of PTSD and we believe are  
4 in need of treatment, less than half actually do  
5 receive treatment. And we've been studying that  
6 since the beginning of the war. So it's fair to  
7 say that there's a lot of individuals who are out  
8 there who have mental health problems who are not  
9 receiving treatment. And despite all of our  
10 efforts with post- deployment screening, with  
11 education campaigns -- and there's a lot of very  
12 good education programs, Battlemind and so forth,  
13 that have been -- that we've even shown are  
14 effective in increasing awareness, but despite  
15 those efforts, still the majority of individuals  
16 who are in need of treatment don't get care. So I  
17 think there's a lot of undiagnosed, unrecognized,  
18 mental health problems.

19 DR. BERMAN: Thank you. And just a  
20 follow-up question, if I may. Are you -- can you  
21 speak to the level of training of primary care  
22 physicians in assessing suicide risk in the

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1 military?

2 COL(RET) HOGE: Ah -- no, that's out -- I'm  
3 not familiar with that. I mean, I'm just not the  
4 person to ask about that.

5 DR. JOBES: This is Dave Jobes. I was  
6 curious about your take on the prescribing of  
7 SSRIs. There's some evidence in the civilian  
8 sector that there have been changes in prescribing  
9 practices among physicians since the black box  
10 warning. Is there any evidence of that in the  
11 military?

12 COL(RET) HOGE: Yeah, I don't -- well, I  
13 haven't looked at that personally, and so I just  
14 -- I don't know if there's evidence. I doubt it.  
15 I would doubt it because SSRIs -- oftentimes  
16 because -- there's a lot of barriers to receiving  
17 twelve sessions of psychotherapy for PTSD.  
18 There's a lot of Service members who are receiving  
19 treatment -- who need treatment or have come into  
20 mental health to receive treatment for PTSD  
21 symptoms. They don't necessarily get the  
22 diagnosis of PTSD. There's a lot of reasons why

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1 that happens. Sometimes that's efforts to reduce  
2 stigma. It may get classified as an anxiety  
3 disorder, NOS. It may get classified as an  
4 adjustment disorder, which is appropriate in the  
5 post-combat period. These are combat stress --  
6 you can consider them in the combat stress  
7 framework. And you don't want to stigmatize the  
8 condition. You want to normalize the condition.  
9 You want to assist people in recovery. You want  
10 to assist people in identification of the symptoms  
11 that need treatment. But you don't want to label  
12 them and stigmatize them, and they don't want the  
13 labels and stigmas. The last thing that a senior  
14 NCO wants when he comes into the clinic or an  
15 officer wants is a diagnosis, especially given the  
16 AHLTA System, the electronic medical records  
17 system, which lists out every single diagnosis  
18 that you ever received in your military career;  
19 even the rule-out diagnoses, I mean, gets listed  
20 as a diagnosis and what your problem was, and it  
21 takes an act of Congress to get those things  
22 removed. So some clinicians are very cautious in

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1 their administration of diagnoses. And so there's  
2 a fair -- I think it's fair to say that there's a  
3 lot of individuals who come into mental health,  
4 get treatment whether or not they receive a PTSD  
5 diagnosis. And -- what was the question again?  
6 I'm sorry. I know I'm --  
7 DR. JOBES: SSRIs.  
8 COL(RET) HOGE: Oh yeah, okay. But it's  
9 difficult for individuals within the military  
10 necessarily to receive twelve sessions of  
11 psychotherapy. I think the evidence suggests that for  
12 the treatment of PTSD, psychotherapy is more effective  
13 than medications. Okay? But, how easy is it for an  
14 individual in the military, for a Service member, to  
15 get twelve sessions of psychotherapy? Not very easy  
16 necessarily. They're doing night training exercises.  
17 They're out at NTC rotation for two months. They're  
18 preparing for another deployment. They want to do a  
19 good job. They don't want to interfere with their  
20 occupation, their career, et cetera. So what do they  
21 get? They get SSRI treatment and that's appropriate  
22 because it's effective for PTSD. It may not be quite

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1 as effective as psychotherapy, but it's effective. So  
2 I'd be surprised if SSRI prescribing has decreased  
3 since the black box warning. It's probably increased  
4 because of the increase in PTSD in the military.

5 MG VOLPE: Okay, last question.

6 MS. CARROLL: Just very quickly. What  
7 is your visibility into suicides for Guard and  
8 Reserve not in a duty status or active duty  
9 post-120 days of ETS?

10 COL(RET) HOGE: Once an individual -- Guard  
11 and Reserve, right? Once an individual leaves the  
12 military or demobilizes, then if they suicide in  
13 the civilian community, it's not very good, the  
14 visibility's not very good. And there -- you can  
15 link -- I mean, the Millennium -- that's why I'd  
16 encourage you to invite the Millennium Cohort  
17 Team. The Millennium Cohort Group is actually  
18 linking with death registry, and I believe you all  
19 are doing that at CHPPM as well, linking with  
20 death registry data which will help to capture  
21 that.

22 MG VOLPE: Okay, Dr. Hoge, thank you

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1 very much for that outstanding presentation. We  
2 would like you to -- if you could be back around  
3 1415 to 1500, we have a Panel of all the speakers.  
4 I have a list of about thirty other questions I  
5 want to ask you and a whole bunch of things! But  
6 thank you very much.

7 We're going to go ahead and take our 10  
8 minute break at this time, and then we'll  
9 reconvene with the next session. Thank you.

10 MG VOLPE: Okay, if everybody could take  
11 a seat, please, we're going to go ahead and get  
12 started.

13 Great, thank you all very much. This is  
14 Phil Volpe, and looking forward to this next  
15 session by a very close friend and colleague of  
16 mine.

17 COL MCPHERSON: Good morning, everyone.  
18 Welcome back. Our second speaker this morning is  
19 BG Loree Sutton from the Defense Centers of  
20 Excellence. BG Sutton, who is the highest ranking  
21 psychiatrist in the U.S. Army, has served as  
22 director of DCOE since November 2007. She also

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1 serves as special assistant to the Assistant  
2 Secretary of Defense for Health Affairs.  
3 BG Sutton has more than 20 years of  
4 leadership experience, encompassing a diverse mix  
5 of domains: Civilian and military, combat and  
6 peacekeeping, command and staff, clinical and  
7 academic, and policy and education. Before  
8 becoming the founding director of DCOE, BG Sutton  
9 was commander of the Carl R. Darnell Army Medical  
10 Center at Fort Hood, Texas. Her earlier positions  
11 include command surgeon for the U.S. Army Forces  
12 Command; commander of the DeWitt Army Community  
13 Hospital and Healthcare Network; deputy commander  
14 for Clinical Services, General Leonard Wood Army  
15 Community Hospital; division surgeon, 4th Infantry  
16 Division (Mechanized); and special assistant to  
17 the Army Surgeon General.

18 BG Sutton also served as a White House  
19 fellow and special assistant to the Director of  
20 the Office of the National Drug Control Program;  
21 assistant professor of psychiatry and a disaster  
22 medicine consultant at USUHS; chief of inpatient

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1 psychiatry at the William Beaumont Medical Center;  
2 and division psychiatrist for the 1st Armored  
3 Division. BG Sutton.

4 BG SUTTON: Thank you so much. I'm  
5 tired just listening to you. But it's great to be  
6 here this morning. And MG Volpe and Bonnie  
7 Carroll, distinguished members of the Task Force,  
8 thank you so much, and all of those of you who  
9 have come to join in this important discussion.  
10 I've got a few slides that I'd like to share with  
11 you, and then I think if we can leave some time  
12 for discussion at the end, that will be really  
13 where the learning occurs. So, let's go ahead and  
14 get started.

15 Next slide please. Just to give you a  
16 brief rundown, to give you a background of where  
17 we've been, overview of the Defense Centers of  
18 Excellence, some key accomplishments with respect  
19 to suicide prevention, and then a few thoughts  
20 about major actions right now concerning oversight  
21 surveillance and research studies.

22 The road to DCOE. Most of us will

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1 recall that prior to 2007, it was really a period  
2 of scarcity; 2007 resulted in a lot of resources,  
3 a lot of time, attention, energy, and money  
4 towards these important programs. The task  
5 forces, the study groups, as you'll see in the far  
6 left-hand corner, generated a number of  
7 recommendations for the Department. Ms. Ellen  
8 Embrey, who was the DoD lead for Line of Action 2  
9 under the Senior Oversight Council, led the red  
10 cell that developed this framework that then led  
11 to the programs to the initiatives that then as we  
12 stood up, the Defense Centers of Excellence, at  
13 the end of November in 2007. We then took on this  
14 portfolio and are now in a position, with many of  
15 these programs and initiatives nearing maturity,  
16 to get the outcome metrics and to be able to move  
17 from what has been clearly at the present time a  
18 proliferation phase. We can move increasingly  
19 into a synchronization phase. This is going to be  
20 so important for us as we determine what works,  
21 for whom, under what circumstances. How can we  
22 simplify, support, and synchronize these programs,

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1 these resources, and then develop this menu of  
2 evidence-based options to add to what we currently  
3 have so that leaders can select the options and  
4 apply them as they best fit the needs of their  
5 communities?

6 I would then say that there's an  
7 additional phase that we need to set our sights  
8 on, and I would call that an "agility phase."  
9 What do I mean by that? Well, it's not enough to  
10 have a portfolio, a menu, of evidence-based  
11 options to meet the current needs. It's vitally  
12 important that we develop our capability, our  
13 capacity, to look over the horizon and to  
14 anticipate the emerging needs and to prepare for  
15 them so that no one coming behind us is ever in  
16 the position that we have been over these last  
17 couple of years.

18 Next slide. What is the Defense Centers  
19 of Excellence? Well, it's that one-stop shop,  
20 which was established in 2007 to be able to  
21 provide horizontal integration and coordination as  
22 well as vertical integration, all the way down to

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1 community level, to be able to validate, assess,  
2 oversee, facilitate programs, evidence-based care,  
3 to extend beyond the traditional medical model,  
4 and to work in support of these core messages  
5 which have never been more important than they are  
6 right now. Those core messages, "You are not  
7 alone." Secondly, "Spiritual and psychological  
8 injuries are on a par with physical injuries" as  
9 our Secretary of Defense and chairman and so many  
10 of our leaders at all levels have emphasized.  
11 Next, "Engagement heals and treatment works." The  
12 earlier we can intervene, clearly the better. And  
13 then finally, "Reaching out for help is an act of  
14 courage and strength."

15 Next slide. This is much bigger than  
16 military medicine. It is, however, an endeavor  
17 which has joined us as never before, not only with  
18 the VA. In fact, our own deputy within DCOE, Dr.  
19 Sonja Batten, one of the VA's best and brightest  
20 psychologists, is a full-fledged member of our  
21 team. We're bringing on additional members of the  
22 VA, so we are clearly joined at the hip every

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1 single day. And I think last week's or the week  
2 before the summit that both secretaries hosted on  
3 mental health really is an example of just how  
4 this partnership continues to deepen and to grow.  
5 But it's much bigger than DoD and VA. It's much  
6 bigger than the federal government. As important  
7 as it has been, for example, our priority working  
8 group with the federal partners program through  
9 SAMHSA to work on reintegration issues, bringing  
10 together the entire interagency. But we also know  
11 that this initiative has to reach out, has to move  
12 way to the left, as we say in the military, to the  
13 first day of a session building resilience, which,  
14 of course, is a leader-led activity. The tough,  
15 realistic, operational training that prepares  
16 troops for in that moment of truth, that hour of  
17 darkness, to do what it is that they've been  
18 trained to do to keep their buddies alive and to  
19 achieve that mission and come home.

20 We also know that recovery starts with  
21 resilience, and it encompasses not only the  
22 on-the-ground resuscitation from our combat

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1 lifesavers, our corpsmen, our medics, but extends  
2 all the way through the system which, as we know,  
3 has been incredible over these last several years  
4 of this conflict in achieving the lowest  
5 died-of-wounds rate ever. And, of course, that is  
6 part of what has led to the challenges of now  
7 caring for these incredibly complex,  
8 polytrauma-injured individuals and their families  
9 who are coming back with injuries that they never  
10 would have survived in any prior conflict. And  
11 that moves to reintegration. Again, leader  
12 driven, but supported by those of us on the  
13 medical team to help our troops whenever possible  
14 return to their units to honor the duty and the  
15 commitment that they've made, keeping in mind that  
16 these young Americans knew that we were at war and  
17 raised their hands and said, "Here I am. Send  
18 me," truly owe them our best. And when that's not  
19 possible, then, of course, to set the conditions  
20 for success for them and their families to live  
21 lives of purpose, passion, and meaning in their  
22 communities of choice.

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1 Next slide. This cultural  
2 transformation that we're talking about is really  
3 driven by recognizing this partnership that I've  
4 described, the partnership that you'll see on the  
5 bottom there between the leaders, the warriors,  
6 and the families on the one end, and our medical  
7 leaders on the other end. Let me just go through  
8 this chart very quickly. On the far left, we have  
9 troops who are in optimal health with some of the  
10 indicators of optimal health. But you'll see that  
11 even when a troop is in optimal health, that the  
12 medical piece never completely goes away because,  
13 of course, there are those daily preventive  
14 medicine, health maintenance, actions and  
15 behaviors that each of us are responsible for to  
16 maintaining optimal health. And we've developed a  
17 toolkit for life that embodies those  
18 evidence-based domains of resilience and it has to  
19 do all with sleep and fuel and friends and love  
20 and faith and hope and growth.

21 You can see that with stress over time,  
22 it's normal for human beings to react to that

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1 stress. And there are signs where leaders and  
2 medical professionals alike can intervene, can  
3 mitigate the risk, and to whenever possible bring  
4 folks back to that optimal state of health and  
5 well being. If you continue along this continuum,  
6 you can see that with additional stress, with  
7 additional load on the human mind, body, and  
8 spirit, that our troops, our family members, can  
9 become frankly injured. And again, there are  
10 warning signs. There are things that we must do,  
11 working in partnership together; and, of course,  
12 the earlier that we intervene, the better whenever  
13 possible to prevent illness. But when illness  
14 does occur, of course, to assure the best,  
15 absolute rehabilitation treatment diagnostic, full  
16 range of services to get folks back to where they  
17 want to be.

18 Next slide. Well, so how are we  
19 organized to do this? Frankly, when we first  
20 started out in November of 2007, we had a concept,  
21 we had a phone number, and we had a bank of empty  
22 offices. And we built this concept on the premise

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1 that what we owned -- in military parlance, what  
2 we commanded and controlled -- would ultimately be  
3 far less important than the expertise we could  
4 connect to. And we knew that that would be  
5 important across the government, within DoD, and  
6 certainly around the country and throughout the  
7 world. And so we started within DoD and looked to  
8 see, what were the current, sort of centers and  
9 areas of expertise that resided within DoD? Well,  
10 we found four of them actually: The Center for  
11 Deployment Psychology, which had been in existence  
12 about three years. David Riggs' team up at  
13 Uniformed Services University, this Center was  
14 really stood up to be able to beef up our ability  
15 to provide evidence-based training to our  
16 providers, not just mental health providers, but  
17 extending to primary care and now we're reaching  
18 out to our TRICARE and our civilian providers at  
19 large. The Center for Study of Traumatic Stress.  
20 Bob Ursano. This Center's been in existence for  
21 20 years, has responded to every major disaster,  
22 including the one that occurred last week, and is

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1 internationally known and respected for the work  
2 that they have done in the area of traumatic  
3 stress. Defense and Veterans Brain Injury Center,  
4 again about 17 years in existence. I never had  
5 heard about this Center until I was commanding at  
6 Fort Hood and where we had the largest number of  
7 concussion, mild TBI, cases. I had no idea that  
8 in 2005, the DVBIC was recognized nationally as  
9 the top clinical integrated care system for brain  
10 injuries. Now I do. And now we have an  
11 opportunity to build on this network, which  
12 encompasses the VA polytrauma centers, military  
13 treatment facilities, as well as two civilian  
14 centers, and it extends across our network. The  
15 Deployment Health Clinical Center came into being  
16 following the first Gulf War. The work that  
17 they've done with RESPECT-Mil -- we'll get to that  
18 in a moment -- as well as the three-week clinical  
19 regimens that this Center holds throughout the  
20 year, widely recognized and praised by families  
21 and troops alike as having saved their lives,  
22 saved their careers, saved their marriages and

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1 families.  
2 We also knew that it was going to be  
3 important to establish a new Center for Telehealth  
4 and Technology, to be able to really harness and  
5 leverage the growing capabilities within this  
6 field. And so we've done that. This is led by  
7 Dr. Greg Gahm. It's located -- headquartered --  
8 out on the West Coast at Fort Lewis and has global  
9 reach.

10 We're in the process right now of  
11 constructing the National Intrepid Center of  
12 Excellence. Some of you have seen this facility.  
13 Perhaps you've seen its sister facility in San  
14 Antonio. Mr. Arnold Fisher and his Intrepid  
15 Fallen Heroes Fund have committed once again to do  
16 for psychological health and traumatic brain  
17 injury what they have already done for amputee  
18 care. Think of the NICOE as being -- as becoming  
19 the Mayo Clinic for psychological health and  
20 traumatic brain injury, the hub of our network of  
21 networks. What do I mean by that? Well, I mean  
22 by that -- in fact, we actually brought in Mayo to

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1 consult early on -- what I mean by that is that  
2 this will be the hub of this network of networks  
3 that will allow us, just as we do at places like  
4 Mayo, for anyone to contact NICOE and to be able  
5 to consult and determine, is there a regimen that  
6 hasn't been tried at home station where we're  
7 building capabilities across our network? And if  
8 so, we'll consult to the home team and follow. If  
9 there's a program elsewhere that would best meet a  
10 Service member's needs, we'll refer and follow.  
11 If there's a diagnostic dilemma, which is going to  
12 be in most cases those situations where we've got  
13 a complex mix of psychological and concussive,  
14 physical, blast-related -- and perhaps I would add  
15 to that, spiritual and moral -- injuries, they  
16 will come to NICOE for a brief period of time with  
17 their families for us to do an advanced diagnostic  
18 evaluation and then get them where they need to  
19 be.

20 Next slide. The scope. You can see  
21 that range everything from resilience and  
22 prevention through standards of care through

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1 research, program evaluation, training and  
2 education, as well as on through communication and  
3 our clearinghouse and outreach programs. Very  
4 comprehensive scope.

5 Let me just now go through some of the  
6 concrete programs that specifically relate to the  
7 imperative that I know all of us share to reduce  
8 and prevent suicides. Theater of War is an  
9 initiative we've started this last year. What it  
10 is, is it's an experienced -- call it a community  
11 immersion experience. You know, during the Trojan  
12 Wars 2500 years ago, to reintegrate, the ancient  
13 Greek warrior culture would fill up amphitheaters  
14 with warriors with family members, with members of  
15 the community, to tell the stories of war, to  
16 connect to each other. Well, we've been able to  
17 link up with Mr. Brian Dories who has translated  
18 the stories of Ajax who died by suicide; the story  
19 of Philoctetes who was injured, abandoned by his  
20 men for nine years on an island until they  
21 realized that they couldn't win the war without  
22 him and went back to get him. The power of this

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1 experience -- I just can't describe it to you. I  
2 just came back this morning from New York. We had  
3 a performance last evening at St. Vincent's Trauma  
4 and Wellness Center with cadets from West Point,  
5 Vietnam veterans, World War II, First Gulf War,  
6 members of the creative community, people who  
7 wouldn't ordinarily come together, sharing their  
8 experiences, their feelings, their connection to  
9 these ancient Greek stories that give us hope and  
10 courage, as well as some insight for what we're  
11 facing today. This is going to go for the next  
12 year to 50 DoD sites, 100 performances, and we're  
13 very heartened by the response it has gotten to  
14 this point.

15 Next slide. RESPECT-Mil. We know that  
16 ultimately part of this cultural transformation  
17 has to do with bringing behavioral health, mental  
18 health, expertise to the places where our troops,  
19 their family members, come and get their  
20 healthcare, and that is primary care. And so  
21 RESPECT-Mil is leading the nation actually. This  
22 program, evidence based, has been adapted. Chuck

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1 Engle has worked with the national leaders to  
2 adapt this to our military setting, and it's just  
3 absolutely already proving its worth. We've got  
4 tri-service implementation that's in the planning  
5 phases. And it's also a model that works well  
6 with, for example, the existing Air Force BEHOP,  
7 the Behavioral Health Optimization Program. They  
8 work in synchrony, they complement each other, and  
9 this is a program that we will continue to build  
10 on over the next several years.

11       Next slide. The Real Warriors Campaign.  
12 This is a campaign that we started this last May.  
13 We knew that, you know, as daunting as it seemed  
14 at the time two years ago in 2007, we knew that we  
15 would establish standards of care, we would  
16 achieve consistent levels of clinical care in  
17 excellence, we would invest in research to close  
18 the knowledge gaps, we would train and educate our  
19 providers, our leaders, our families and  
20 communities. But we knew also along the way that  
21 if we failed to address the issue of stigma, that  
22 toxic, deadly threat that all too often prevents

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1 our troops and their loved ones from getting the  
2 help that now is available, we would fall short of  
3 our potential. And for any of us working on this  
4 endeavor, failure is simply not an option. And so  
5 we went to the National Institute of Mental  
6 Health. We knew that they'd had a very successful  
7 campaign years ago, Real Men Real Depression, and  
8 we consulted with them. We adopted those  
9 principles. And the power of this campaign really  
10 has to do with the fact that its real warriors who  
11 are telling their stories about the real battles  
12 they have faced, on and off the battlefield,  
13 dealing with wounds, injuries, illnesses, both  
14 seen and unseen, and leading to the strength that  
15 post-traumatic growth that is any of ours to claim  
16 no matter how tough, how adverse, the conditions  
17 have been. So if you go to our Website you'll see  
18 that we've got a message board, we've got chat  
19 functions, we've got our Outreach Center which is  
20 available 24/7 with trained coaches. We also have  
21 campaign materials that have been customized to  
22 each of the Services. We've conducted countless

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1 focus groups to inform our efforts. And we've  
2 also got a number of video profiles that are just  
3 truly compelling to witness. This is a volunteer  
4 program so we are contacted on a regular basis by  
5 individuals who would like to be part of this and  
6 tell their story. And we're always eager for more  
7 stories to really make this a campaign of  
8 campaigns with complementary and reinforcing  
9 messages. Again, you are not alone. The physical  
10 injuries of battle are no more, no less, important  
11 than the psychological and the spiritual injuries.  
12 Engagement heals. Treatment works. The earlier  
13 the better. And yes, reaching out is an act of  
14 courage and strength.

15 Next slide. The next tool here,  
16 [afterdeployment.org](http://afterdeployment.org). This is a tool. It's a Web  
17 2.03.0 tool that our T2 team has developed. It's  
18 been online now for a little over a year; August  
19 of 2008 was when we came online and we continue to  
20 develop this. It provides tools where family  
21 members and troops -- particularly those who are  
22 in remote geographic locations like our Guard

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1 members, our Reservists, other folks who may be in  
2 remote areas -- where they can, in the safety and  
3 comfort of their own homes, their own Smartphone,  
4 their own laptop, they can access tools, they can  
5 plug into assessments, they can chat with others,  
6 they can invest in the experience of going into  
7 our new life. We've got Psychological Health  
8 Island, which is really, you know, pushing the  
9 limits of Web 2.03.0 and the social interaction  
10 tools, and we'll continue to develop this. It's  
11 getting over 7,000 visits a month already, and it  
12 continues to grow and develop.

13 I've mentioned already the 24/7 Outreach  
14 Center that also has in addition to the phone  
15 number, the e-mail, fax, as well as the online  
16 chat which has been very popular. We are  
17 absolutely coordinated very closely with not only  
18 Bonnie Carroll, of course, and her TAPS team, but  
19 the VA, National Suicide Hotline, the 273-TALK for  
20 veterans, button number one, as well as with  
21 Military One Source, to make sure that no matter  
22 where a troop or a family member contacts us, that

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1 we can make sure that we have a warm hand out that  
2 gets them to the right place.

3 Next slide. Last January we had our  
4 first DoD-VA Annual Suicide Prevention Conference.  
5 We had several hundred individuals there. We were  
6 so pleased to be able to bring Bonnie Carroll and  
7 Kim Ruocco and, you know, numerous -- Liz Sweet,  
8 other family members, survivors of suicide. We  
9 learned so much from them and we're looking  
10 forward to our Second Annual Conference coming up  
11 in January.

12 Oversight. I think you're aware of the  
13 DODSER, which, thanks to the work over the last  
14 several years of COL Bob Ireland in Health  
15 Affairs, Clinical Programs, and Policy, it was  
16 truly a labor of love bringing the Services  
17 together, developing standard ways of reporting  
18 suicide- related metrics and data. And now for  
19 the first time we will actually have this annual  
20 standardization that will much better serve our  
21 efforts to analyze, to understand, to put this  
22 data in context with what we learn from families,

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1 with what we learn from 15-6 investigations -- and  
2 MG Volpe, as you and I have talked about -- I  
3 think there's much that we can do to develop this  
4 tool to make it prove its full value with the  
5 other factors I've mentioned.

6 The SPARRC, the Suicide Prevention and  
7 Risk Reduction Committee. This is a committee  
8 that has representation from DoD, from VA, from  
9 SAMHSA, to just a very broad-based committee that  
10 DCOE has taken on this past year, and we're  
11 working like fury under these current  
12 circumstances to be able to, you know, identify  
13 the policies that need to be updated, the  
14 programs, to provide oversight, to be a resource  
15 for those who are looking for effective tools and  
16 programs and policies.

17 Next slide. And then finally, just a  
18 few of the major suicide prevention studies.  
19 We've been able to bring on the RAND Corporation  
20 who is conducting a very thorough review for us  
21 right now to identify potential enhancements  
22 across the board for suicide prevention. Also

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1 some of you may be aware that the Caring Letter  
2 Program -- this has really been one of the few  
3 programs that has been shown on an educational and  
4 outreach intervention basis with a randomized  
5 control clinical trial and showed to be effective  
6 in reducing suicide. And so we've got a pilot  
7 project going on in that domain. We are also  
8 teaming up with the National Institute of Mental  
9 Health on this very extensive longitudinal  
10 perspective suicide study, and then finally,  
11 working with the Army Medical Research and  
12 Development Command with their efforts as well.  
13 It's a multi-pronged effort. We know that in  
14 working particularly with the Army Suicide  
15 Prevention Task Force, what a complex issue this  
16 is. And so we're joined together to really make  
17 this a team of teams, a center of centers, a  
18 network of networks, a national effort in support  
19 of those whom we serve.

20 So let me just stop there. I think  
21 that's the last slide that I've got and go ahead  
22 and welcome your comments, your questions, your

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1 ideas, please.

2 DR. MCKEON: Richard McKeon. Thank you  
3 very much for your presentation. I had a couple  
4 of questions about where the Task Force might be  
5 able to get more information on some of the things  
6 that you've referenced. And it looks like there  
7 are a number of excellent programs that are under  
8 the purview of the Centers of Excellence. Your  
9 presentation has referenced standards of care, and  
10 one question would be how -- are there either  
11 documents or are there processes in place for  
12 looking at the quality of military mental  
13 healthcare that is the -- are the Centers of  
14 Excellence involved in that? And if so, how does  
15 that work?

16 BG SUTTON: You know that is an effort  
17 that we are engaged in particularly over this  
18 coming year as some of these programs are coming  
19 to maturity. We brought on the RAND Corporation.  
20 We're working very closely with the Samueli  
21 Institute as well as with the NIH with their  
22 Biomedical Informatics Center to be able to

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1 develop on the research side, the common analytics  
2 platform, as well as on then the program  
3 evaluation side, to really determine where are we  
4 in terms of the quality? We know we're not where  
5 we need to be at this point. We know we've had  
6 struggles in terms of hiring. We know that hiring  
7 is not enough. Once you hire an individual, then  
8 you've got to acculturate them and bring them  
9 onboard, and it's no simple task. For as much  
10 progress that has been made -- and I will say that  
11 both on the VA side, the last numbers I saw, I  
12 think there were over 4,000 additional behavioral  
13 health professionals that have been hired. I  
14 think in the TRICARE Network, there have been  
15 several thousand more than that. And certainly  
16 within the active component -- talking with Dave  
17 Orman, we're really, you know, making progress.  
18 We're not where we want to be yet.

19 We also know that it's not just about  
20 hiring, training, and preparing mental health  
21 professionals. That's where our efforts with the  
22 primary care clinic are so important. We've

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1 invested in some research that, you know, over  
2 these next one to two to three years will really  
3 help us on the quality road. We're working with,  
4 for example -- and I'm sorry, I'm blanking on his  
5 name -- the individual in Utah who was featured  
6 this last week in the New York Times Sunday paper,  
7 who's done so much of the quality work. He came  
8 out and addressed a group of us about a month ago,  
9 and we're following up with him so that we can  
10 learn from his efforts.

11 One additional initiative that you might  
12 be interested in right now is we've taken the  
13 Clinical Practice Guideline, which was finalized  
14 last year for the deployed management of  
15 concussion or mild TBI. We've taken that and we  
16 are now converting that to a mandatory event  
17 driven protocol. So that from the time of blast,  
18 from the time of exposure or injury downrange,  
19 there will be a set of mandatory actions, both  
20 from line leaders as well as medical leaders, to  
21 be able to standardize the interventions that  
22 cannot be argued away, that cannot be dismissed,

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1 that cannot -- you know, all of the things that  
2 we've, you know, struggle with in the civilian  
3 world with motivated athletes. We also struggle  
4 with those same issues with our motivated troops.  
5 But this is going to be really a first-step  
6 forward. We're starting with concussion care, and  
7 we're just getting ready to launch a pilot with a  
8 brigade at Fort Campbell. And we are also working  
9 on what we know will be a bit more complex, and  
10 that is the post traumatic stress protocols that  
11 likewise will accompany, again, to better address  
12 and standardize our way of providing quality care  
13 and intervention as soon as possible to address  
14 the invisible wounds of war. Thank you. And by  
15 the way, in terms of any information, my team  
16 stands ready. MG Volpe, you know where to find  
17 me. And whatever we can share with you from our  
18 work, we'll certainly move heaven and earth.  
19 Thank you.

20 MG VOLPE: Questions?

21 DR. MCKEON: I'll ask another question  
22 then. This is a question regarding the DODSER,

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1 which if I understand correctly, flows through T2.  
2 So two questions related to that: Is it anyone's  
3 assigned responsibility, as part of the process of  
4 getting that information, to look at the  
5 surveillance data and to analyze it specifically  
6 to make prevention recommendations? To go from  
7 the surveillance data and to move it into the  
8 arena of prevention? Does anybody specifically  
9 look at it from that perspective?

10 BG SUTTON: That's precisely one of the  
11 domains that we're working with the RAND  
12 Corporation to help us look at the DODSER data, not  
13 only with respect to treatment and, you know, sort  
14 of on the right-hand side, but also as you  
15 mentioned, prevention.

16 We've also been able to benefit from the  
17 work from Dr. Thomas Joiner who presented at our  
18 conference last January. And some of you, I know,  
19 are aware of his work. I think he published a  
20 book in 2005, *Why People Die By Suicide*. And I  
21 think the three factors that his research has  
22 identified really do have valiance and relevance

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1 for our challenges within our military troop and  
2 family population. That is to say -- and I call  
3 them the three "Ds." I know he has a little  
4 different terminology -- but basically, you know,  
5 the first and most important factor is  
6 "displacement." We know from decades of research  
7 and work and leadership working with troops that  
8 unit cohesion, that feeling like one belongs to a  
9 strong team, that you're committed to a common  
10 goal, that's always been our greatest strength.  
11 And we also know that at eight years into this  
12 conflict, we need to redouble our efforts given  
13 all that is going on, to help our leaders,  
14 particularly our front-line leaders, think through  
15 that lens of, "Is this action going to have the  
16 net impact of increasing that sense of belonging,  
17 that sense of cohesion, or diminishing it?" There  
18 was an article -- and you might be -- in fact, MG  
19 Volpe shared it with me recently -- in the Army  
20 Times. I think it was a psychologist who laid out  
21 in very simple terms, you know, both the  
22 compassionate, tough, positive examples of

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1 leadership, and then the abusive, punitive, and  
2 frankly toxic aspects of leadership. So we have  
3 our challenges there, and I think it's mostly  
4 within our middle management, if you will. For  
5 example, there's the E-7 platoon sergeant I was  
6 talking to several months ago who said, "Ma'am,  
7 you know," he says, "I guess I think there really  
8 is something about our culture, this suck-it-up  
9 and drive-on culture, that is not serving us  
10 well." And it was very poignant, I thought, the  
11 way he phrased this. He said, "You know, I was  
12 raised in the Army. I've been in 14 years now."  
13 He said, "That's how I was raised, to suck it up  
14 and drive on. That's how I've motivated myself,  
15 kept myself going, the same with my troops. It's  
16 not working anymore." And he says, "So I guess  
17 I'm supposed to figure out how to take the lid  
18 off" -- these were his words "to take the lid off"  
19 but he says, "I don't know how to do that, and if  
20 I did, what would I do once I had it off?" But he  
21 says, "I'm afraid that if I don't learn how, it  
22 will blow off." And so this is his dilemma. And

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1 it's also our opportunity. And, of course, the  
2 Services are working to do just that, to be able  
3 to provide the tools, frankly the cultural  
4 transformation. And it is a transformation. And  
5 that's so important to be able to shore up that  
6 sense of belonging.

7       The second factor, of course, is the  
8 "distortion." The distortion that can occur,  
9 cognitive distortion, whether it's related to  
10 issues of depression, post traumatic stress,  
11 anxiety, substance misuse, but that distortion  
12 that can lead an individual to feeling like he or  
13 she is such a burden, that killing themselves  
14 would actually be a gift, an honorable thing to  
15 do. Well, we know that in this case, I mean,  
16 that's a clinical challenge. We have  
17 evidence-based treatments for all of those  
18 conditions, and that's where stigma and its  
19 elimination, that's where that campaign is so  
20 vitally important.

21       And then thirdly, the third "D" is  
22 "desensitization." I'm very concerned about this

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1 domain. On the one hand, you know, going to  
2 combat, performing in combat, involves a degree of  
3 desensitization, compartmentalization if you will,  
4 to dial up and to dial down, and to, you know, use  
5 breathing techniques and ways of focusing to  
6 achieve maximum performance. But I wonder, what  
7 is the impact of hours and hours of engaging in  
8 the interactive video war games or shootum-up  
9 games? I was reading this morning about a new  
10 game coming out that incorporates the player,  
11 serving as a terrorist and committing civilian  
12 atrocities. Let's keep in mind that our troop  
13 population, the majority of our troops, you know,  
14 To 24, their brains as we well know have  
15 not yet fully matured. And so I think there are a  
16 lot of questions here that we'll probably want to  
17 be able to address with the broader scientific  
18 community to help us understand the impact, and as  
19 you said, to then be able to rally and identify  
20 some preventive, some interventions, that will be  
21 effective.

22 In fact, to that end, let me just

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1 digress for a moment on the feeder of war. This  
2 has attracted a fair amount of attention this last  
3 year, and it has attracted the attention of a  
4 major video interactive game that has approached  
5 Mr. Dories and said, "You know, what we'd like to  
6 do -- we've seen what you've done with DoD with  
7 Theater of War, we've seen the Real Warriors  
8 Campaign, we want to develop a suite of Real  
9 Warrior products that will be as compelling as the  
10 destructive games that are currently out there,  
11 but will imbed psychological health principles.  
12 In fact, one of the creative guys thinking this  
13 through thought, "Maybe we can take some  
14 characters from some of the existing games and  
15 bring them forward and imbed them in ancient Greek  
16 warrior culture." So we're not there yet, but  
17 we've got some ideas of how we can move forward.

18 And then the last component of that  
19 desensitization is just the subculture that, you  
20 know, if you go to Amazon.com and just type in  
21 "suicide products" under the search engine, you'll  
22 see T-shirts and lyrics and books and just a

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1 glorification of destruction and homicide and  
2 suicidal dynamics. So I think that's part of what  
3 our troops bring in.

4 And so all of that is what we must  
5 understand better so we can do just exactly what  
6 you're saying and intervene as early as we can, at  
7 the same time as we are working together as a  
8 nation to transform our culture to one of  
9 resilience and strength.

10 DR. MCKEON: Thank you. I think that's  
11 a very astute analysis. If I could just ask one  
12 brief follow-up question about the DODSER?

13 BG SUTTON: Sure.

14 DR. MCKEON: Do you know when the 2008  
15 DODSER report might be able to be available for  
16 this Task Force?

17 BG SUTTON: You know I know it is in the  
18 very final stages of staffing, so I owe you an  
19 answer on that. Major General Volpe, I'll  
20 certainly check to see the status. I know it's  
21 left our headquarters. So let me check on that,  
22 but I think it will be fairly soon.

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1 DR. MCKEON: Thank you.

2 BG SUTTON: Thank you very much.

3 MS. CARROLL: Could you -- your

4 wonderful "got fuel" -- Bonnie Carroll -- could

5 you share the "got fuel," "got sleep" and how you

6 arrived at that and the impact it's having.

7 BG SUTTON: You know, as so many

8 advances do, this was an idea, an initiative, that

9 was borne out of tragedy. Some of you will recall

10 SSgt Travis Twiggs, a young Marine whom I first

11 encountered in Tom Rick's column in the Washington

12 Post. And this young Marine had fairly extensive

13 issues with post traumatic stress and had gotten

14 treatment and been deployed a couple of times, and

15 now was, you know, very active, giving talks and

16 lectures and very active in helping fellow

17 Marines. And fast forward several months later

18 and this young Marine went on a killing rampage to

19 the Grand Canyon, and he killed his brother and

20 himself. So as we were doing the hot wash in the

21 Pentagon, one of the Marine leaders there looked

22 at me and said, "Doc, can't you just come up with

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1 a simple tool, a simple tool that will allow our  
2 front-line E-5 Marines to figure out who among  
3 their troops is most at risk?" And so we took  
4 that on as a challenge, and I'm very fortunate.  
5 One of the best things that's happened over this  
6 last year is that I've been able to bring on a  
7 young Marine. E-5 Sgt Jack Eubanks: Two  
8 deployments, concussion, mild TBI, post traumatic  
9 stress, spinal injuries. He's been with us about  
10 six months now. And as you know, Bonnie, he's  
11 just becoming a prolific poet. He's got a book in  
12 the office that he's titled now, Ramblings of a  
13 Poetic Grunt, and is now -- whereas six months ago  
14 thought he would be, you know, kind of unable to  
15 do much in life -- he's now wanting to become a  
16 foreign war correspondent, and he ran five miles  
17 last week and is still writing poetry. So at any  
18 rate, he's been part of our team to help us  
19 develop tools like this one -- the toolkit for  
20 life -- very simple -- just eight questions.  
21 We're currently working with some folks to  
22 operationalize this and to put it into the context

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1 of an interactive video game that can be positive,  
2 to make resilience edgy, to make it cool, to make  
3 it hip, to make it smart. And so the eight  
4 questions just go, you know -- "got sleep, got  
5 fuel, got friends, got love, got face, got hope,  
6 got growth" -- and every one of those domains of  
7 resilience has a strong, robust, body of research  
8 that supports it. And so we look forward to  
9 developing this. We think that this could be  
10 perhaps helpful for the nation as a whole. You  
11 know, this is beyond my direct domain of control,  
12 but certainly within my sphere of influence. You  
13 know, when only three out of every young Americans  
14 aged 18 to 25 is even eligible to wear this  
15 uniform, we have a resilience problem. And so one  
16 of the things we've wondered about is, you know,  
17 what if we were to take the generation of children  
18 who have been born within DoD since 9/11. You  
19 know, there've been about a million of them as it  
20 turns out. And what if we were to call them, you  
21 know, Gen-R -- Generation Resilient -- you know,  
22 and to apply everything we've learned about

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1 resilience over these last 20 years to this  
2 generation, the leading edge of that cohort is now  
3 8 years old. So that maybe in 10 years, maybe we  
4 could double that so that six out of 10 would be  
5 eligible to wear this uniform. Not that we would  
6 necessarily need or want them to, but they would  
7 be ready for citizenship and resilient for life.  
8 And so that's one of the things where a tool like  
9 the toolkit for life perhaps could lead, but in  
10 the near term, we know that if every front-line  
11 leader knew the answers to those questions about  
12 his or her troops and was able to engage in a  
13 meaningful dialog and link them up to resources, I  
14 think we'd be in a better position than where we  
15 are right now with the tragic suicides that we're  
16 confronting.

17 MG VOLPE: Okay, final two questions.  
18 This is Phil Volpe. We're going to hog them both,  
19 the final two questions, and then we're going to  
20 take a break. Or excuse me, we have a next  
21 speaker.

22 Based on your extensive experience in

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1 psychiatry, mental health, leadership positions,  
2 but also in the line and operational roles as  
3 division surgeon and stuff, if we had to produce a  
4 report tomorrow and there was one recommendation  
5 that you would like to see come out of this Task  
6 Force, what would that be?

7 BG SUTTON: White space.

8 MG VOLPE: Okay.

9 BG SUTTON: And let me explain what I  
10 mean by that. When you think about everything  
11 that we have added to our plate since 9/11, I mean  
12 it's incredible, and of course we're "can do"  
13 people. And I'm thinking of all of the Services  
14 now and the, you know -- it's just, it's been  
15 incredible what we've added to our plate. But  
16 what have we taken off? Speaking from my  
17 experience, not much, and what does that mean?  
18 Well, here's my concern. It's that it's not just  
19 that we've added so much and we haven't taken  
20 anything off -- that's part of it -- but it's  
21 complicated by the fact that since 9/11, you know,  
22 what have we added in terms of the cognitive load,

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1 the demands that we make from our brain? Well, we  
2 didn't have Smartphones then. We didn't have  
3 BlackBerries. We didn't, you know, I mean so many  
4 things that now, you know, make this a 24/7  
5 barrage of demands from our brains. And I'll tell  
6 you, when you think about what it is that we're  
7 asking from our young junior front-line leaders --  
8 cause they're the ones who ultimately are going to  
9 make the difference in pulling us back from the  
10 brink of suicide, and as importantly not just back  
11 from the brink, but way over to the left in that  
12 continuum to optimal health and well being. It  
13 takes time. It takes time to be able to know your  
14 troops and to know whose mom is in the hospital  
15 right now, and whose spouse perhaps is having  
16 health problems, and who's having financial  
17 problems. And we don't have white space on our  
18 calendars right now. And, in fact, our culture  
19 actually takes us away from that. For most of us,  
20 you know, for most of our careers it's been a  
21 matter of pride that we're so busy, always doing  
22 something -- yeah, you too, Major Phil Volpe,

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1 Major General Philip Volpe -- and so what does  
2 this mean? Well, it's not just a, you know, a  
3 fluff thing or a nice- to-do thing, but  
4 neuroscience tells us what we are asking from our  
5 brains is unsustainable.

6 And so that's where -- one of the things  
7 that we've been playing with to develop -- and I  
8 say "playing with" in the sense of laying it out  
9 there on a white board and just, you know,  
10 bringing in Sgt Eubanks and saying, "Okay, save us  
11 from ourselves, Sarge. What do you think?" But  
12 to develop what we've just called is a task value  
13 inventory. There's probably a better name for it,  
14 but just a 2x2 so that -- you know, what if we  
15 were at the next stand-down to challenge our  
16 leaders, down to the most junior levels, to just,  
17 you know, on a 4x4 high value-low value, high  
18 time-low time. Put everything that we do in the  
19 course of, you know, one's duties. Put them in  
20 one of those domains and then engage in a  
21 discussion with the leadership. You know, high  
22 value-high time? Well, of course you want to

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1 continue doing those things, but maybe we can Lean  
2 Six Sigma or we can somehow, you know, streamline  
3 the time demands. High value-low time? Yes,  
4 let's celebrate them and keep doing them. Low  
5 value-high time? Well, it may be in the course of  
6 discussing with senior leadership what appears to  
7 have no value at ground level may have  
8 considerable value up here. So we may continue  
9 doing it and at least then we know it has value to  
10 somebody. But there's going to be a lot of that  
11 stuff, and you know it, that we can jettison. We  
12 can lighten our load. We can increase the time  
13 and space that we need to think, to reflect, to  
14 connect with our troops and our families and our  
15 communities. And then low value-low time? Those  
16 are the ankle biters, easy to kind of dismiss  
17 them, but you know they can eat up your whole  
18 calendar as well. And I suspect that if we were  
19 to take a good close look at how we're spending  
20 our time, we could carve out some white space that  
21 would really reap dividends. And I will tell you,  
22 I've got out to a few junior leaders, both NCOs

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1 and young lieutenants and captains, both in the  
2 Marine Corps and the Army, to kind of lay this out  
3 to pilot it with them as a concept. Initial  
4 reaction has been typically "Ah, it'll never  
5 happen." So I say, "Well, you know, it might.  
6 What if it did happen?" "Well" -- and this is one  
7 of the most poignant comments -- "Ma'am, we don't  
8 think it'll happen, but if it did happen, we don't  
9 think it will help us but it would give us hope  
10 that maybe for the troops that come behind us  
11 there'll be hope" so that we really can have the  
12 time to learn the fundamentals of leadership, to  
13 apply the principles, the tools from the toolbox  
14 for life, and to connect with human beings in a  
15 way that gets back to what Secretary Shinseki said  
16 so frequently when he was the Chief of Staff of  
17 the Army, "But soldiering is an affair of the  
18 heart and that's heart to heart, human to human,  
19 you are not alone, we're all in this together."

20 MG VOLPE: Okay. Thank you very much.  
21 Appreciate your briefing and fielding of questions  
22 and your passion for a lot of these issues. By

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1 the way, my office folks tell me when I come to  
2 work, that's white space for them.

3 BG SUTTON: You've come so far, General  
4 Volpe.

5 MG VOLPE: Thank you very much.

6 COL MCPHERSON: Ladies and gentlemen.

7 Our third speaker this morning is BG Colleen  
8 McGuire from the Army Suicide Prevention Task  
9 Force. BG McGuire has served as the director,  
10 Senior Leader Development Office, Office of the  
11 Chief of Staff, Army, since January 2008 and is  
12 currently leading the Army Suicide Prevention Task  
13 Force.

14 BG McGuire is a 1979 graduate of the  
15 University of Montana where she was commissioned  
16 in the Military Police Corps. During nearly  
17 thirty years of active service, she has been  
18 assigned in key command and staff billets from  
19 platoon level to Army staff. Her most recent tour  
20 in Washington, DC, has included her service as the  
21 Chief, Colonels Management Office, Senior Leader  
22 Development, Office of the Chief of Staff, Army.

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1 BG McGuire's deployment experience includes  
2 service as the Public Affairs Officer, Joint Task  
3 Force-Somalia and as a Provost Marshal, Multi  
4 National Corps-Iraq.  
5 BG McGuire is a graduate of the Military  
6 Police Officer Basic and Advanced Courses, the  
7 Command and General Staff College, the Public  
8 Affairs Officers Course, and the Army War College.  
9 She holds a Master of Military Arts and Science  
10 from the Command and General Staff College at Fort  
11 Leavenworth, Kansas, and a Master of Strategic  
12 Studies from the Army War College, Carlisle  
13 Barracks, Pennsylvania.

14 BG MCGUIRE: Ms. Carroll and MG Volpe  
15 and Task Force members, thank you very much. It's  
16 really an honor for me to be able to talk with you  
17 today and also to kind of share what we're doing  
18 here with the Army and our Suicide Prevention Task  
19 Force. I know that you've already had a briefing  
20 on the Task Force and its background and genesis,  
21 and from here I'm going to go into a little bit of  
22 our conceptual work and then open it up for

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1 discussions, which is so much more meaningful for  
2 me, too.

3 This is a slide that we present every  
4 Wednesday to the senior leadership, senior Army  
5 leadership. What this slide shows you today is  
6 that -- and this is an as-of date -- as of last  
7 Wednesday, which was the last time we updated this  
8 slide, we've had 134 potential suicides. You'll  
9 note that the green shows those suicides that --  
10 or those deaths -- have been confirmed as  
11 suicides, and the yellow are those that we have  
12 not yet determined death or suicide. But this is  
13 an as-of date, so comparatively in calendar year  
14 '08 on the -- I believe this slide is around the  
15 3rd or 2nd of November -- on the 2nd of November  
16 of 2008 we had 115. So it's just a comparative  
17 slide of where we were last year and the years  
18 previously as of that date.

19 This is for active duty suicides.  
20 Active duty is our Reserve components that are  
21 also serving on active duty. So it's just not  
22 active Army, it's Reserve component as well.

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1           This is non-active duty suicides in  
2 comparison as well. Again, non-active duty are  
3 those individuals, Reserve component, that may be  
4 on M-Day or TPU status, but are not -- have not  
5 been activated for regular service, for active  
6 service.

7           What I want to just talk a little bit  
8 about today, and then we'll open up some  
9 discussion, is a discussion about transformation,  
10 institutional risk, and our soldier behavior, and  
11 that it's an effort that the Army is going through  
12 right now in looking at our legacy programs -- and  
13 I'll talk more about that -- that our effort is  
14 just not a suicide prevention program. When we  
15 stood up the Task Force back in March, the initial  
16 direction was to look at our suicide prevention  
17 program. We went to six different installations  
18 over the course of eight days, and it was after  
19 the first couple of hours at the first  
20 installation that we realized this is so much more  
21 than just suicide prevention; that we, in fact,  
22 need to look at all of the health promotion, risk

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1 reduction programs in the military to address  
2 suicide.

3       So one of the approaches we looked at  
4 was a pre- transformational Army and our  
5 transformed Army. What you'll note there is we're  
6 more familiar -- and I grew up with a division  
7 centric Army. We were more linear focused battle  
8 mind and a doctrine-based decision making order  
9 and discipline. You know, the IG was going to  
10 come and inspect and we had inventories and  
11 accountability. And it was training centric in  
12 that we trained as a team. It was very well  
13 documented. Now I'm being very general in my  
14 comparisons here because then when you look over  
15 at the transformed Army, yes, we're now BCT  
16 centric and that in and of itself brings on a lot  
17 more requirements and demand on a colonel-level  
18 commander now than it used to as a division. Full  
19 spectrum battle mind in that we have soldiers that  
20 are simultaneously performing four phases of an  
21 operation at any one time, engaging in operations  
22 and peacekeeping and/or contingency

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1 simultaneously. You've got experimentation,  
2 creative solutions, that we're frankly posing --  
3 and this is the flexibility and adaptivity that we  
4 enjoy and celebrate in our soldiers -- and this is  
5 the way that they're operating in a field  
6 environment.

7       We're hot-seating equipment. We're  
8 mission centric in that it might be a field  
9 artillery officer or a team that's going to be  
10 doing military police. They're not particularly  
11 trained through several years, but this is their  
12 mission. They're trained to that particular  
13 mission. They perform it.

14       And the last two bullets there are on  
15 both sides of that slide, the UCMJ Administrative  
16 Separations. I'll use the example of alcohol/drug  
17 abuse and substance abuse, positive urine  
18 analysis. Back several years ago, if you were a  
19 non-commissioned officer and you tested positive  
20 for a urinalysis test, there was nothing that  
21 could help you. You were going to be chaptered  
22 out of the military. That is not the case

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1 anymore. We leave that up to the commander. They  
2 have got a formation to fill in preparation for  
3 deployment, and if that particular skill set is  
4 required, then that commander has that authority  
5 then to make that decision. And they're too often  
6 making the decision to maintain and retain  
7 soldiers that just a few years ago we would have  
8 chaptered out of the military. I had a brigade  
9 commander actually admit to me that that was the  
10 case. It's a hard decision to make, but they're  
11 going to war. In the past it was reduced risk is  
12 equal success. A lot of risk-reduction programs.  
13 Now today, we applaud and promote risk taking, and  
14 it's even codified in our doctrine.

15       So if you look at our growing population  
16 -- the upper left-hand part of that slide -- we  
17 have a population that is super warriors,  
18 phenomenal soldiers. Given a population of 1.1  
19 million and an active duty population of 700,000  
20 soldiers, active duty 700,000 soldiers -- that  
21 includes our Reserve component that are on active  
22 duty and serving -- we've had last year 140

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1 suicides; 140 too many, but given the larger  
2 population, we have got a pretty solid base.  
3 However, we are growing a larger population of at-  
4 risk soldiers, and they're engaging in risky  
5 behavior. I've outlined some of that risky  
6 behavior there -- infidelities, alcohol, substance  
7 abuse, erratic behaviors -- one of them, sleep  
8 deprivation, is a risky behavior. So, many of  
9 those soldiers believe that they can operate well  
10 given this environment, they can operate in this  
11 environment; however, we've got a small population  
12 of soldiers that are high-risk soldiers. It could  
13 be a high accumulation of all those risky  
14 behaviors, it could be undiagnosed mental illness,  
15 it could be PTSD undiagnosed. But they're  
16 engaging and living and working in this  
17 environment and the outcomes are expressed there.  
18 Now, we in the Army do have mitigation programs  
19 and procedures and policies to meet or address  
20 some of these risky behaviors -- relationship  
21 counseling, admin separation. We have the ASAP  
22 program. But if I draw your attention to the

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1 upper right-hand part of the slide, you'll see a  
2 triangle there. And it's a triangle that is very  
3 critical and key as we try to link the behaviors  
4 of soldiers with mitigation programs and the  
5 people that know about these programs to be able  
6 to offer them help. So we have leaders who  
7 sometimes are young to the Army, or their entire  
8 career has been deployed. I had a young captain  
9 still within her five-year commitment, a West  
10 Point graduate, that was on her third deployment  
11 to Iraq. Said she was getting out because she  
12 wanted to start a family. I had another MP  
13 captain tell me -- and with military police we  
14 operate with a sidearm by our side all the time --  
15 but she admitted to me that she had never been in  
16 a arms room and she was getting ready to take  
17 command of a company and she's never been in a  
18 garrison command environment. So she said, "Isn't  
19 that something? I've never even been to an arms  
20 room. We always carried our weapons with us."  
21 And so we have a population of soldiers who have  
22 never operated or worked in a garrison

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1 environment, yet when they're in a garrison  
2 environment, that's where they get their help.  
3 But they don't know what programs are available to  
4 them. I was listening to BG Sutton talk about all  
5 the programs and, you know, .net,.org, and I'm  
6 familiar with all these programs now only because  
7 I'm involved in this Task Force. You ask a  
8 soldier on the ground at any post, camp, or  
9 station, and just the plethora of programs and  
10 Websites -- they wouldn't even know or begin to  
11 know where to go. So we've got young leaders --  
12 or the other scenario is we've got seasoned  
13 leaders that when they redeploy from theater,  
14 they've got to -- in a short period of time  
15 they've got to start punching these professional  
16 development opportunities. So as soon as they get  
17 back, boots -- they've redeployed, their unit is  
18 going through reset, the first 60 days they're  
19 going off to the captain's career course, they're  
20 going to the ILE, they're going to their war  
21 college or senior service college, the  
22 non-commissioned officers need to go out and do

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1 their ANOC, BNOC, and get their professional  
2 military education, that they're then leaving.  
3 This is a transitional period where soldiers who  
4 may need help or don't yet know that they need  
5 help because it hasn't manifested itself yet, that  
6 they're most vulnerable. And then they -- then in  
7 come a new group of leaders and they're not  
8 risking -- they are not recognizing the at-risk  
9 behaviors of this new soldier set because they're  
10 not familiar and they don't know this population.

11       So how are we addressing this? We're  
12 going to take a two-pronged approach in dealing  
13 with our programs. One: The Comprehensive  
14 Soldier Fitness focusing on the individual  
15 soldiers, the unit, and family resilience.  
16 They'll have already started up a program. The  
17 intent is to target initially our soldiers coming  
18 in through the basic training and that given over  
19 time -- as you'll see in the blue -- over time we  
20 will grow a larger population of resilient  
21 soldiers. Now this program will go through an  
22 assessment of the individual and their needs.

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1 They go through an education training piece. And  
2 then there's interventions if required.  
3 If you look at the yellow half of the  
4 slide, that's where the Army Suicide Prevention  
5 Task Force effort resides. We're going to look at  
6 all of the legacy programs as they relate to  
7 health promotion, risk reduction, and suicide  
8 prevention. The intent is that our one-size-fits-  
9 all siloed programs, many of which were designed  
10 in the post or near the end of our draft and the  
11 beginning of our all-volunteer Army, have they  
12 transformed to meet the needs of this new soldier,  
13 a soldier that now we promote, the risk taking,  
14 the agility. Do our legacy programs meet their  
15 needs? So we're in the throws right now of doing  
16 an assessment on each of our programs. And that's  
17 everything from -- that was any program that was  
18 developed at grassroots level at post, camp, or  
19 station, or at the headquarters, Department of the  
20 Army level, that was meant to alleviate chronic  
21 soldier stressors, the soldiers or the families.  
22 So we're looking at family programs. We're

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1 looking at soldier programs, not just suicide  
2 prevention, but their alcohol -- this even looks  
3 at our education programs. Let's look at our --  
4 the leave programs -- anything to alleviate  
5 soldier stressors -- PCS, moving -- that over time  
6 we will assess these programs, develop, refine,  
7 adjust them, get rid of them if necessary, and  
8 that over time -- and integrate them up into that  
9 other model of assessing -- and that over time we  
10 will have more tailored programs to meet the needs  
11 of this new population. How long is that? That's  
12 going to take a cultural shift and a change over  
13 time, but we're starting just now in developing  
14 the evaluation criteria, and the program owners  
15 will be assessing their programs here shortly.

16       So let me just use for an example: The  
17 Army Science Board did a review of the -- just  
18 this last year -- on the suicide prevention  
19 program. When the Army Science Board did it, you  
20 can see their findings there -- 30 different  
21 programs, 32 different organizations, and 27  
22 different data bases, all having their fingers in

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1 something suicide. So if you look at -- and I  
2 went back and culled that plethora of programs and  
3 helping opportunities that we have out there for  
4 soldiers and their families -- just off the top of  
5 my head as we were developing this slide, just  
6 threw some ideas out there. These are all  
7 programs out there that were developed to  
8 alleviate chronic soldier stressors. And you can  
9 imagine if we were to take each one of them  
10 singularly, we would probably find similar things  
11 where we've got 30 different programs that kind of  
12 do the same thing. We've got 32 different  
13 organizations that have got a piece of this pie.  
14 And they're saying maybe 30 different data bases.

15 The last -- one of the last things I  
16 wanted to also share with you and you're already  
17 familiar with, the National Institute of Mental  
18 Health and our partnership with the Uniformed  
19 Services University of Health Sciences, the  
20 University of Michigan, Harvard and Columbia  
21 University, in studying suicides. So while the  
22 Army is trying to help itself in looking at our

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1 own programs, looking at how we're training our  
2 soldiers, looking at all of the other initiatives  
3 that are borne by both the DCOE initiatives and  
4 the Comprehensive Soldier Fitness initiatives and  
5 how we can implement that in programs that our  
6 leaders can use to help our soldiers,  
7 simultaneously this, much like the Framingham  
8 Heart Study, is going to study not only past  
9 suicides, but data from our living soldiers right  
10 now in the entire population of the Army. I  
11 believe the Marines are also going to participate  
12 in this as well. So over time maybe they will be  
13 able to find, just as the Heart Study did, that  
14 it's a combination or these are some of the help  
15 factors, or these are some of the things you could  
16 do to preclude this incidence of suicides. Like  
17 the Heart Study with everything from diet to  
18 cholesterol to exercise, maybe we'll find out the  
19 same things, that magic combination of the sleep,  
20 the diet, the exercise, and the eight, you know,  
21 the go for, you know, the life, got all those  
22 things that we were just, she just shared with us.

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1 You know, maybe that's the type of mantra that our  
2 soldiers then will implement in their life that  
3 will help to turn this around.

4 And lastly, the way ahead. I've pretty  
5 much articulated already where we are in expanding  
6 the Task Force focus and looking at all of our  
7 programs, not just suicide, but how they all link  
8 together to deal with soldier stressors. And then  
9 the National Institute of Mental Health; and then  
10 working with CHPPM, SAMHSA, and other professional  
11 public health-type organizations in helping us  
12 truly come up with the measures for effectiveness  
13 for all of our programs.

14 And that concludes my presentation. I'm  
15 open for questions, please.

16 DR. BERMAN: Thank you very much. This  
17 is Lanny Berman. If you go back to slide 6, you  
18 have very nicely indicated in the left-hand side  
19 indications of increasing risk and have, give or  
20 take, a dozen bullets. And I presume those are  
21 data-driven indications. Could you talk at all  
22 about any one or more of those to which the Army

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1 has identified or instituted active outreach  
2 interventions or specific programs to respond  
3 individually and/or in combination with others?

4 BG MCGUIRE: We have over -- right now  
5 we're counting over 400 different programs as they  
6 deal with all of these types of risk factors. So,  
7 for example, alcohol, substance abuse -- the first  
8 one that comes to mind, of course, is ASAP. The  
9 infidelities, you know, we have UCMJ law, but we  
10 also have the Strong Bonds Program, and we have  
11 other family-oriented programs. So one specific  
12 or the multitude of programs to deal with it.

13 DR. BERMAN: Well, specifically what I'm  
14 thinking about is whether there is an observation  
15 of a relationship problem -- infidelity as an  
16 example -- or there's an observation of a soldier  
17 who is sleep-deprived or an observation by someone  
18 of a soldier who is binge drinking. Is there some  
19 immediate -- is there some program in place to  
20 identify and/or outreach to that soldier in such a  
21 way that if, in deed, that is a potential marker  
22 for risk for suicide, that the pathway can be

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1 interfered with?  
2 BG MCGUIRE: What I was careful not to  
3 say is that although these are risk factors, we do  
4 not know that this specifically causes suicide.  
5 It's the accumulation and bioaccumulation based on  
6 an individual's resilience cap per se. Because  
7 one of things and one of the frustrating things  
8 that leaders have to deal with -- and it was  
9 shared a little bit earlier by BG Sutton from what  
10 I heard -- is that if we look internally, many of  
11 us may have had a relationship issue. You know,  
12 if you look at the reasons -- when we look at  
13 soldiers who have died by suicide, they -- we try  
14 to figure out why. You know, we look at their  
15 notes. What were some of their behaviors just  
16 before they died? And some of them were, well,  
17 they had relationship issues. They had substance  
18 abuse issues. They were pending UCMJ. They were  
19 pending some sort of a legal or some sort of  
20 punishment. So you -- they were engaging in some  
21 form of risky behavior, but when you talk to  
22 individuals, many of them will say, "Well, geez,

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1 you know, I went through a divorce. There was  
2 some involvement of infidelity -- my spouse, not  
3 me, of course, you know." Or there were, "Yes, I  
4 have gotten drunk occasionally." Or "I know I  
5 don't sleep as well as I should, but am I going to  
6 commit suicide?" You know, is every single one of  
7 -- you know, when I've got a population of 700,000  
8 soldiers that are on active duty, you know, how am  
9 I going to pick that small percentage of the one  
10 person who may commit suicide, but he's engaging  
11 in what a good number of soldiers are also  
12 engaging in? So if we know, for example -- and  
13 this is where our junior leaders are key to the  
14 solution, and when I'm talk junior leaders, I'm  
15 talking our non- commissioned officers, E-5s,  
16 E-6s, squad leaders, team leaders, and platoon  
17 sergeants and below -- that yes, they can and  
18 should recognize when it appears that this guy's  
19 always on a binge drinking process, you know. So  
20 he's drinking all the time. He seems to be -- we  
21 have debt collectors calling the unit, and so  
22 obviously he has a financial issue as well. So

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1 they call him in. They'll counsel him. They'll  
2 send him to ACS maybe for some financial training.  
3 They'll send him to ASAP to get some alcohol/drug  
4 assistance or care. And then they'll probably  
5 punish him as well because it was probably a --  
6 some sort of an offense was committed. And those  
7 three things alone, where many -- unfortunately we  
8 do have many soldiers that experience that -- but  
9 for this one individual, it's more than he can  
10 handle, but we didn't know that. Does that make  
11 sense? We didn't know this one person was going  
12 to commit suicide. We had an incident at Fort --  
13 in Iraq. We had about ten soldiers were caught  
14 drinking. They were all brought in UCMJ and were  
15 all given Article 15s. One soldier committed  
16 suicide. The other nine didn't. So what were the  
17 other stressors that were in his life that weren't  
18 also in their lives as well? And we could not  
19 determine any determinations because there was a  
20 couple of them that were also going through family  
21 crises. They've got relationship issues, pay  
22 concerns. They were all getting punished. So

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1 that's what's hard, is to try to determine what is  
2 that resilience cap event of that one soldier  
3 that's contemplating suicide.

4 DR. BERMAN: Thank you.

5 DR. MCKEON: BG McGuire, if I understood  
6 you correctly -- Richard McKeon -- under the  
7 indications of increasing risk that you have  
8 there. If I understood you correctly, you  
9 indicated that the prevalence of these risk  
10 factors or at least around substance abuse may be  
11 at an increased level --

12 BG MCGUIRE: Yes.

13 DR. MCKEON: -- currently compared to in  
14 the past because of a change in policy; that  
15 soldiers would have been chaptered out.

16 BG MCGUIRE: It's not so much a change  
17 in policy. The policy's always been there in that  
18 the commander has always had the authority whether  
19 or not to relieve somebody. Now they feel  
20 compelled to keep an individual more often than  
21 not.

22 DR. MCKEON: Okay. And are there any of

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1 these other risk factors that you -- would there  
2 be any reason to say to think that they are have  
3 increased in addition to the fact that more  
4 soldiers with a substance abuse issue may be  
5 retained than previously?

6 BG MCGUIRE: I don't know, and I don't  
7 have -- some of the data that we have does show a  
8 slight up tick, but not to the degree you would  
9 think. But what I can tell you is that the means  
10 to take care of these soldiers are not there in  
11 the numbers that we need them or were in the past.  
12 Again, I get back up to the upper right quadrant  
13 where those leaders were able to either see them,  
14 refer them, and take charge, and take care of  
15 them. We're missing that link up there because  
16 we've got a bifurcation of responsibilities and  
17 this on-off switch. When I'm deployed, I've got  
18 my eye on my soldiers, I've got my eye on my  
19 mission. But when I get home, I've also got my  
20 family to deal with. I'm dealing with, you know,  
21 a different mission set. I want to give my guys,  
22 you know, the freedom to do what they need to do.

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1 We're not as structured to some degree in a  
2 garrison environment as we would deployed. So  
3 we're missing that component. When you've got  
4 young soldiers or soldiers or leaders that are in  
5 that transitional period going off to their  
6 commands, I mean, a PCS or a school opportunity.

7 MG VOLPE: This is Phil Volpe. BG  
8 McGuire, could you just quickly -- slide number 2  
9 -- I just wanted to -- can you -- all the way back  
10 at the beginning, it's your second slide. No, go  
11 back one more. There you go. Yeah. Is this the  
12 one with the "pending" on it?

13 BG MCGUIRE: Yes, sir. Yellow is  
14 pending.

15 MG VOLPE: How long does it typically  
16 take to determine, or is it all over the map?

17 BG MCGUIRE: It's all over the map, sir.  
18 In fact, as you recalled, we've been and were  
19 correcting the calendar year '08 numbers up until  
20 only a couple of months ago.

21 MG VOLPE: Okay. The question I want to  
22 ask you -- just clarify for me because when I go

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1 back and look over the last 20 years or whatever,  
2 it -- in DoD, DoD-wide, of all the pending ones or  
3 undetermined, 9 out of 10 end up being determined  
4 to be a suicide. So I guess what I'm saying is,  
5 is the reason why you put it on the slide  
6 essentially because if it's being investigated and  
7 determined historically 9 out of 10 are being  
8 suicides so we just count them in the numbers?

9 BG MCGUIRE: And the -- yes, sir. Yes,  
10 sir.

11 DR. JOBES: Could we jump ahead, please?

12 It's Dave Jobes. Back to this slide here with all  
13 the programs? That one. So one of the things I'm  
14 thinking about or reflecting on is in the private  
15 sector, in the civilian sector, I'm thinking of  
16 the school-based programs of the 1980s and a lot  
17 of programs that were stood up but not studied and  
18 well meaning and well intended. And I've attended  
19 a few of these meetings, reviewing some of this,  
20 and one of the observations was that a lot of  
21 these programs perhaps are similarly well meaning,  
22 well intended, but don't have an evidence base?

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1 BG MCGUIRE: Correct.

2 DR. JOBES: Can you comment where you  
3 see the Army going forward in terms of the role of  
4 evidence-based approaches, especially -- I mean  
5 it's impressive, and we don't think ever that but  
6 for these programs, the Army's rate might be  
7 extraordinarily high, even higher than we're  
8 already concerned about.

9 BG MCGUIRE: Right.

10 DR. JOBES: So we don't -- who knows?  
11 But going forward, it would seem to me that  
12 there's an opportunity -- and I think this is  
13 relevant to the Task Force and it serves a bias --  
14 to actually be thoughtful about consolidating  
15 programs and then actually studying them. And how  
16 do you all see that in your mission?

17 BG MCGUIRE: Simply, because again,  
18 because of the urgency of this issue that we're  
19 dealing with, I think the first phase is to do a  
20 quick identification of what programs are out  
21 there. So just a simple list at this point. And  
22 then next is a very rudimentary assessment of a

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1 quantitative nature that just addresses some of  
2 the criteria that we're -- so we can just start  
3 grouping or binning like-programs together. And  
4 once we get to that point, then those experts and  
5 those folks that either own the programs and  
6 whether or not to determine, you know, evidence  
7 based or some other measures of effectiveness,  
8 then we'll agree upon with like-type programs.  
9 Why do I need 15 youth programs when these three  
10 seem to be the most effective? Let's focus our  
11 energies on these three. And so that's our  
12 effort, to kind of cull all these programs to  
13 meet, I think, a more focused need.

14 CDR WERBEL: This is Aaron Werbel.  
15 General, thank you very much for your  
16 presentation. My impression from your bio is that  
17 you're not a medical officer. And I'm really  
18 interested, given that, in your opinion -- and  
19 this follows on from Dr. Jobes' question. I think  
20 it leads right into it that -- I think your  
21 presentation and the two we had previously, and  
22 members of the Task Force have noted on a number

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1 of occasions, the importance of studying programs  
2 and studying specific resources or interventions.  
3 There's often an important but a very difficult  
4 tension between the need -- and the very correct  
5 need -- for senior leadership to move out quickly  
6 when there's a problem. And obviously when  
7 Service members are dying, there's a very  
8 important need to implement something right away.  
9 But that is often in conflict with the importance  
10 of studying and taking the time to set up a  
11 program of evaluation with the University in a way  
12 that's going to be effective to see whether or not  
13 this new intervention works.

14 I'm very interested in your opinion  
15 about, you know, some thoughts maybe on how to  
16 balance the importance of getting something into  
17 the hopper quickly and responding and trying to  
18 save lives, with the importance of studying new  
19 initiatives.

20 BG MCGUIRE: Thank you for asking my  
21 question. Again, I think this Task Force brings  
22 an operational bent to this whole effort. There

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1 are many great studies already out there. I think  
2 if we were to -- and we have -- my group of laymen  
3 are, you know, Googling all the time and we're  
4 finding these great studies. And then we look to  
5 see how were they ever implemented. And the  
6 efforts that we've got going on with NIMH, for  
7 example, their contract with us is to quarterly  
8 meet with us. And if they were to find anything  
9 of any interest that could be actionable, then we  
10 would get involved in that and be able to then  
11 implement it into the field. We're the bridge  
12 from the study to the operator. And we've done  
13 that, in fact, a little bit painfully. I know  
14 that Dr. Orman is here, and he was a member of our  
15 council as well. And we brought in the  
16 representatives and the subject matter experts  
17 from -- everything from behavioral health to the  
18 medical community to the law enforcement community  
19 to the inspector generals. We've got the  
20 personnel, installation management. We've got  
21 nearly 30 council members that have a piece of all  
22 of this that given the studies, how are we

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1 implementing what we're finding in these studies?  
2 I -- analogies are so dangerous -- but all of us  
3 have a spare tire in our trunk, but we haven't had  
4 to use it. But we know it's there and I feel  
5 confident that I can change my tire, until I have  
6 to change my tire. And then just going through  
7 the mechanics of trying to figure out how to  
8 change my tire with the equipment that I was  
9 given; the spare tire being the study, and me  
10 being the guy on the ground. I am the bridge or  
11 this Task Force is the bridge to translate that  
12 study, show them how to use it, make them practice  
13 it, employ it and touch it, and then now they feel  
14 confident with it. You may have heard of the ACE  
15 program which is a new training initiative of the  
16 Army that was in line with Assist. And then, of  
17 course, the training tools -- the Beyond the Front  
18 and Shoulder to Shoulder. What the ACE does to  
19 some degree is it forces them to practice changing  
20 the tire. Assist does that in an even more  
21 hands-on manner. But again, it's one thing to  
22 study it, but it's another thing to implement it.

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1 And we do that through the Task Force through  
2 policy, through compliance checks, and then  
3 eventually getting to our measures of  
4 effectiveness. And then once we know that they've  
5 got the tools, they're working the tools, they  
6 know how to use them, now let's start measuring  
7 how well it's working. We're missing that right  
8 now.

9 MG VOLPE: Okay. Thank you very much,  
10 BG McGuire. Really appreciate your briefing and  
11 your candid answers to the questions.

12 At this time we're going to go ahead and  
13 break the public session. We have a working lunch  
14 admin session for Task Force members, and we will  
15 give some administrative announcements on that in  
16 a moment. And then we'll reconvene here at the  
17 public session at 1315 hours, which is 1:15 for  
18 those who don't know military time. 1:15 p.m.

19 MG VOLPE: (in progress) with Ms. Bonnie  
20 Carroll who will be here in a moment for the Task  
21 Force on the Prevention of Suicide by Members of  
22 the Armed Forces.

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1 I'd like to request that no flash  
2 photography is taken at the Task Force meeting as  
3 this may be distracting to speakers and the  
4 public. And please turn off any electronic  
5 devices so speakers will not be distracted or  
6 interfered with.

7 As a reminder, if time allows, we will  
8 take questions and statements from the public at  
9 the end of the Panel Session. And I believe we  
10 will have some time to do that so we'll be able to  
11 take some questions and/or statements in order to  
12 document that for the Task Force deliberations.  
13 We ask that you register to speak at the desk  
14 outside the room if you are going to speak.  
15 Everyone, however, has an opportunity to submit  
16 written statements to the Task Force. Statements  
17 may be submitted today at the registration desk or  
18 by e-mail, and that e-mail is available at the  
19 registration desk, or may be mailed to the Defense  
20 Health Board and that address will be on flyers  
21 outside over here. So please help yourself if you  
22 do want to make a written statement and provide

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1 that information to the Task Force.

2 At this time I'll turn it over to COL

3 McPherson.

4 COL MCPHERSON: Thank you, sir. Our

5 fourth speaker today is LTC Michael Bell who leads

6 the Behavioral and Social Health Outcomes Program

7 at the U.S. Army Center for Health Promotion and

8 Preventive Medicine. The mission of the

9 Behavioral and Social Outcomes Program is to

10 maximize total soldier health and combat readiness

11 by addressing psychological and social threats

12 through the public health process. As the Army's

13 Center of Excellence for behavioral health and

14 social outcomes epidemiology, the program conducts

15 surveillance and in-depth analysis of Army

16 behavioral health trends and outcomes, provides

17 behavioral health epidemiological consultations,

18 advises the Army on behavioral health program

19 development and evaluation, and disseminates best

20 practices.

21 LTC Bell is board certified in

22 Occupational and Environmental Medicine. Prior to

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1 his assignment at CHPPM, LTC Bell served as the  
2 Medical Director for the Warrior Transition  
3 Brigade at the Walter Reed Army Medical Center.  
4 In addition to behavioral health epidemiology, LTC  
5 Bell's major areas of interest are chemical  
6 casualty care, cardiac risk assessment and  
7 prevention, respiratory protection, disaster  
8 response, and reproductive toxicology. LTC Bell.

9 LTC BELL: Thank you. MG Volpe,  
10 distinguished Panel members, it's a privilege to  
11 be here today to speak with you. I'm going to  
12 speak briefly about the program that we have at  
13 CHPPM in an overview-type of sense; then I'm going  
14 to dive into the data that we have to date in  
15 terms of the epidemiology of suicides in the U.S.  
16 Army.

17 MG VOLPE: For those who aren't aware,  
18 could you just describe what CHPPM stands for?

19 LTC BELL: CHPPM is the U.S. Army Center  
20 for Health Promotion and Preventive Medicine. It  
21 is the more or less the Centers of Disease Control  
22 analog for the Army. We're the public health

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1 department for the Army.

2 So this is just the briefing outline.

3 We're going to talk briefly about the mission of  
4 the Behavioral and Social Health Outcomes Program  
5 and our capabilities. I'm going to describe the  
6 epidemiology of suicide in the U.S. Army, talk  
7 briefly about some underlying factors, and then  
8 leave you with some of our thoughts on the  
9 population health implications of the data that  
10 I've described. And then, of course, there'll be  
11 ample opportunity for questions.

12 You can see our mission statement there,  
13 which is really focused on bringing the soldier  
14 health in combat readiness into focus in terms of  
15 understanding the psychological and social threats  
16 that impact that. Our program as a whole has  
17 several objectives. The first is to identify the  
18 threats through surveillance. Once we have  
19 identified a threat, we'll typically do a  
20 response-type mission or an epidemiologic  
21 consultation where we'll send teams out into the  
22 field to gather more data and really get the rich

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1 detail that's needed to provide in-depth analysis.

2 We also have a big function in terms of  
3 providing qualitative analysis and support from  
4 design of custom surveys and focus groups. And  
5 then finally, we have a strategic analysis cell  
6 which maintains a registry of all Army suicides.  
7 And this is being used as one of the main data  
8 engines to inform the Army's STARS Study.

9 You can see our functional organization  
10 here. We're broken up into four main branches.  
11 Our focus areas are listed there, and our interest  
12 is in the public health implications of those  
13 various areas of behavioral health and deployment  
14 health, not so much the clinical practice because  
15 that's very well covered by our colleagues that  
16 are in the clinical care mission.

17 I have a staff of about 20 social  
18 scientists at the PhD and master's level that work  
19 in this area. It runs the gamut from  
20 epidemiologists to psychologists, social workers,  
21 so it's a multidisciplinary team that is doing the  
22 applied analytic science to understand this

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1 problem in a public health context.  
2 I wanted to speak very briefly about the  
3 Army Behavioral Health Integrated Data  
4 Environment. This is the Army's registry of  
5 suicides. It builds on the DoD suicide event  
6 report; that's the sort of the foundation of the  
7 report. And then we pull in a lot more data  
8 that's not there in the DoD suicide event report.  
9 We have for every suicide in the Army, their  
10 complete demographic history, their deployment  
11 history, medical history, all their post  
12 deployment health assessments, and family advocacy  
13 and substance abuse records. So we have a very  
14 rich data set on all the suicide completions and  
15 suicide attempts and suicide ideations that have  
16 occurred in the Army since 2001. And we're  
17 working with CIO/G-6 to bring in additional  
18 sources of data, and I think that ultimately we're  
19 going to have the most complete set of suicide  
20 data on a population that exists anywhere in the  
21 country and perhaps the world. So it's going to  
22 be a tool that is really valuable as an asset to

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1 the Army and the DoD, and hopefully something that  
2 we can leverage to great effect.

3 So that's enough of the sort of  
4 propaganda about the program. I wanted to dive in  
5 and start talking about the epidemiology of U.S.  
6 suicide. This is a chart that we produced about  
7 eight months ago or so. COL(RET) HOGE's already talked  
8 about it, so I'm not going to dwell on too much.  
9 I think the thing that's clear on the chart,  
10 though, is that we're outside of our control  
11 bounds. If you go back to even the 1970s, the  
12 pattern that you see here of suicides being in a  
13 range from 10 to 15 per 100,000, that's been our  
14 pattern. You see a departure starting at around  
15 2004 and moving steadily upward where we're  
16 clearly outside of our control limits starting in  
17 about 2006/2007. And in 2008 we're projected to  
18 exceed what would be the U.S. population rate  
19 adjusted for age and sex once that data is  
20 available. The national population data lags  
21 about two years behind, so we're still kind of  
22 waiting to see what those things are, but we're

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1 pretty confident that, unfortunately, the Army's  
2 going to exceed the civilian rates.  
3 If you look at the rates of suicide by  
4 component, you can see that the trend is there for  
5 all components. Don't get distracted by the  
6 jaggedness of the Army Reserve and National Guard  
7 line. That's an artifact of the data as COL(RET) HOGE  
8 was describing earlier. You know what you need to  
9 do is just draw yourself a little trend line in  
10 your mind, and you can see that the trend is  
11 exactly the same for the Army and Guard as it is  
12 for the regular Army and overall active duty.

13 This chart describes some of the key  
14 demographic differences between the suicide  
15 population and the overall population. The ones  
16 that are statistically significant are highlighted  
17 with the asterisks. You know, obviously the  
18 suicide population is more predominantly male;  
19 it's slightly older than the average age of the  
20 Army, which is somewhat surprising; and it's also  
21 more likely to be single than the rest of the  
22 Army.

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1           The method of death overwhelmingly for  
2 Army suicides is gunshot wounds. And this is a  
3 potential area, I think, for some better outreach.  
4 You know, if you go around Army Posts, you don't  
5 see a whole lot of public health outreach-type  
6 campaigns around gun safety and things like that,  
7 at least not the Posts that I've visited recently.  
8 I mean, you often will see all kinds of campaigns  
9 out there about motorcycle/vehicle safety or, you  
10 know, preventing drunk driving, and things like  
11 that. But I'm not sure that we're focusing the  
12 same amount of attention on, you know, high-risk  
13 activities with firearms that may be warranted  
14 given this data here. If you look at suicides in  
15 both theater and in CONUS, firearms are the number  
16 one cause of death by suicide. And this ties into  
17 the fact that as a group, the deaths by suicide in  
18 the Army, it's very common -- or there's a very  
19 high lethality and intent to die in those suicide  
20 attempts.

21           When we go back and analyze the data,  
22 about 76 percent of Army suicide, there's obvious

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1 intent to die based on the method chosen and the  
2 circumstances around the event and the location  
3 and a variety of other factors. There's evidence  
4 of prior planning in about 41 percent of Army  
5 deaths by suicide. And disturbingly, 36 percent  
6 have communicated in the week prior to the event  
7 some kind of inkling of their intent to commit  
8 suicide. That's increased this year from 25  
9 percent as an average in previous years. So, you  
10 know, that's another potential opportunity or  
11 missed signal that we might be able to intervene  
12 on and focus a little bit more on if we're able to  
13 get out in front of the problem.

14 This slide describes Army suicide rates  
15 by functional group. You can see there that the  
16 maneuver firing effects have the highest rate of  
17 suicide since 2004. Dr. Hoge talked about that at  
18 some length this morning in relation to combat  
19 intensity. It certainly fits with that  
20 hypothesis. One thing to keep in mind as you look  
21 at this; these rates are not adjusted for age,  
22 gender, and other demographic factors. So there

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1 may be some confounding there because the combat  
2 arms soldiers as a group tend to be younger, and  
3 younger soldiers have more of the constellation of  
4 suicide risks oftentimes than others.

5       If you drill down into the suicide rates  
6 by branch, however, you can start to see that  
7 there's some interesting differences within the  
8 combat arms. It seems that the high rate in the  
9 combat arms is really driven by the rate in the  
10 infantry, which is almost 29 per 100,000. Some of  
11 the other combat arms branches, such as armor and  
12 field artillery, are substantially less than that.  
13 Now there's some potential confounding there in  
14 terms of demographics because there's ethnic  
15 differences in terms of the ethnic-racial  
16 composition of branches that may play into the  
17 suicide issue. Some branches have higher  
18 percentages of African-Americans and Hispanics,  
19 which traditionally are groups that have lower  
20 suicide rates than the infantry. So that may play  
21 into it as well. An area that we haven't had a  
22 chance to explore fully is the differences in

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1 personality and underlying skills that go into the  
2 choice of branch in the Army. But this is  
3 certainly an area I think has great potential for  
4 further examination and study.

5 This slide describes the suicide rate  
6 trends by age group, and as I mentioned before,  
7 the highest risk group is the young soldiers in  
8 the 18 to 24 year old group. The overall trend,  
9 though, is very similar no matter which age group  
10 you look at, and the slopes of the lines are all  
11 fairly close. You see the same sort of trends  
12 when you look at suicide rates by rank.

13 Place of death is predominantly in the  
14 United States. There's an error on this chart. I  
15 apologize for that. The 2005 data point should be  
16 up here at 29 percent. So overall you've seen an  
17 increase in suicide in-theater. Really about as  
18 soon as we got into theater, we started to have a  
19 fairly high proportion of suicides in-theater  
20 level off, and it's actually decreased a little  
21 bit in the last two years which is somewhat  
22 surprising.

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1 Dr. Hoge already mentioned a couple of  
2 things about the mental healthcare utilization of  
3 Army suicides, so I'm not going to dwell on this  
4 slide too much. I think it's interesting, you  
5 know, in the context of our discussion here today.  
6 You know, in absolute numbers or percentages, the  
7 percent that have a history of PTSD is fairly low.  
8 As Dr. Hoge mentioned, that's something that's  
9 difficult to tease out because a lot of people get  
10 placed in the anxiety disorder or some kind of  
11 acute stress disorder or adjustment disorder  
12 hopper, when the symptoms that they're presenting  
13 for are probably related to PTSD. I think this is  
14 an opportunity, though, as we move forward, you  
15 know, since only 44 percent of suicides have a  
16 history of having had outpatient care, if we could  
17 get more of our soldiers into appropriate  
18 treatment, we may be able to have better outcomes,  
19 especially for the areas where there's, you know,  
20 good evidence that the treatments work like in  
21 depression.

22 This slide in a nutshell really explains

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1 why the Army made the decision to stand up my  
2 program at CHPPM about a year and a half ago.  
3 Looking at healthcare encounter data, starting in  
4 2007, the mental health diagnoses became the  
5 number one reason for hospital bed days. The  
6 number two reason for medical encounters went into  
7 the top five in terms of individuals affected.  
8 So, you know, that's a really compelling burden of  
9 disease and something that the MedCom and CHPPM  
10 leadership felt like they couldn't pass by. And,  
11 you know, they felt like we needed to get out in  
12 front of this burden of disease with public health  
13 programs that intervene at the primary prevention  
14 level rather than continuing in a paradigm of  
15 medical treatment for the mental health problems.

16 If you look at the overall trend of  
17 suicides with any mental disorder compared to the  
18 Army with any mental disorder, you know, the  
19 trends almost mirror exactly. You know, what this  
20 indicates to us is that the suicides are just an  
21 extreme manifestation of the overall burden of the  
22 mental health problems in the force. So, you

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1 know, to attack the problem of suicide, we really  
2 need to come at it from the perspective of our  
3 entire population, not just from the standpoint of  
4 treating individuals.

5 If you look at modifiable risk factors,  
6 there's a couple of interesting things to be seen  
7 in the data. As I mentioned previously, the  
8 percentage of individuals who die by suicide that  
9 have a diagnosed condition are fairly low for any  
10 particular disorder. Relationship problems have  
11 been highlighted very frequently as the major  
12 driver of suicide risk, and that's something that  
13 the data definitely bears out. But if you look at  
14 this chart down here, what you see in the red line  
15 up above, that's the relationship risk which has  
16 been pretty flat since 2005. The thing that --  
17 the new driver of risk or that's causing the  
18 acceleration in the rate of suicides that you saw  
19 on the first slide a while back, you know, since  
20 2005 we've had more than a doubling of the  
21 military work stress and an increase of probably  
22 two-thirds or so in terms of mental health

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1 disorders that are not related to substance abuse.  
2 The other risk driver that's important, but flat,  
3 has been substance abuse. It's kind of remained  
4 at a steady baseline of the suicide cases.  
5 We've done quite a bit of focus group  
6 work looking at stigma, especially in the context  
7 of our Fort Carson EPICON, which was a field  
8 investigation we did that looked at violent death  
9 at Fort Carson. We looked at both suicide and  
10 homicide. And what we found in talking to  
11 hundreds of soldiers there at Fort Carson was that  
12 there's a real differentiation in terms of what  
13 drives stigma based on the rank of the individual,  
14 the age of the individual, and sort of where they  
15 are in their career path. And we think that this  
16 is a really important opportunity because from our  
17 perspective to this point, the Army's anti-stigma  
18 efforts have been fairly homogeneous,  
19 one-size-fits-all type of programs. And if we  
20 could target the programs better, we may be able  
21 to get some traction with soldiers and hit them  
22 with information they're ready to hear and

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1 information that resonates with them that could  
2 potentially get them to act on the mental health  
3 issues that are bothering them. Because we've  
4 really seen very sharply that the things that  
5 drive stigma for your E-1 through E-4 are quite a  
6 bit different than the drivers of stigma or the  
7 perceptions of stigma at higher levels.  
8 Frequently the things that somebody that's in  
9 mid-level management brings along with them in  
10 terms of their perceptions and reaction to stigma  
11 that resonate with them actually are not important  
12 at all with the junior soldiers.

13       So in terms of putting this all into  
14 sort of a multi-factorial model, if you think  
15 about the individual, an individual comes into the  
16 Army with a certain background. You know, they  
17 may have positive factors from a mental health  
18 standpoint, negative factors from a mental health  
19 standpoint, and positive and negative factors from  
20 a resiliency standpoint. Once they're in the  
21 Army, there's things that go on in their unit  
22 environment in terms of their leadership; in terms

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1 of the combat the unit is exposed to; the  
2 deployments the unit takes part in, et cetera; the  
3 training that the unit gets; that can either  
4 amplify or attenuate the influences of those  
5 factors that the individuals have. And likewise,  
6 there's things out there in our Army communities'  
7 and in the surrounding communities' environments  
8 that can amplify or attenuate the underlying  
9 characteristics of the individual. So what we are  
10 proposing has happened in the Army since 2001 is  
11 that we've accumulated a lot of risk in the Army.  
12 And our overall risk curve as an organization has  
13 moved to the right in the last eight years. And  
14 because of that, we have more and more soldiers  
15 that have a pretty high density of risk factors.  
16 Now at the individual level, those risk factors  
17 can increase or decrease pretty dynamically. You  
18 know, think about the soldier that gets -- maybe  
19 he has three risk factors, you know. A history of  
20 depression, maybe he drinks a little bit, and he's  
21 got some financial problems, you know, that  
22 person's risk could increase dramatically if they

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1 got a "Dear John" letter. Now we're not going to  
2 be able to predict that person's risk in any kind  
3 of meaningful way and tell a commander, "Watch out  
4 for Johnnie because we know that he's going to get  
5 that, you know, 'Dear John' letter that's going to  
6 put him over the edge." But if we look at their  
7 whole population, if we look at a battalion, and  
8 we're able to find battalions that have  
9 aggregations of risk because of the individuals  
10 that are assigned to them and because of the  
11 experiences that that battalion or grouping has  
12 had, we may be able then to identify groups that  
13 have high risk and apply additional resources or  
14 programs or attention to those units and bring  
15 back the overall level of risk.

16 What we've been doing so far in a lot of  
17 our programs is trying to take individuals out of  
18 this part of the curve and put them back into this  
19 part of the curve. You know, that's what you're  
20 trying to do when you send somebody to treatment.  
21 You know, you're trying to take their level of  
22 risk and either truncate it or move it back to a

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1 lower level. What we need to do if we're going to  
2 fix the problem for the Army is we've got to shift  
3 the whole population's risk back to the left.

4 The good thing is, there's a lot of  
5 smart people in the Army working on this,  
6 including the Suicide Prevention Task Force and  
7 General Cornum's Soldier Fitness Task Force. And  
8 there's good efforts in the Army that, you know,  
9 if allowed to grow and proceed along the lines  
10 that they're moving already, should begin to  
11 systemically, I hope, move the overall population  
12 risk back to the left because that's really where  
13 the money is. And, you know, these are all just  
14 examples of things that can be done to move  
15 population risk back to the left.

16 The population-based strategies for  
17 mitigating suicide -- some of them are listed  
18 here. The Army spent a lot of time with  
19 gatekeeper strategies for identifying high-risk  
20 individuals and those can be very productive,  
21 especially if paired with good treatment that's  
22 evidence based and proven to be efficacious like

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1 cognitive behavioral therapy, DBT -- dialectic  
2 behavioral therapy -- and appropriate use of  
3 pharmaceuticals.  
4 So that pretty much it in a nutshell,  
5 sir, and to the group is what I had prepared to  
6 talk about. I'm happy to take your questions and,  
7 you know, have an extended discussion around these  
8 issues. Thank you.

9 MG VOLPE: Thanks, Dr. Bell, for that.  
10 Is there a question? Members of the Task Force  
11 have any questions?

12 DR. LITTS: David Litts. Couple of  
13 questions. One, this Maneuver Fire and Effects  
14 group. Is their gender distribution known to be  
15 different than some of the other groups with lower  
16 rates?

17 LTC BELL: The gender distribution of  
18 that group is almost exclusively male. Only 5  
19 percent of Army suicides, though, are among  
20 females. So, you know, the gender distribution  
21 isn't going to explain a great deal of the  
22 variance in rates from group to group.

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1           Now one thing that has been interesting  
2 as we look at the female suicides, especially the  
3 death spot suicide, is over the years of the war  
4 the females have begun to choose means of suicide  
5 that are more and more like their male  
6 contemporaries. So they're choosing more lethal  
7 methods. That's potentially very worrisome  
8 because there's a lot more female suicides, or  
9 attempters, as a proportion than there are  
10 completers. So if the trend is truly evolving  
11 that females are choosing more and more lethal  
12 means for their suicide attempts, we're going to  
13 have a further increase in our suicides because  
14 they're going to be more likely to have a death by  
15 suicide because of choosing a more lethal means.

16           DR. LITTS: It just seems to me that if  
17 you have a subgroup that is almost exclusively  
18 male and they have a -- and that subgroup has a  
19 higher suicide rate than the other subgroups, that  
20 you would have to adjust for gender --

21           LTC BELL: Yes.

22           DR. LITTS: -- because it may be that

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1 that group actually has a lower suicide rate, it's  
2 just, you know -- when -- after it's adjusted.

3 LTC BELL: Right. And I pointed out  
4 that these figures weren't adjusted for age, race,  
5 sex, and that's definitely something that we're in  
6 the midst of doing. That will be in our next  
7 report which is coming out in about a few weeks.  
8 But the number of females that have died by  
9 suicide in the data set is such a small percentage  
10 of the data set that even after we adjust for it,  
11 it's not going to move the overall rate in those  
12 categories by very much at all.

13 DR. LITTS: No, but the adjusted -- it  
14 could move the adjusted rate.

15 LTC BELL: Yes, it'll bring the rate  
16 down slightly, but it's not going to erase the  
17 difference.

18 MG VOLPE: This is Phil Volpe. Can we  
19 put slide back on for that? And I wanted to chime  
20 off of what David's saying here because I think  
21 the point that we're trying to get at -- and this  
22 is what you're talking about, Dr. Bell, is that

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1 the data's not normalized.

2 LTC BELL: That's correct.

3 MG VOLPE: And so when you get to that,  
4 I think everybody here will be very interested in  
5 seeing that, and that's the normalization for age,  
6 marital status, lower ranking, ethnicity, gender,  
7 and education level, which we were all briefed  
8 previously as pretty significant factors or  
9 epidemiologic factors.

10 LTC BELL: We're in the process of  
11 running this data as a multi-variant model, but  
12 we're not ready to release that yet.

13 MG VOLPE: Okay. Great.

14 DR. LITTS: I have one other observation  
15 from slide 20. You summarized that slide as  
16 saying that the substance abuse factor had not  
17 changed much, and yet as I look at that, it looks  
18 like it went from about 23 up to maybe 39, which  
19 is, you know, what, a 50 some odd percent  
20 increase. And so --

21 LTC BELL: The substance abuse is the  
22 purple, which has gone from about 19 to 22 --

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1 DR. LITTS: Oh, I'm sorry. I apologize.

2 I misread the slide.

3 LTC BELL: Right.

4 MG VOLPE: Phil Volpe. Yeah, I have a  
5 question on your slide 7, if we can go there. I  
6 keep seeing this briefed by multiple briefers at  
7 different levels, but I just want to clarify, or I  
8 want to be clarified, I guess or educated here,  
9 that when we're looking at suicide rates and doing  
10 a comparison between military and civilian, I'm  
11 also being told that there's -- I don't know how  
12 to describe it -- an artful difference in how that  
13 is calculated and determined in that there's a lot  
14 more undetermined deaths on the civilian side and  
15 not as definitive in making a suicide -- in other  
16 words, are we comparing a little bit of apples and  
17 oranges in the way suicides are determined in each  
18 of these rate factors for civilian versus military  
19 a little bit in that I'm being told that a lot of  
20 the civilian data is probably higher than what  
21 it's really representing on there.

22 And then the other part is that we would

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1 -- and I don't know how the research is going to  
2 show this or epidemiologically, but we're talking  
3 about this military population who's been screened  
4 when they're assessed and is in general a fitter,  
5 more healthy population than the civilian  
6 counterpart for the same demographics, what we  
7 take in the military. So you would think that it  
8 would be a lower rate, but at the same time those  
9 individuals get exposed to much more tragic and  
10 demanding environments, challenging environments,  
11 to deal with from a mental health capacity  
12 standpoint. Can you make any sort of comments on  
13 that in these rates of comparing civilian to  
14 military and the differences between selection and  
15 the fitter population in the military, but being  
16 exposed to greater amounts of stress and those  
17 kinds of things? And also how it's measured in  
18 military -- in other words, is this really useful?  
19 What I'm really getting at, is this useful? Is  
20 this useless, or just less useful to compare  
21 military and civilian over time, year by year?  
22 And if it is, is it just a media standpoint to

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1 publish to sell newspapers or is it something

2 important that we need to know?

3 LTC BELL: Well, there's a lot of parts

4 to that. Hopefully, I'll be able to hit them all.

5 The data in this figure here -- the blue line

6 comes from death certificate data. It comes from

7 the National Death Index. You know, so you're

8 absolutely correct, sir. What goes into this line

9 varies from state to state to state. And, you

10 know, there can be a lot of pressures and

11 influences at the local level in terms of what a

12 coroner determines is a suicide.

13 Now, the red line, the Army line, we get

14 our determination of whether or not something is

15 ultimately a suicide or not from the Armed Forces

16 Medical Examiner. So that's a bit more of a

17 uniform standard applied across suicides. Now

18 that being said, I think that we have quite a bit

19 of misclassification bias in our own data. You

20 know, especially for things that occur in-theater.

21 I think there's probably a fair number of cases

22 where, you know, it's a questionable death

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1 in-theater, that probably don't end up getting  
2 reported as a suicide. But, you know, that's not  
3 something that I think we can say throw out all  
4 the data just because we have some squeamishness  
5 about the quality of that. I think the really key  
6 point on this slide is the departure from what's  
7 our own historical baseline as an organization for  
8 the last 30 years. You know, going back to the  
9 1970s, our baseline in the Army has been a suicide  
10 rate somewhere between 10 and 15 per 100,000. So,  
11 you know, to now have a suicide rate in 2008 of  
12 20.2 per 100,000 is a significant departure and I  
13 think, you know, very important.

14 On your question of -- or do you want to  
15 follow-up before --

16 MG VOLPE: Yeah, let me just -- because  
17 I want to mention another point. Phil Volpe  
18 again. And again, it was briefed by BG McGuire  
19 and then she admitted she doesn't have evidence to  
20 show, you know, specifically. But she mentions  
21 specifically that there's a lot of pressure on  
22 commanders. And we retain many more people over

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1 these last 5 to 6 years in the military who  
2 previously in the '90s, when we had a larger  
3 military and stuff, would separate. In other  
4 words, people that had problems that interfered  
5 with their performance or legal problems or  
6 whatever it was, we were more apt -- leadership  
7 was more apt -- to separate them from the military  
8 a while back.

9 LTC BELL: Yes, sir.

10 MG VOLPE: So wouldn't that then  
11 logically -- they may still be people who commit  
12 suicide, but they've been pushed out of the Army.  
13 And so wouldn't that logically lower the rate  
14 because now we keep them in and they commit  
15 suicide while they're in the Army versus  
16 previously where we separated? We labeled them as  
17 -- I was a commander, too -- we labeled people as  
18 problem people, and it was just easy to just  
19 chapter them out of the military and let somebody  
20 else deal with it back then. Would that -- does  
21 that -- I guess I'm not sure of the magnitude or  
22 intensity of how that would tamper this rate

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1 increase on that.

2 LTC BELL: Right. That could

3 potentially confound the rate increase and it

4 would tend to increase the slope of the rate

5 increase -- if we're keeping people in now that we

6 would have previously not have kept in because

7 what -- the issue that we've had is we have not

8 had a very good ability to track what happens to a

9 person after they get out of the military. Now we

10 have a protocol that's up for review right now

11 with Medical Research and Material Command, our

12 institutional review board, to examine the causes

13 of death among individuals who've been discharged

14 from the Service since 2001. So that will give us

15 an indication to a certain extent of what you're

16 talking about there, sir. You know, we'll be able

17 to see if people that have been separated from the

18 Service, you know, for chapter actions or problems

19 like that, have a greater likelihood of death by

20 suicide than individuals who have separated for

21 other reasons. Does that answer your question,

22 sir? I don't want to go too far.

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1 MG VOLPE: Yes. Other questions? Yes.

2 DR. HOLLOWAY: Marjan Holloway. Thank

3 you for your presentation. Could I ask you a

4 question about slide number 21? I thought that

5 was very important information that you presented

6 to us. So my first question related to that slide

7 is when did you do this research based on the

8 focus groups?

9 LTC BELL: Well, we did this field study

10 at Fort Carson last winter. The report was just

11 released in July of this year, and there's a whole

12 appendix on the focus group methodology and

13 details of the result that's available on the

14 Internet, or I could certainly provide you with a

15 copy. We've done a follow-up investigation at

16 Fort Carson with another brigade where we asked

17 did the same focus group work and also gave them

18 the same surveys. So we're in the process of

19 analyzing that data to have a more robust set, and

20 we'll hopefully have some output there that we can

21 share in a month or so.

22 DR. HOLLOWAY: I think that would

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1 definitely be nice for us to see because this is  
2 really important work that you're doing.  
3 But related to this -- and you mentioned  
4 it a couple of times -- I'm wondering what happens  
5 when these reports come out? So for example, how  
6 would leadership respond to this research that  
7 you've done on the issue of stigma?

8 LTC BELL: Well, I think, you know, as a  
9 group the response is very favorable. The senior  
10 Army leaders that I've worked with, especially for  
11 instance at Fort Carson where we did this study,  
12 the commanding general was just intensely  
13 problem-focused and oriented on fixing this  
14 problem. And during the course of our field  
15 investigation there, which took several months, we  
16 had several in-progress reviews with him. And he  
17 and his team fixed items that we identified at  
18 each in-progress review. So it was not a static  
19 process at all. I think that the Army senior  
20 leadership from the Vice on down is extremely  
21 engaged and has this as one of their top  
22 priorities to address these issues.

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1           Now it's difficult questions and the  
2 data is not always really clear, so I think  
3 there's, you know, definitely a lot of friction  
4 that goes along with making progress. But I think  
5 that in terms of the level of commitment, you  
6 can't question that at all.

7           DR. HOLLOWAY: So what do you think  
8 about the role stigma could, in general -- stigma  
9 reduction -- could play in terms of shifting that  
10 curve that you were mentioning to the left?

11          LTC BELL: I personally think that  
12 stigma reduction could be a powerful part of  
13 moving the curve back to the left. You know, when  
14 we talk about our model, it's really rough at this  
15 point. We have no idea what the relative weight  
16 of any factor in the model is. And quite frankly,  
17 you know, it probably varies quite a bit from  
18 individual to individual. You know, for some  
19 individuals, stigma might be the absolute thing  
20 that's keeping them from getting care. For others  
21 it might be physical barriers, like, you know,  
22 they're just too far away. That's an issue that

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1 we've seen in some of the data coming out of  
2 theater, that depending on -- and this is another  
3 one of those interactions with MOS, you know,  
4 depending on what your MOS is, you may be at a  
5 location where it's more difficult for you to get  
6 mental health care, in addition to being at a  
7 location where it's more likely that you're going  
8 to receive fire and see horrible things. So, you  
9 know, it's a very murky, complicated, type of  
10 issue to sort out, but my feeling is that these  
11 are treatable conditions and there's good  
12 treatment for depression. So -- and some of the  
13 other things that are driving suicides -- so if we  
14 get people to treatment, I think, you know, reduce  
15 the stigma as a population and get people to where  
16 they can get their individual treatment, we can  
17 reduce the risk of these conditions in our  
18 population because, you know -- there's -- as  
19 we're talking about our population risk, if you  
20 think about it, if we have, you know, 1,000 people  
21 in a room with mild depression that's being  
22 treated, we're probably going to have a much

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1 different outcome than if we have a room that's  
2 got, you know, obviously with 1,000 people with  
3 severe depression, or, you know, 900 people with  
4 mild depression that's treated and 100 people with  
5 severe depression that's untreated. So to the  
6 extent that we can break down barriers and remove  
7 stigma, I think that that is productive and is a  
8 strategy that's worth following.

9 DR. HOLLOWAY: Thank you.

10 MG VOLPE: Phil Volpe. Can we go to  
11 slide 8, please? So my question here really has  
12 to do with the Reserves and National Guard. So  
13 this is the Army, U.S. Army Reserves and U.S.  
14 Army National Guard --

15 LTC BELL: Yes, sir.

16 MG VOLPE: -- who are serving on active  
17 duty, who are mobilized in the statistics?

18 LTC BELL: That's correct.

19 MG VOLPE: Do we have any data on  
20 pre-mobilized or demobilized Service members -- is  
21 anyone collecting it and doing epidemiologic  
22 studies and information while they're -- I realize

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1 when they ETS and they're no longer in the  
2 Reserves, we completely lose it, just like we do  
3 for active component when they leave the military  
4 -- but in the demobilized status, but still  
5 members of the U.S. Army Reserve and National  
6 Guard?

7 LTC BELL: Right. That's been a major  
8 thrust of the Task Force is to get better capture  
9 of that data. And that's something that we've  
10 seen a big improvement in in the last year. So  
11 we're starting to bring that data into our data  
12 set and have it available for analysis. If we go  
13 back to the out years, though, we don't have good  
14 capture of that data at all. So it is a gap. And  
15 it's something that's being closed. It's a  
16 recognized priority area.

17 MG VOLPE: I say that -- I only say that  
18 because just for everybody, when a Reserve  
19 component soldier is mobilized, either in the  
20 National Guard or U.S. Army Reserves, of which I  
21 think we've mobilized -- well, don't quote me on  
22 this, over 200,000 over the past eight years or

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1 whatever since OIF and OEF have been going on --  
2 for the most part the vast majority of them,  
3 unless they were wounded, ill, or injured, when  
4 they get back are demobilized within 7 to 10 days?

5 SPEAKER: 30 days.

6 MG VOLPE: 30 days, okay, within 30  
7 days. And so anyone who would then develop  
8 problems, picked up by family members or whenever  
9 they go back to their communities and everything,  
10 they would not be in any of the data you're  
11 presenting essentially is what you're describing.  
12 I know we're cleaning it up and starting to gather  
13 that, but we really have no historical context to  
14 put with what that is.

15 LTC BELL: Not really before 2007-2008  
16 we didn't have good capture of that data. It's  
17 included now, but it's hard to do on one year of  
18 data.

19 MG VOLPE: Okay. Lanny?

20 DR. BERMAN: Two questions if I might.

21 I'm Lanny Berman. Number one: It's clear from  
22 this slide and as well slide number 7 that the

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1 slope of the curve -- I'm sorry -- yeah, that's  
2 it. No, that was correct -- the slope of the  
3 curve increases, give or take in 2004-2005. Slide  
4 number 7 suggests it's OIF and this slide -- I'm  
5 sorry, slide number 20 -- related it to some shift  
6 in military and work stress. And I'm curious,  
7 your hypotheses and/or data that defines what is  
8 different relative to stress, if in deed that is  
9 related. Or what is different in OIF that somehow  
10 might be part of the problem?

11 LTC BELL: Well, if you look at this  
12 temporally, at least at the first cut of analysis,  
13 it seems that the increase in slope is temporally  
14 related to the intensity of combat operations and  
15 also sort of the deployment cycle that we've been  
16 in by that point. Now, we haven't controlled for  
17 a whole lot of factors that need to be looked at,  
18 so you know, I don't want to make the conclusion  
19 today that that's the cause and effect. You know,  
20 I think Dr. Hoge did a good job of explaining why  
21 that's a hypothesis that is worthy of detailed  
22 consideration. But I think that that is one of

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1 the things is, you know, when you start looking at  
2 the time period after 2005-2006 especially that's  
3 when operations in Iraq became very intense. The  
4 insurgency was underway, and then we were in the  
5 surge. It's also when you're starting to get  
6 units that, you know, have been on their second or  
7 third deployment. You know, so I think temporally  
8 there's some striking things that would make you  
9 look that way in terms of combat intensity.

10 In the same Fort Carson EPICON, we did  
11 survey work where we looked at combat intensity.  
12 Now this was self reported, and this was in one  
13 brigade combat team, so I'm not standing here  
14 saying that this is generalizable to the Army or  
15 even to the other units at Fort Carson. But  
16 within that one brigade, there was a pretty  
17 compelling relationship between the level of  
18 combat intensity experienced or reported and other  
19 factors such as aggression, behavioral health  
20 encounters, and substance abuse. So I think that  
21 that's a risk factor that, you know, we need to  
22 pay attention to, and it's something, you know,

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1 really potentially we can target for intervention  
2 because we can tell to a certain extent, you know,  
3 which units have really been beaten up pretty bad  
4 when they're downrange. So, you know, prudently  
5 we could plan to have special levels of resources  
6 or intervention available for those units, and you  
7 know, maybe we could mitigate some of this stress  
8 that accumulates in the unit as a result of the  
9 intense combat exposures.

10 MG VOLPE: Okay.

11 LTC BELL: Dr. Hoge is here now, too, so

12 I know --

13 MG VOLPE: Yeah, can you -- why don't  
14 you have a seat up here. We're going to go right  
15 into the Panel Discussion.

16 LTC BELL: We're going to shift fires to  
17 the Panel.

18 MG VOLPE: Yeah, why don't you shift so  
19 you can have a seat there. That'd be great. Dr.  
20 Bell, Dr. Hoge. Bruce, if you want to fill in for  
21 BG McGuire. You were here the whole time and you  
22 work directly for her.

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1 MR. SHABAZ: I solemnly swear to tell  
2 the truth, the whole truth, and nothing but --

3 MG VOLPE: Yeah, this is not a subpoena!  
4 And we'll go right into Panel -- and then we'll go  
5 ahead and take a break while you guys are here  
6 because I know you need to get back to work. But  
7 Doug -- yeah, questions?

8 DR. BERMAN: I just had a second  
9 question. It's probably very quick. You noted  
10 the gatekeeper programs that the Army has had in  
11 effect for some years now. Any evaluation of  
12 outcomes that you can talk to?

13 LTC BELL: Are you directing that to me  
14 or to Dr. Hoge?

15 DR. BERMAN: I'm happy to direct it  
16 wherever it should be directed, but you're the one  
17 who mentioned it, so you can pass it on if you'd  
18 like.

19 LTC BELL: Do you want to speak to that,  
20 Dr. Hoge?

21 COL(RET) HOGGE: I'm not sure what you're  
22 talking about actually. What is the gatekeeper

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1 program?

2 LTC BELL: Well, the gatekeeper programs

3 are programs like the ACE and the Assist.

4 They're, you know, generally --

5 COL(RET) HOGE: Training focused on the

6 gatekeepers.

7 LTC BELL: Right.

8 DR. BERMAN: So my curiosity is how are

9 you measuring and evaluating the outcomes of the

10 training?

11 COL(RET) HOGE: Being the researcher, the

12 only randomized control trial of any training that

13 I'm aware of is the work that we've done at RAIR

14 on Battlemind, and that was specifically post

15 deployment Battlemind training. And we were

16 looking at a variety of outcomes, you know,

17 depressions -- scores in the depression measure,

18 scores in the PTSD measure, reduction of stigma,

19 changes in behavior, and alcohol-related

20 incidents, and that type of thing. And we -- that

21 paper's just come out. It's just been published

22 and I can provide that for the committee. And

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1 what we found was that the training -- and that  
2 was a single episode of post deployment training,  
3 Battlemind compared with standard stress education  
4 which the Army was using at the time point that we  
5 initiated the study -- and we did show that we  
6 could actually demonstrate statistically  
7 significant benefits, although they were very  
8 small. The effect sizes were very small and only  
9 in those soldiers who had the highest levels of  
10 combat experience. So we have a ways to go in  
11 terms of our training, but it did provide us with  
12 sort of the first indication that training can be  
13 effective in maybe in reducing symptoms and maybe  
14 in changing perceptions of stigma. So we've got a  
15 ways to go.

16 LTC BELL: And I guess one of my points  
17 I was trying to make there is that, that can't be  
18 our only focus in terms of a mitigation strategy.  
19 You know, kind of the assumption is, well, if we  
20 can only identify people that have a problem and  
21 get them to treatment, then, you know,  
22 everything's going to be fine. And that's clearly

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1 not the case. So we have to have a, you know,  
2 multi-layered prevention strategy that, you know,  
3 taxes as a public health problem rather than as a  
4 clinical problem that can be solved with  
5 individual patient accounting.

6 DR. MCKEON: I have two questions, COL  
7 Bell. One is related to mental health diagnosis,  
8 the other to the issue of clustering. On page 16,  
9 slide 16, on mental health diagnoses, I think the  
10 wisdom of your point about not getting entirely on  
11 mental health treatment is kind of underscored by  
12 the figure that 44 percent of the U.S. Army  
13 suicides had outpatient care for some mental  
14 health disorder. Let me ask you about -- in terms  
15 of this data, to what extent does the inpatient  
16 care, the outpatient care, et cetera, to what ways  
17 is it taking place within the military or was this  
18 a past treatment in history that the individual  
19 brought into the Service with them? Is there any  
20 way of teasing that out?

21 LTC BELL: Well, in this data, all the  
22 care that's captured is care that the military

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1 health system has provided. Now, at the different  
2 installations, the distribution of how that care  
3 is provided is very different sometimes. You  
4 know, some locations have very robust behavioral  
5 health resources within the military treatment  
6 facility. You know, a great example of that would  
7 be Walter Reed or Brooke Army Medical Center or,  
8 you know, even some place like Fort Hood that has  
9 an inpatient psych unit. Other places like Fort  
10 Carson don't have inpatient care, so they have to  
11 send a lot of their care out to the network. Now  
12 as long as it's care that the Army has bought and  
13 paid for, we capture that data within this. But  
14 if it's a diagnosis that they had prior to coming  
15 into the Army, the only way we capture it within  
16 our data set is through the suicide event report,  
17 if that's something the individual that filled out  
18 the suicide event report has picked out by  
19 scanning through the individual's clinical  
20 records, so our capturing would be very incomplete  
21 in terms of that outside treatment.

22 The other thing that we don't capture in

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1 this data at all is if the person received  
2 counseling through Army One Source because that's  
3 a confidential treatment stream that's outside of  
4 the military health system.

5 DR. MCKEON: And by Partner In Care --  
6 sorry, this is Richard McKeon -- Partner In Care  
7 physicians prescribing antidepressant, for  
8 example, that would be captured under outpatient  
9 care for any mental health disorder?

10 LTC BELL: Yes, it would. If it's coded  
11 as a mental health diagnosis, then it could  
12 potentially be caught in the data as a mental  
13 health encounter. Now we have the capability to  
14 go in and look -- if the diagnosis came from a  
15 behavioral health clinic because we have, you  
16 know, not only the encounter code, we have the  
17 location code. I can't recall off the top of my  
18 head how it was organized here. The inpatient  
19 care is all going to be obviously diagnoses that  
20 were made by mental healthcare providers.

21 DR. MCKEON: I would make a point that  
22 when you compare it to the national data, at least

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1 my understanding of national data -- this is  
2 Richard McKeon again -- the Army is actually doing  
3 pretty good at getting mental healthcare to  
4 Service members; 44 percent for outpatient mental  
5 healthcare is higher. And when you consider this  
6 is all -- this is recent past history -- that that  
7 looks very well compared to any national data.  
8 For males in the National Violent Death Reporting  
9 System, the number comes out to 28 percent and  
10 from what I've been tracking. So that suggests  
11 that we're not doing so badly in getting  
12 treatment, but it does raise the question of  
13 what's happening in treatment or what doesn't get  
14 responded to are the missing components of the  
15 system and would be reasonable questions based on  
16 this to look into because these numbers are really  
17 pretty, you know, pretty good for treatment  
18 access.

19 LTC BELL: Right, and that -- this is  
20 Mike Bell again -- that is something that we're  
21 interested in following up with time series  
22 analysis to see whether -- you know, for these

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1 individuals that receive treatment, did they get  
2 what would be considered an effective course of  
3 treatment in terms of the number of visits that  
4 would go with a certain diagnosis, and we haven't  
5 gotten to that point in the analysis yet.

6 COL BRADLEY: John Bradley. Mike,  
7 another question for you with regard to this  
8 slide. What is the timeframe that those visits  
9 would have been captured? Is it any history of,  
10 or is it within the past year, related to the  
11 suicide?

12 LTC BELL: In this particular slide,  
13 that would have been I believe any history. We  
14 have analyses that we've done where we look at  
15 whether they were in treatment within the 30- or  
16 90-day period prior to the suicide. If we come  
17 back, I can present that data for you.

18 COL BRADLEY: Thank you. That would be  
19 helpful.

20 DR. JOBES: This is Dave Jobes. I've  
21 been thinking about this in a really simplistic  
22 way with regard to the DoD suicide problem, which

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1 has emerged today as a problem primarily focused  
2 with the Army and the Marines, and primarily a  
3 problem that's occurred over these last few years.  
4 And I was really thinking about Dr. Hoge's notion  
5 about dwell time. The Marine Corps has a  
6 different length of deployment -- I'm thinking  
7 about the Devil's aspect of this -- the Marine  
8 Corps has a different length of deployment, right,  
9 than the Army does? And also are the dwell times  
10 comparable? And is the data such that you could  
11 actually look at those responses? And are there  
12 changes in deployment lengths or dwell times that  
13 could ever be statistically tracked or is that  
14 just overly simplistic?

15 COL(RET) HOGE: The confounder again is  
16 looking at dwell time from a post deployment  
17 stand, you know, at the post deployment period  
18 where you're confounded by attrition. Our MHATs  
19 have focused mostly on Army units. We have had  
20 some Marine involvement in MHATs. I know -- I  
21 believe the Navy's conducting their own MHAT now.  
22 In prior years, but in the most recent year where

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1 we've -- and that report will be coming out at the  
2 end of the week -- where we've done the dwell time  
3 modeling, where we've taken all multiple  
4 deployers, actually looked at what their dwell  
5 time was. It was only an Army sample, so that's a  
6 very good question and it would be, you know, very  
7 worth looking at.

8 DR. JOBES: Because the Marine Corps is  
9 a little bit lower in their rate than the Army,  
10 right?

11 COL(RET) HOGE: They have shorter  
12 deployments, but I think they're just as --

13 **SPEAKER:** The dwell times are shorter  
14 also, sir. COL(RET) HOGE: Is it?

15 DR. JOBES: The dwell time's shorter as  
16 well.

17 **SPEAKER:** The deployments are shorter  
18 and dwell time is shorter also.

19 DR. JOBES: I'm just sort of fascinated  
20 by that because if -- I mean, I don't know  
21 anything about the operation side of it and I'm  
22 sure those are huge considerations -- but, you

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1 know, if that is something that could actually be  
2 studied -- and maybe it's impossible to study  
3 because of the attrition issue -- that would seem  
4 to me to be huge. That if it's a matter -- and  
5 again, I'm sure there are real reality-based  
6 problems or challenges that come after that, but  
7 if there can be tweaking of the deployment time or  
8 dwell time, that could actually have an impact. I  
9 think that would be incredible.

10 COL(RET) HOGE: Agreed.

11 LTC BELL: This is Mike Bell again.

12 Another problem that's related to that in terms of  
13 the analysis is, you know, dwell time is based on  
14 how long it's been since you were there. Okay?  
15 Now a big part of the stress around the ARFORGEN  
16 cycle and deployment is what's coming up.

17 DR. JOBES: The what cycle?

18 LTC BELL: The Army Force Generation  
19 Cycle, the ARFORGEN cycle.

20 SPEAKER: It's just another word for  
21 deployment cycle.

22 LTC BELL: Yeah, the deployment cycle.

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1 So a lot of the stress is built -- is derived  
2 based on what's coming up. And looking at dwell  
3 time doesn't give us a good indicator of where  
4 somebody is in terms of their next deployment.  
5 There's not really a good metric that we have  
6 right now for looking at aggregate data and  
7 seeing, you know, where an individual is with  
8 respect to their next deployment unless we, you  
9 know, tracked it down sort of retrospectively.  
10 Okay, this person has committed suicide and they  
11 were two weeks away from deployment. You know,  
12 there's not a countdown clock, if you will, that  
13 keeps track of how far somebody is from their next  
14 deployment. It's just how far they are from their  
15 last. So we don't have really the whole picture  
16 available for review, unless maybe Col (Ret) Hoge  
17 has figured out some way to track that better than  
18 we have.

19 DR. JOBES: I'm sort of preoccupied with  
20 the traumatology literature where the dose  
21 matters. And that when you look at trauma or  
22 sexual abuse, that type of thing, that the

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1 behaviors, the duration, the intensity, there's  
2 lots of details we don't want to get into, it  
3 matters. It makes me wonder if -- this is again,  
4 too simplistic, I just don't know -- but the dose  
5 aspect of this is relevant. And then would there  
6 be any consideration in inoculation-kind of model  
7 during the dwell time, you know, that -- about  
8 people habituating or having lower/higher  
9 thresholds or getting, you know, being overly  
10 sensitized. There could be exposure models, it  
11 seems to me, that you could do proactively  
12 pre-deployment or not? Is that right?

13 COL(RET) HOGE: Yeah, I'm not sure exactly  
14 what that means, exposure models pre-deployment?

15 DR. JOBES: Well, like you do prolonged  
16 exposure or a treatment of PTSD, could there be  
17 inoculation-kind of model that would prepare  
18 somebody to go back into theater?

19 COL(RET) HOGE: So that's -- I guess another  
20 way to ask the question of how you improve  
21 resiliency or how do you train soldiers to be  
22 resilient, to be more resilient? And there's

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1 certainly an enormous focus right now on exactly  
2 that question. And one of the models that's being  
3 looked at a lot is the positive psychology model  
4 and Seligman's work and that's actually being  
5 crafted into the new training program, the  
6 Comprehensive Soldier Fitness. Battlemind is  
7 being merged into that as well.

8 DR. JOBES: So that's --

9 COL(RET) HOGE: Right. Now, do we really know  
10 how to make soldiers more resilient? No, I mean we  
11 don't -- I don't think -- I think we've got --  
12 there's a lot of good ideas. We have a lot of --  
13 there's evidence from the positive psychology  
14 literature and the occupational psychology literature  
15 that can be drawn from. There's evidence from the  
16 Battlemind training work that we've done that can be  
17 drawn from, but we really, you know, I don't think we  
18 have the answers yet per se as to how, you know,  
19 clearly how to make someone more resilient to a  
20 horrific or catastrophic event in combat. We can, you  
21 know, there's no doubt that tough realistic training  
22 prepares soldiers, you know, to fall back on their

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1 training in combat during very touch situations. You  
2 know, if they're able to stay focused and do what  
3 they're trained to do, then they'll be successful in  
4 combat and then they'll be more successful -- the  
5 better they're trained, the more successful. But will  
6 they be, you know, more resilient if they lose their  
7 buddy, I'm not so sure. I don't think so.

8 DR. JOBES: I'm also thinking from a  
9 treatment research standpoint because there's a  
10 lot of emphasis for treatment researchers to focus  
11 on coping sensitization or rehearsal or role plays  
12 or practicing coping. And it --

13 COL(RET) HOGE: I think that makes sense for  
14 sort of general -- I mean, the more that you can  
15 prepare someone for what to expect in the combat  
16 environment, the better off they'll be. We've  
17 seen, for instance, in our earlier MHATs when  
18 we've compared transport and support units with  
19 infantry units. Sometimes we've seen higher rates  
20 of mental health problems in the transport and  
21 support units despite much lower combat intensity  
22 because the cohesion was lower, the leadership --

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1 the perceptions of leadership -- were not as high.  
2 It was the -- and the perception of the individual  
3 soldier's perception of how well trained they were  
4 to handle significant events, like ambushes, was  
5 much lower. They were less -- they felt less  
6 prepared, and so there was more anxiety and that  
7 actually contributed to higher rates of PTSD  
8 despite lower combat intensity. So these are  
9 important. Very good.

10 LTC BELL: And that was something that I  
11 wanted to highlight as well -- this is Mike Bell.  
12 You know, we do not really have really good,  
13 effective, training programs in place that are  
14 proven to increase individual resiliency, but the  
15 Army has a long history of increasing unit  
16 resiliency or unit cohesion. And, you know, if  
17 you look at that model that I was describing  
18 earlier where, you know, you have the individual's  
19 risk factors that are amplified or attenuated by  
20 unit environmental factors, to the extent that we  
21 can do things to increase unit cohesion, I think  
22 we're going to have an impact on individual

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1 outcomes such as suicide. And if you think about  
2 the way our deployment cycle is structured right  
3 now, there are a lot of major hits on unit  
4 cohesion that occur almost immediately after units  
5 come back from war. And that may be a potential  
6 area that is target for improvement or maybe it's  
7 a vulnerability we need to address depending on  
8 how you want to, you know, look at it.

9 REVEREND CERTAIN: This is Robert  
10 Certain on the phone.

11 MG VOLPE: Go ahead, Reverend.

12 REVEREND CERTAIN: Hey guys. My own  
13 experience (inaudible)

14 MG VOLPE: You're breaking up, and you  
15 fell off.

16 REVEREND CERTAIN: Okay. Is that  
17 better?

18 MG VOLPE: Now it is, yeah. If you  
19 could start over, that would be great.

20 REVEREND CERTAIN: (inaudible)

21 MG VOLPE: Well, we can't hear you.

22 SPEAKER: Sir, can you get closer to the

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1 phone?

2 REVEREND CERTAIN: I've got the phone

3 right up next to me, but (inaudible)

4 MG VOLPE: We're not picking you up.

5 REVEREND CERTAIN: I have feedback on

6 the phone, but the point I was making concerning

7 Vietnam. The aircrews had (inaudible) part of

8 survival (inaudible). So it was a fairly short

9 but clearly intense bit of resilience training and

10 it plays into the conversation we're having right

11 now.

12 MG VOLPE: Thanks, Reverend, we heard

13 you loud and clear!

14 REVEREND CERTAIN: Oh, good.

15 MG VOLPE: Yeah, it sort of related to

16 SEAL training in preparation of people for those

17 stressful human conditions of a battlefield as far

18 as building resiliency and their ability to think

19 through the problem-solving when they're in the

20 real situation through that training. Is that

21 essentially what you were getting across?

22 REVEREND CERTAIN: Right. Well, it was

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1 both unit and individuals. Frequently, aircrews  
2 were clearly (inaudible) when they got shot down.  
3 (Inaudible) isolation for much of the time. But  
4 (inaudible) part of it (inaudible) military  
5 cohesion (inaudible)

6 MG VOLPE: You're breaking up again.

7 REVEREND CERTAIN: Yeah, I know. I'm  
8 hearing myself talking about a half second after  
9 I've spoken. Maybe I'll just go back to being  
10 quiet again!

11 MG VOLPE: Okay. I think we got your  
12 point, but, you know, if you want to just go ahead  
13 and e-mail -- summarize that and e-mail us, we'll  
14 include it in the minutes. Thanks. Appreciate  
15 that.

16 This is Phil Volpe. I think a lot of  
17 what we were discussing -- we used to call it in  
18 the Army -- the term "tough realistic training"  
19 was always used in a lot of realistic training in  
20 trying to, in a non -- well, I guess it was  
21 threatening -- in a non-life threatening  
22 situation, try to meet the same demands as if you

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1 were in a life- threatening situation. So you  
2 could experience the problem solving and the  
3 emotions, the physical and emotional demands on an  
4 individual when they're going through that. I  
5 mean, we used to do a significant amount of  
6 training, even to the point where if someone made  
7 an error and Service members were killed, like at  
8 JRTC or whatever where you would go through  
9 commanders writing a letter home to the spouse or  
10 the parents so they could physically, you know, go  
11 through that, and doing a memorial ceremony and  
12 those kinds of things so that the unit could  
13 realize the actual emotions -- as close as  
14 possible to the real thing. Questions?

15 DR. LITTS: Yeah, I'd just like to thank  
16 you all for the kind of public health framework  
17 that you kind of came to us today with. I think  
18 those things have been very helpful.

19 I think over the course of the times  
20 that we've met, a lot of times we've looked at  
21 slides with just numerators on them. Sometimes  
22 we've looked at slides with numerators and

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1 denominators, but the theme today has been that so  
2 much of this is unadjusted for even age, sex, and  
3 race, that it's very hard to know what to make of  
4 it. It seems like some of that adjusting could be  
5 done. It's just perhaps a matter of having the  
6 people to do it. Are there other barriers than  
7 that, to that? It seems like -- it seems to me  
8 that it would be really helpful if we could have  
9 some more of this analysis done of data that you  
10 have. Is there anything that we can do or that  
11 can be done to get the pace of this analysis maybe  
12 accelerated a bit so that we might see this?

13 MG VOLPE: You represent the  
14 normalization of the data, everything reported in  
15 rates, and stuff normalized.

16 LTC BELL: We recognize that the data  
17 that we have currently presented is rather  
18 unsatisfying on a number of levels. And our next  
19 report, which is due out this month, should  
20 address several of those concerns.

21 One area that we've had a great deal of  
22 difficulty in is getting adequate comparison data,

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1 and we're close to having a good comparison data  
2 set for our registry. It was held up for several  
3 months because of a lot of issues around data use  
4 disagreements and privacy concerns. But I think  
5 we've resolved those and there should be some  
6 pretty productive analysis that comes out now that  
7 we actually have data that's suitable for doing,  
8 you know, beyond rudimentary epidemiology on.

9 So I share your frustration, Dr. Litts,  
10 and I certainly hate to stand up and, you know,  
11 present a bunch of numerator data. And I  
12 appreciate the offer for help and we're certainly  
13 happy to work together with our colleagues at  
14 other institutions. We're working very closely  
15 with the STAR Study and hopefully we'll have some  
16 fruitful results in the short term.

17 MG VOLPE: This is Phil Volpe. I think  
18 basically what -- I mean, we've established the  
19 Defense Center of Excellence. We've established  
20 the SPARRC, and emphasize that. We've established  
21 the DODSER. And we've established all of these  
22 types of things really in the last couple of

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1 years, tying -- recognizing this rising rate and  
2 made the moves to establish these things, and I  
3 don't believe we've matured it at enough level in  
4 collecting data and have told people to report and  
5 collect it in a synergistic way throughout the  
6 enterprise yet through that. And I just wanted to  
7 throw that out so -- I think some of it you'll be  
8 able to get, but I'm not sure that you're going to  
9 get the level in every aspect that you may be  
10 thinking about. And I'll just throw that out  
11 there, unless you guys think that -- or maybe we  
12 should just come up with a list of questions of  
13 what it is we're looking for, and then see if they  
14 can go through the data search, data mining, that  
15 they currently have to put that together. But I  
16 don't know what that ability is.

17 DR. LITTS: It just seems like some of  
18 the key questions could be answered with kind of  
19 pretty basic even adjusting.

20 COL(RET) HOGE: I agree. It's not hard to  
21 adjust for demographics.

22 DR. LITTS: It's just a matter of

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1 putting enough staffing against it, I think, to  
2 get it done.

3 MG VOLPE: The occupational specialties  
4 is one that we just need to know. I mean, we --  
5 that one I would think is the -- would probably be  
6 the highest priority one is to get to that level,  
7 and I only say that because that's one of the  
8 major functions of the Task Force here is to  
9 determine specific occupational hazards  
10 associated, you know, for the risk of suicide.

11 DR. LITTS: And not at all to take away  
12 from the great work that you've done -- I'm just  
13 thinking about the H1N1 inoculations, you know,  
14 and every public health officer in the country --  
15 from the country level, city level, state -- I  
16 mean, everyone was totally focused on getting  
17 these inoculations out. If we had that kind of  
18 focus here, we would have slides with all the  
19 adjusting done and, you know -- but thank you for  
20 what you presented today.

21 MR. SHABAZ: Sir, this is Bruce Shabaz  
22 from the Army Suicide Prevention Task Force. Not

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1 to try to provide excuses, but I'd like to say  
2 that my job, my full-time job, is not the Army  
3 Suicide Prevention Task Force. I was hired by the  
4 Army for a very specific job and have spent eight  
5 months working on this data. We have continued to  
6 slice the data. We are getting to the point that  
7 you're describing. We have worked very hard. I'm  
8 having a hard time remembering my last day off,  
9 working very hard.

10 MG VOLPE: White space.

11 MR. SHABAZ: And I can assure you that  
12 the Vice Chief of Staff of the Army's appetite  
13 exceeds the sum appetite of everyone sitting at  
14 this table for this data. We work it. COL Bell  
15 and his folks receive an unending stream of  
16 e-mails. Every time we answer a question, it  
17 opens the door for five more questions, as you  
18 know. And so we're --

19 COL(RET) HOGE: It's part of the reason why  
20 we don't have the time to do the adjustments, not  
21 just -- that was a joke!

22 MR. SHABAZ: We're getting there. It

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1 has been a far more painful process for my senior  
2 leadership to get where we are today, but if you  
3 compared that to where we were three months ago  
4 and six months ago, it is a world of difference as  
5 MG Volpe mentioned. So we are getting there.

6 CDR WERBEL: This is Aaron Werbel.

7 MG VOLPE: Okay. Last two questions.

8 Aaron and Dr. Holloway.

9 CDR WERBEL: Thank you, sir. You know,  
10 this is not for the Army, but you're the one  
11 sitting in front of us at this moment. I think  
12 all of the Services know a lot more about their  
13 data and suicides than we did even a year ago, let  
14 alone 10 years ago, a lot more. What I think you  
15 can really help this Task Force in, in terms of  
16 our mission of reporting back to the Secretary of  
17 Defense and Congress, is, you know, what are --  
18 why do we not have -- in any of the Services, not  
19 just the Army -- the data sliced and diced and  
20 analyzed in the way that Dr. Litts was talking  
21 about? And maybe it is as simple as resources and  
22 staffing. And if there were more staffing and

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1 more dollars, then the analysis would be done  
2 already. Because when it comes to competing  
3 priorities, you know, if the Vice Chief -- if this  
4 is the number one priority, then it'd be done.  
5 But there's always competing priorities of course.  
6 So maybe it really is a staffing issue, and I  
7 would ask you to tell us because that's the sort  
8 of thing that we can put in our recommendations if  
9 the question is for -- and again, I would open  
10 this up for the public record for all the  
11 Services, although, you know, you're here today.  
12 Is that what the issue is? And would more  
13 staffing get us the answers quicker? And then be  
14 able to analyze it for more effective prevention  
15 programs?

16 MR. SHABAZ: This is Bruce Shabaz again  
17 from the Suicide Prevention Task Force. The Army  
18 committed \$50 million dollars to the NIMH study.  
19 Resources are available and being put against it.  
20 At the risk of overusing an analogy, nine women  
21 cannot have a baby in one month. We can throw  
22 more staffing at it immediately, but we need to

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1 have this as a sustained effort, and that's what  
2 we've built over the last several months is a  
3 sustainable effort and a process for us to gather  
4 the information, analyze the information, and put  
5 the information out.

6 CDR WERBEL: Okay. Then I guess I'll  
7 follow up that then, because \$50 million is a  
8 great sum of money. It's over six years now that  
9 that study will be going on. But the question is,  
10 you know, what everyone has agreed is a pretty  
11 simple analysis to get done hasn't gotten done  
12 yet. And that shouldn't take five years or a year  
13 or the \$50 million. And again, this is not just  
14 you guys, you know, all the Services have the  
15 exact same issue right now that there's questions  
16 that would be pretty simple to answer that just  
17 don't get answered. I think it has to do with  
18 staffing and resources. I don't know.

19 COL(RET) HOGE: Yeah, our program -- this is  
20 Charles Hoge -- our program at RAIR, psych  
21 resiliency research program, behavioral health  
22 research program, has really not focused on

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1 suicide. Suicide's been a very minor component of  
2 our program. It's primarily been focused on PTSD,  
3 MTBI, there's sleep deprivation research going on  
4 there, there's the MHATs missions, and a lot  
5 focused on, you know, the utility of screening,  
6 the validity of screening instruments for PTSD and  
7 that sort of thing. We really haven't done much  
8 research. I showed some of the basic, the  
9 baseline information that we collected several  
10 years ago from the prior decade, but that's not,  
11 you know, not been a major area of research.

12 I believe that MRMC has now created a  
13 new task area for suicide that's as of this fiscal  
14 year and Carl Castro would be the point of contact  
15 for that. We have a little piece of that, very  
16 small piece, but Millennium Cohort has a larger  
17 piece of that. And that's where they're doing  
18 their death registry linkage with their 20- year  
19 cohort, which started actually in 2000 or 2001, so  
20 it was pre-war. And they now have several cohorts  
21 of deployed individuals, some with multiple  
22 deployments, and so that's a very promising data

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1 set to be able to answer some of these questions.  
2 Also the Reserve and National Guard versus active  
3 component questions and it's tri-Service so it's  
4 got a lot of advantages. I don't know if the  
5 number of suicides in that particular cohort is  
6 going to be enough to be able, you know, is going  
7 to have the sample size to do everything that they  
8 want to do with it, but that's a very promising  
9 area of research.

10 Your group at CHPPM is, you know,  
11 relatively new. I mean it stood up, what, about  
12 three years ago?

13 LTC BELL: No, it stood up less than a  
14 year, you know -- in terms of having more than me  
15 sitting at a desk. I got there about 16 months  
16 ago. We hired our first people in September of  
17 last year.

18 COL(RET) HOGE: This is a very -- this is a  
19 tremendous step forward because it really  
20 acknowledges that behavioral health is a very  
21 integral part of public health.

22 LTC BELL: Right.

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1 COL(RET) HOGGE: So that was a huge, huge, step  
2 forward.

3 LTC BELL: Big data quality issues and  
4 big data access issues.

5 MG VOLPE: Phil Volpe here. I mean I  
6 think the point is what I stated before, that  
7 these are all relatively new. They need time to  
8 grow. We're moving in the right direction, but at  
9 the same time, do not be afraid to tell us if  
10 there's a better way for you to get the  
11 information. If you need us to make  
12 recommendations on reorganization, priority,  
13 resources, and those kinds of things because this  
14 Task Force can do that, we're willing to do that.  
15 That would then help you produce what needs to be  
16 done, that we can make a difference and save lives  
17 in the future. I mean, that's what it's really  
18 all about. So, last question, Dr. Holloway.

19 DR. HOLLOWAY: Marjan Holloway. Thank  
20 you, all of you, for your presentations. My  
21 question is actually not focusing on the research  
22 that you presented. I was more interested to get

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1 your perspective on the issue of resilience and  
2 this term "resilience" that's commonly used in the  
3 military and its potential implications in terms  
4 of stigma reduction and mental healthcare.

5 Now my area of specialty is cognitive  
6 behavioral therapy, as some of you know. And one  
7 of the common core beliefs that often comes up in  
8 individuals who are suicidal is that these  
9 individuals have a tendency to believe that, "I'm  
10 a failure," "I'm weak," "I'm incompetent and  
11 helpless." So I just wondering, what are your  
12 thoughts about the usage of this term "resilience"  
13 and potential negative implications associated  
14 with it in terms of our efforts or DoD's efforts  
15 in terms of trying to relieve stigma?

16 COL(RET) HOGE: Negative implications in  
17 terms of what? How do you see that?

18 DR. HOLLOWAY: That if you want me to be  
19 a resilient soldier; that means I'm not good  
20 enough, I'm flawed. And that, you know, if I do  
21 come out and say that I have PTSD or depression or  
22 have thoughts about suicide, that I would be

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1 considered by my peers and my commander as  
2 somebody who's weak.

3 COL(RET) HOGE: Yeah, that's -- I've  
4 struggled personally with the question of what is  
5 resilience, and I think we as a field have. And  
6 there's -- and you can define resilience as the  
7 absence of clinical disease, but it's not a good  
8 definition as you just pointed out. And you can  
9 define resilience in terms of growth, and there's  
10 a lot of attention now on post traumatic growth  
11 and there's literature that supports that focus.

12 And there is, I think, maybe sometimes the  
13 perception that it's either-or. You know, you  
14 either grow from your traumatic or combat  
15 experiences or you develop PTSD. And that's just  
16 an absolutely, you know, inappropriate approach or  
17 thinking because it's not a dichotomy. And PTSD  
18 is also -- is not a, you know, it's not a  
19 disorder. It's a disorder from one perspective,  
20 it's a -- but every symptom, what we call a  
21 symptom of PTSD, is actually a beneficial adaptive  
22 function in combat, every single one of them --

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1 hyper-vigilance, shutting down your emotion, you  
2 know, even nightmares is part of the  
3 hyper-vigilant process. It's related  
4 physiologically to being physiologically revved  
5 up. You need that in combat. So when we talk  
6 about -- when we -- and there is a risk of labels.  
7 So, you know, when, you know, individuals -- I  
8 think that some day we may get to the point where  
9 we can think of some of these post combat  
10 reactions as normal, physiological processes that  
11 individuals go through that are adaptive, that  
12 also may require treatment, but are not  
13 necessarily a, you know, disorder and certainly  
14 should not lead to stigmatization for it. And I  
15 think we have a long way to go in that regard. I  
16 don't know if I answered the question, but --

17 DR. HOLLOWAY: No, you did. Thank you  
18 so much.

19 MG VOLPE: Okay. Dr. Bell, thank you  
20 very much for the presentation. And all three of  
21 you, thank you very much for the Panel Discussion  
22 and being candid with us on your response and

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1 sharing of information that you have. Appreciate  
2 it very much.

3 We're going to go ahead and take a 10  
4 minute break and then reconvene here in 10  
5 minutes.

6 COL MCPHERSON: Ladies and gentlemen, if  
7 we could be seated, please. Thank you everyone.  
8 This afternoon on our agenda is a discussion with  
9 Service members, three young ladies who have  
10 attempted suicide and are willing to share their  
11 stories with us. I'll provide a brief description  
12 of each of the ladies, and then pass the floor  
13 over to them.

14 CPT Emily Stehr is an orthopedic  
15 physical therapist currently serving at Fort Drum,  
16 New York. She also serves as the Assistant Chief  
17 of Physical Therapy there. She received her  
18 bachelor of science in health sciences and master  
19 of physical therapy from the University of  
20 Scranton, Scranton, Pennsylvania. She is  
21 currently working on her doctorate of physical  
22 therapy at the same institution. She served in

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1 Operation Iraqi Freedom from 2007 to 2009 with the  
2 2nd Stryker Cavalry Regiment in Vilseck, Germany,  
3 as the regimental physical therapist from August  
4 2007 to October 2008. She is a suicide survivor.

5 Cpl. Kaitlyn Scarboro-Vinklarek has  
6 served five years in the Marine Corps as a combat  
7 correspondent. She is currently stationed at  
8 Headquarters Marine Corps, Henderson Hall, as an  
9 office automation clerk for S-6 Communications  
10 Office. She enlisted in the Marine Corps after  
11 her high school graduation in El Paso, Texas, in  
12 2004. She has a two-year-old son, and she is a  
13 suicide survivor.

14 A1C Taylor Yager is a military justice  
15 paralegal at the Office of the Staff Judge  
16 Advocate, 82nd Training Wing, Air Education and  
17 Training Command, Sheppard Air Force Base, Texas.  
18 She's responsible for processing court martial  
19 cases, assisting trial counsel with case  
20 preparation, and advising commanders, first  
21 sergeants, and supervisors on administrative and  
22 judicial matters relating to the military justice

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1 system in one of the busiest wing- level offices  
2 in the Air Force. ALC Yager is from Sutter,  
3 California. She enlisted in the Air Force in July  
4 of 2007 after attending a year of college at the  
5 University of Nevada in Reno on a rifle  
6 scholarship. She is a suicide survivor.

7 Ladies, CPT Stehr.

8 CPT STEHR: Hello. My name is CPT  
9 Stehr. Thanks for having me here today, MG Volpe  
10 and everybody else. I did write some thoughts  
11 down because that's why you all asked me to come.  
12 So I thought I'd maximize my opportunity. So I'm  
13 going to read. So I apologize if it gets boring  
14 or whatever.

15 So what is suicide? The Merriam-Webster  
16 Dictionary defines suicide as follows: "The act  
17 or instance of taking one's own life voluntarily  
18 and intentionally."

19 I am by trade an orthopedic physical  
20 therapist and a U.S. Army officer. I am also a  
21 suicide survivor. I have a history of anxiety and  
22 depression, but I've never been suicidal. I

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1 deployed to Iraq in August 2007 and spent 15  
2 months with the 2nd Stryker Cavalry Regiment,  
3 redeployed in October 2008, expecting to return to  
4 my normal neurotic self. I waited for the return  
5 of my former temperament, but it was lost.

6 In December 2008, I went home to  
7 Pennsylvania to spend time with my family. I was  
8 jittery around crowds, spastic to loud noises. I  
9 always wanted my back to the wall in case of  
10 attack. I took my cousin's dog for a walk and  
11 started noticing that I envied the bodies in the  
12 Church cemetery near my parents' home. They had  
13 peace and quiet, and I envied that. This became a  
14 craving that I could no longer ignore.

15 As December turned to January, I started  
16 to fixate on death, especially my own death. I  
17 would think of different ways to kill myself. My  
18 husband and I had a conflict, and I told him  
19 truthfully that, "If you leave me, I will kill  
20 myself," and I meant it.

21 February, on a death anniversary, I  
22 slipped under a shroud of suicide. I told my

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1 husband and my family, and promised not to do  
2 anything drastic and stayed away from knives --  
3 evidently my choice of self termination. The  
4 anniversary passed, and my suicidal ideation  
5 lessened, and I thought the worst was over. But I  
6 was wrong. I was wrong.

7 A few weeks later, on a day that is not  
8 a death anniversary, I read an e-mail from a  
9 co-worker describing how a female medic had died  
10 from shrapnel cutting a major artery in her neck.  
11 That for me was the straw that broke the camel's  
12 back. I didn't even know the girl, but I was  
13 done. No more life. No more pain. There is no  
14 hope. Can't do this anymore. I give up. I  
15 surrender. And I just want to read a quote by  
16 Matt Harmon. "Suicide is the remedy of pain."  
17 Here's another quote, too, by Clifford Odets. "If  
18 they tell you she died of sleeping pills, you must  
19 know that she died of a wasting grief of a slow  
20 bleeding of the soul."

21 Suicide is a disease of the mind that  
22 can be equated to cancer. Every cancer has a

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1 tumor. I think that for lots of folks debating  
2 suicide, their suicidal ideation has a tumor or a  
3 source. Suicide is insidious. It creeps into the  
4 mind slowly but thoroughly. It starts to alter  
5 the rules of the effective universe. Those in the  
6 black hole or the land of suicide or the vortex of  
7 the shroud of suicide know what I'm talking about.  
8 Rational, healthy people listen to classes about  
9 suicide prevention and seem to totally understand.  
10 I sat through suicide prevention classes and I  
11 laughed. I was the alien in the room. Those  
12 normal societal rules didn't apply to my reality.  
13 I was starting to fade away. I was starting to  
14 disappear.

15 The turning point for me was talking to  
16 good friends. Their kids are like pseudo kids to  
17 me. I've held them for years. My friends said  
18 that if I committed suicide, they would tell their  
19 kids when they were age appropriate. "Emily left  
20 us early. She killed herself." I remember when I  
21 lost a patient when he killed himself in Iraq, I  
22 was upset, but I neglected to recognize how my

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1 death would affect others. Those thoughts didn't  
2 penetrate the shroud of my suicidality. But one  
3 thing that made it through the suicide shroud was  
4 understanding what the pain of my suicide would  
5 mean to those two little ones. I was unwilling to  
6 hurt them like that and that saved me. Then Peter  
7 Green says, "Has anyone who has been close to  
8 someone that has committed suicide knows, there is  
9 no other pain like that after the incident."  
10 Alison Wertheimer says, "In most cases suicide is  
11 a solitary event, and yet it has often  
12 far-reaching repercussions for many others. It is  
13 rather like throwing a stone into a pond. The  
14 ripples spread and spread." And Phil Donahue,  
15 "Suicide is a permanent solution to a temporary  
16 problem."

17       So I decided not to kill myself. So  
18 what happens now? I ended up in the Landstuhl  
19 inpatient psych ward, stayed there for about a  
20 week. In the beginning I thought maybe killing  
21 myself was the right answer; however,  
22 transformation occurred in those sterile, militant

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1 halls. I walked in consumed with my own death,  
2 and I walked out determined to live.  
3 I learned that I was sick, ill, but not  
4 crazy, weak, or defective. My mind doesn't work  
5 like other minds. Mine is unique. It's not  
6 better or worse; it's just different. People with  
7 cancer don't feel guilty that they have cancer.  
8 They fight the disease. That's what I decided to  
9 do; fight the disease. Suicide is not a terminal  
10 illness; it is treatable.  
11 Through group therapy and individual  
12 appointments, I recognized that my depression was  
13 trapped -- anger about the repercussions of war.  
14 I didn't realize how angry I was, how much pain I  
15 was in, and how exhausted I was. I recognized the  
16 anger. I recognized the pain. I started sleeping  
17 better because of medication I was taking. The  
18 nightmares abated, and I no longer feared the  
19 demons of my mind that nighttime revealed. I  
20 learned that suicide is a maladaptive, coping  
21 mechanism for pain. Pain and anger was the source  
22 of my suicidality, but they can be expressed with

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1 and dealt with. Through therapy, medication, and  
2 self empowerment, I could diffuse this anger and  
3 pain that were fueling my suicidal affliction.  
4 I still have episodes on death  
5 anniversaries, but I understand that this is a  
6 symptom of the disease. I recognized that these  
7 thoughts of self injury and self termination are  
8 cancerous lies, masking the pain and the anger. I  
9 recognized the pain and the anger instead of  
10 fixating on the death thoughts. I'm better able  
11 to cope, and I actually feel good. I never  
12 thought I would feel better. I thought suicide  
13 was terminal, thought my situation was terminal, I  
14 thought I was terminal. I was wrong. And here's  
15 another quote. "Here in the bathroom with me are  
16 razor blades. Here is iodine to drink. Here are  
17 sleeping pills to swallow. You have a choice.  
18 Every breath is a choice. Every minute is a  
19 choice. To be or not to be. Every time you don't  
20 throw yourself down the stairs, that's a choice.  
21 Every time you don't crash your car, you  
22 re-enlist." And that's by Chuck Palahniuk -- I

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1 think I pronounced that wrong -- So I chose to  
2 say, "So long as I have breath in my lungs, I have  
3 a purpose." There is anger and pain in this  
4 world, but there is also hope. There are things  
5 here worth staying and fighting for. For me  
6 suicide prevention is a reason for me to stay, to  
7 try to help those who are self terminal, to shout  
8 to them through their shrouds that there is help  
9 and hope. You can survive and thrive. It's not  
10 an easy choice, but when you are contemplating  
11 suicide, easy is not a word that applies to  
12 everyday existence. Easy left the building a long  
13 time ago.

14 So I got out of the hospital and quickly  
15 encountered the stigma. Earl Groman says,  
16 "Suicide is a whispered word, inappropriate for  
17 polite company. Family and friends often pretend.  
18 They do not hear the word's dreaded sound even  
19 when it is uttered, for suicide is a taboo subject  
20 that stigmatizes not only the victim, but the  
21 survivors as well." So people came up to me and  
22 whispered that they were glad I was out of the

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1 hospital for my "episode." No one would say the  
2 "s" word. I finally just started saying it out  
3 loud. "I was in the hospital for suicide ideation  
4 and plan. It's my reality. It's the truth. I've  
5 had a really bad case of suiciditis -- that's what  
6 I call it -- but I persevered and am in  
7 remission."

8 I had too many patients going through  
9 the same thing, but unwilling to recognize the  
10 problem and get treatment because of the stigma.  
11 These patients weren't necessarily suicidal, maybe  
12 just angry or grieving in maladaptive ways. But  
13 they can't be the weak link. The stigma tells us  
14 that people with mental health problems are crazy  
15 or weak or defective. I've been told that I am a  
16 less quality person because I've had suiciditis.  
17 I've been told I'm a bad Christian because I've  
18 had suiciditis. I've been forbidden to talk about  
19 my experience for fear of vocational retribution.  
20 These are toxic lies by our culture. The truth  
21 is this: I am competent, strong, and mental  
22 health issues that are in remission because I have

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1 taken steps to recovery. Suicide is not weakness.  
2 Suicide is not craziness. Suicide is a disease.  
3 The stigma that people seeking mental health  
4 treatment are weak and crazy doesn't only apply to  
5 the suicidal, but to everyone who has experienced  
6 the emotional trauma of war. We have people  
7 walking among us who are afraid to talk about  
8 their anger when their friend died, or how sad  
9 they are because they accidentally killed a child.  
10 These people aren't out and out trying to kill  
11 themselves, but they are embracing other  
12 maladaptive behaviors -- alcoholism, drug use,  
13 gambling, spousal abuse, or their coping  
14 strategies.  
15 Our current culture encourages shame and  
16 guilt for emotional injuries. If someone with  
17 emotional injuries gets treatment, they are weak,  
18 they are crazy, they are less-quality individuals,  
19 they are bad humans. The time has come for the  
20 culture to change. Emotional injuries are as  
21 legitimate as physical injuries. They are just  
22 invisible.

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1           When our soldiers, Marines, airmen, and  
2 sailors tend to their emotional injuries through  
3 treatment, as simple as talking to a buddy or as  
4 complex as inpatient psych hospitalization, they  
5 are not weak or crazy or defective or bad. They  
6 are humans who are in pain and who are strong and  
7 competent and equally important and make vital  
8 contributions to our society. Taking care of  
9 emotional injuries enhances our ability to achieve  
10 the objective and helps our Service members and  
11 their families live better lives. And this is a  
12 quote from Judy Collins, and then I'm almost done.  
13 "I think suicide is sort of like cancer was 50  
14 years ago. People don't want to talk about it.  
15 They don't want to know about it. People are  
16 frightened by it. They don't understand when  
17 actually these issues are medically treatable."

18           In July of 2009 I waited for the  
19 military suicide rate to be published on the  
20 Internet. I assumed that with the increased  
21 suicide prevention training that the rate would be  
22 reduced. It was a naïve assumption. I've thought

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1 long and hard about how to reach my population,  
2 the ones that would self terminate. My population  
3 is the extreme on the continuum of maladaptive  
4 behaviors. I ask myself, "How do we reach people  
5 like me?" "How was I reached?" One of the most  
6 important things in my recovery was recognizing  
7 that I was not alone. I met people in the  
8 hospital totally different from me in every way,  
9 but going through the same thing. Something in  
10 their life was causing them to want to end their  
11 lives. The circumstances were different, the  
12 places were different, the people were different,  
13 the reason was the same: Pain or whatever had  
14 pushed them to the point where they craved  
15 nonexistence over existence.

16 I thought I was the only suicidal freak  
17 out there, but I learned in the hospital that  
18 there are a lot of people like me. Misery does  
19 love company. I recognized my suiciditis and gave  
20 up the shame and guilt. I accepted that I was  
21 sick, but it didn't have to be a terminal disease.

22 So I started to tell my story on

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1 DoD-endorsed media and on realwarriors.net. I  
2 have to believe that the way I was reached --  
3 through people like me saying, "I know how you  
4 feel. Don't give up. There is hope." Is the way  
5 to reach everyone in their suicide shrouds or  
6 their abusing shrouds or whatever their  
7 maladaptive behavior is.

8 I hope that by me raising awareness  
9 based on my experience, I make it okay for a grunt  
10 to get help for his anger problem. I hope that as  
11 I continue to do well professionally and  
12 personally, I make it okay to have a mental health  
13 issue but still be a contributing member of  
14 society. People like me need to speak up. We  
15 need to destroy the cancerous stigma embedded  
16 within our culture and replace it with the truth.  
17 Humans all have emotions and feel pain. Taking  
18 care of our emotional selves makes us stronger  
19 people, able to achieve the mission more  
20 effectively. There should be no shame in being  
21 human. There should be no shame in having painful  
22 emotions. The strong recognize their emotional

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1 states and get help when it's needed. Suicide  
2 doesn't need to be a terminal illness. Thank you.

3 COL MCPHERSON: Thank you, CPT Stehr.

4 Cpl. Scarboro-Vinklarek.

5 CPL SCARBORO-VINKLAREK: Good afternoon,

6 ladies and gentlemen. Thank you for having me.

7 My story is not a unique one, but I'm going to

8 tell it anyway.

9 On February 5th I overdosed on

10 medication that had been prescribed to me for an

11 anxiety disorder that I was diagnosed with. I was

12 also on antidepressants for post partum

13 depression. The anxiety disorder was also

14 diagnosed in conjunction with PTSD from being

15 attacked in the barracks. I have not deployed,

16 but I have been attacked multiple times, and that

17 continues to linger on in my life now. It causes

18 a lot of problems emotionally -- in relationships,

19 financially. I can't sleep with the lights off.

20 I can't go to bed with my husband. It did push

21 him away. It got to the point where he found

22 other means of comfort, which needless to say was

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1 detrimental to my self esteem.  
2 I started to become very distracted at  
3 work based on the problems that I was having with  
4 my family and the problems that I was having  
5 emotionally. I was having severe anxiety attacks.  
6 I was having very severe shaking problems. My  
7 body would twitch. I would shake at night, almost  
8 to the point where it looked like I was having a  
9 seizure, and it would cause my muscles to become  
10 exhausted. And I couldn't actually get up in the  
11 morning half the time. It would take a lot of  
12 effort for me to wake up, to move. Eventually the  
13 pain became so overwhelming that I just didn't  
14 want to do it anymore. I didn't want to suffer  
15 through it anymore.

16 I talked to my doctors. I got  
17 antidepressants. She thought it was going to help  
18 me out. We kept upping the dose. Eventually the  
19 command started to get upset with me because I  
20 wasn't functioning at the level that they thought  
21 I should have been. But I was doing everything  
22 that I could. I was waking up in the morning, and

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1 for me that was a very, very big and noble deed.  
2 I didn't want to. I didn't want to put my uniform  
3 on. I didn't want to go to work. But I knew that  
4 I had an obligation, and I was going to fulfill  
5 it.

6 The command started to reprimand me,  
7 started to chastise me. And on February 5th when  
8 I went home, I started an argument with my  
9 husband, looking for some kind of sympathy from  
10 him. In return I actually got more chastising.  
11 He told me that I wasn't a good Marine. He told  
12 me that I wasn't fit to be in the Marine Corps,  
13 and as a Marine, that's just not something you say  
14 to me. It's not something you say to any Marine.  
15 It's a very, very hurtful thing.

16 That night I started to lose self  
17 control. I started to lose sight of who I was and  
18 what I wanted from life and where I wanted to go  
19 and who I wanted to be. And I sat down and  
20 started to write, and I tried to think of all of  
21 the reasons to live, all of things that I wanted  
22 to do with my life, which is traditionally what my

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1 family always does. Whenever we have a problem,  
2 we sit down and think things through logically and  
3 rationally, and slowly but surely I couldn't find  
4 anything to write down. I tried talking to my  
5 husband, and he started to argue with me. The  
6 arguing progressed, and he started to threaten to  
7 leave. He threatened to take my son with him. He  
8 threatened divorce. He threatened to not let me  
9 see my son ever again. And I thought that if I  
10 was such a bad person that someone thought I  
11 shouldn't see my son, then maybe I didn't deserve  
12 to see my son. I thought that maybe he would be  
13 better off without me. I knew that my family  
14 would take care of him, and I knew that he would  
15 grow up to be a wonderful boy and an amazing man.  
16 It's tradition in my family. We're all great, and  
17 I knew he would be, too. And I didn't think that  
18 he would need me to fulfill his legacy. I didn't  
19 want to cause him pain. I didn't want to cause my  
20 family any more pain than I already had. I didn't  
21 want to live this life. I didn't want to live  
22 through the pain that I was already suffering

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1 through. I didn't want to fight the internal war  
2 that I was fighting every single day. So I took  
3 the medication. I drank a wine cooler with it  
4 just for effect, and I fell asleep. My husband  
5 sat next to me the entire time. He watched me  
6 take the medication. He watched me drink the  
7 alcohol. And he sat there. And he didn't call  
8 the ambulance. He didn't call anybody. He sat  
9 there. I had overdosed, and he did nothing. He  
10 was scared, and he didn't know what to do. The  
11 next morning he tried waking me up, and I didn't  
12 wake up. He said that I mumbled something to him,  
13 but I wasn't really making much sense.

14       So he called my command and told them  
15 that I wouldn't be coming to work today. When my  
16 commander asked what was wrong and if I had gone  
17 to sick call, he said, "No, she didn't go to sick  
18 call." And they said, "Well, is she -- does she  
19 have a cold? Is she nauseous? What's going on?"  
20 And he said, "Well, she took a bunch of pills and  
21 she won't wake up." Immediately my command  
22 expressed to my husband that he needed to call

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1 an ambulance. His first response was to call his  
2 command and let his command know that he wouldn't  
3 be coming into work because he had to take care of  
4 some family problems, and then he called the  
5 ambulance. This was about 9 hours after I  
6 overdosed. The ambulance came to pick me up. I  
7 went to the hospital and I spent the entire day in  
8 the hospital essentially asleep. The nurses came  
9 in, woke me up a couple of times, and asked me if  
10 I wanted anything, if I wanted to see my husband  
11 who was waiting for me. And I said, "No." I  
12 didn't want to see someone who had so little  
13 concern for my life.

14 I went to Bethesda. I was transferred  
15 to 7 West in Bethesda where I met some very unique  
16 people who all have very similar stories. One of  
17 these stories is something that I have discussed  
18 with my friends and think maybe beneficial to you  
19 all. Unfortunately, I couldn't get the Marine to  
20 come today, but he does have a very unique story.  
21 His father was diagnosed as being bipolar and he's  
22 a Marine veteran. He was diagnosed as being

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1 bipolar, but he has served two combat tours. He's  
2 a Reserve Marine. He's actually been on active  
3 duty longer than I have as a Reserve Marine. He  
4 was mortuary affairs. He's got severe PTSD. He's  
5 got traumatic brain injury, depression, anxiety.  
6 He was one of the reasons that I'm alive today  
7 because he understood what I was going through,  
8 and he cared enough to listen. And I listened to  
9 him in response. And we talked to each other  
10 through our stories, through our situations, and  
11 we helped each other through our situations.  
12 Unfortunately, he was separated from the Marine  
13 Corps, sent home, and he is continuing to have  
14 problems. Whether or not those problems will ever  
15 be resolved is of great concern to him and me and  
16 his family and all of his friends. But it's  
17 definitely something that we would all like to see  
18 hopefully addressed by the Task Force. He  
19 regularly commits suicide or attempts to commit  
20 suicide -- overdosing, cutting -- and though he's  
21 been such a benefit to me, he can't find the value  
22 in himself which is very difficult as a Marine, as

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1 a fellow Marine, to see another Marine standing in  
2 front of you who is not aware of their own worth  
3 is heartbreaking.

4 After I was hospitalized at Bethesda, I  
5 went back to my original command. My gunny picked  
6 me up from the hospital. He didn't say, "Hello."  
7 He didn't say, "Welcome back." He said, "We're  
8 two hours late. Hurry up. Let's go." Okay. I  
9 sat in the car on the drive back from Bethesda,  
10 and he talked about how PTSD wasn't real. How so  
11 many Marines are malingerers and don't really have  
12 problems. He never directly said that I was one  
13 of those Marines, but it was implied.

14 Shortly thereafter, when I went back to  
15 my office, I was directed to go talk to my OIC,  
16 officer in charge. I expected some type of  
17 "welcome back" or "we're glad to have you." I was  
18 wrong. I was told to sit down, so I sat. My  
19 gunny and my lieutenant were directed to come into  
20 the office as well, and I was told that I had let  
21 the command down. I had imposed upon the command  
22 my problems. They were now responsible for me.

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1 While I was gone -- while I was being hospitalized  
2 at Bethesda -- they had to take over my  
3 responsibilities. The irony of this to me was  
4 that I was the most junior Marine in the office.  
5 I was the lone NCO. There were seven  
6 senior-ranking staff and COs, and it was an  
7 imposition to help me. It was an imposition to do  
8 my job while I was trying to get better. I don't  
9 believe that that is a common denominator amongst  
10 Marines. I do think that that was just one  
11 Marine's opinion, but it was a very detrimental  
12 opinion.

13 The command continued to monitor  
14 everything I did. I was immediately put into the  
15 barracks, removed from my house, restricted to  
16 seeing my son only under supervision, most of  
17 which I was not actually authorized supervision.  
18 Pretty much every move I made was monitored. The  
19 command had the barracks duty come and check on me  
20 every night. They knocked on my door and scared  
21 the living daylights out of me every single night.  
22 You don't really expect people to knock on your

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1 barracks door unless you actually know someone in  
2 the barracks. They knocked on my door.  
3       Eventually it got to the point where it  
4 would cause such anxiety that I couldn't sleep. I  
5 became sleep deprived. I couldn't function at  
6 work. The anxiety was becoming overwhelming. I  
7 started shaking at work. The shaking got so  
8 severe that I couldn't stand up, and I would  
9 literally have to sit at my desk for hours after  
10 everybody had left to calm down to the point where  
11 I could walk again to go home.

12       The doctors continued to monitor me and  
13 became very concerned with the amount of anxiety  
14 that I was experiencing. They tried to up the  
15 doses of my medication, which were ineffective.  
16 Eventually, one of my doctors suggested to do an  
17 outpatient program at Walter Reed. While I was  
18 there I met a staff sergeant who had an  
19 interesting story that pretty much everybody  
20 related to. He expressed that his wife had lost  
21 her father during the holidays. She went to a  
22 command function and got extremely drunk. The

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1 command decided that she was an alcoholic and that  
2 she would need to undergo substance abuse  
3 counseling and therapy. While she was in therapy,  
4 she requested to be treated for psychiatric  
5 conditions and was told that she needed to  
6 complete her substance abuse counseling first.  
7 She kept requesting to be sent to a psych ward  
8 instead of to go to substance abuse counseling.  
9 Eventually, they completely denied it, and she  
10 killed herself. She hung herself in their closet.  
11 The staff sergeant was so overwrought that he  
12 couldn't wake up in the morning. He couldn't take  
13 care of his two daughters. And he said that he no  
14 longer could see himself living without her, and  
15 he tried to kill himself as well.

16 Because of the alcohol that I consumed  
17 with my medication, I went to substance abuse  
18 counseling. It was overwhelmingly inappropriate,  
19 not in the sense that it was wrong. It most  
20 likely would have been beneficial, but it was not  
21 something I could handle at the time. When you go  
22 to substance abuse counseling, they talk about all

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1 of the damage that's done to your body. I already  
2 know all the damage that's going on in my body. I  
3 don't want to know anymore about it. I just want  
4 to get better. And it caused even more anxiety,  
5 and most of the soldiers that I had met that were  
6 going through substance abuse counseling felt the  
7 same way. That their substance abuse was not a  
8 cause of their suicide attempt, but was just  
9 actually in a sense another form of a suicidal  
10 gesture. They were just trying to get rid of the  
11 pain. Using substances, using suicidal gestures,  
12 it's just a way to get rid of the pain.

13       When I got out of Walter Reed, I was  
14 still very depressed, still had very bad anxiety.  
15 As a journalist, it was very difficult for me,  
16 that because of the situation, I could no longer  
17 convince myself to write anything. I couldn't  
18 read anything. I couldn't sit down and read a  
19 book without being overwhelmed with anxiety. Any  
20 normal task that I had done previously as a way of  
21 relaxing sent me into fits. I couldn't control  
22 myself anymore. I couldn't do anything I wanted

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1 to do anymore. My body wouldn't let me. So I had  
2 to come up with other things. I started painting.  
3 I've got paintings in my apartment now. They're  
4 not great by any means. And eventually after  
5 working with my therapist, I've started to slowly  
6 but surely find myself again. I'm still having  
7 difficulties talking with my family. My mother  
8 always says, "Just get over it." "You can do  
9 this." "Just get over it." "It's just another  
10 day." "It's just another problem."

11 But now I'm currently working on a book  
12 that I hope to publish about surviving suicide for  
13 family members and those who may be contemplating  
14 suicide. And for me, it's very significant, not  
15 in the fact that it's a book that I want to  
16 publish, but that I've managed to overcome  
17 everything and find my ability to write again. I  
18 absolutely love my job. I love being a Marine. I  
19 love being a journalist. I love being Public  
20 Affairs. And it's very hard to have that taken  
21 away from me, but slowly but surely I'm finding it  
22 on my own again. And it's difficult, but it's

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1 working.  
2 The one suggestion that I would have for  
3 the Task Force as far as a solution to suicidal  
4 gestures is to add personality back into the  
5 military. We sat here and we watched the data be  
6 presented, the statistics be presented. We  
7 listened to everybody analyze. One of the things  
8 we feel was not only represented today, but has  
9 been represented by commands multiple times over,  
10 is a lack of concern for the individual. You can  
11 follow policy. You can follow procedure. But  
12 when it comes down to, "Why did this Marine do  
13 it?" somebody will know. I talked to my gunny the  
14 day that I attempted suicide. I told him I was  
15 going to hurt myself. I told him I felt like  
16 dying. I told him I felt like killing myself. I  
17 told him I was probably going to go home that  
18 night and do it. He ignored me. He turned around  
19 and said, "You should probably talk to someone  
20 about that," and turned his back to me.

21 Everybody's trying to treat suicide with  
22 medication and technical procedures and setting in

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1 place policies and programs, when in reality I  
2 think that the best source is just force people to  
3 care about each other. "I don't have to like you,  
4 but if you tell me you've got a problem, I'm going  
5 to find an answer for you." That's really all it  
6 takes. You don't have to like me, but if I need  
7 your help, that's what we're here for. We're here  
8 to help each other. When we're gone, nobody else  
9 is going to do it. Might as well do it now.  
10 Might as well take advantage of what we've got.  
11 If there's anything that I've learned, it's  
12 definitely it. Take advantage of what you've got  
13 now. Don't wait for tomorrow to appreciate what  
14 you've got today. That's all I've got. Are there  
15 any questions?

16 COL MCPHERSON: Thank you so much,  
17 Corporal.

18 CPL SCARBORO-VINKLAREK: Yes, ma'am.

19 COL MCPHERSON: Airman Yager.

20 A1C YAGER: Good afternoon, ladies and  
21 gentlemen. I'm A1C Taylor Yager. As my bio said,  
22 I'm stationed at Sheppard Air Force Base. I'm a

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1 normal 21-year-old kid. I joined the military  
2 when I was 19, and I never had any prior history  
3 with depression until I came in the military.  
4 My transition from being a civilian into  
5 becoming an airman was very smooth. I adapted  
6 very easily. Growing up I was pretty much taught  
7 to "man up" when it came to emotional situations.  
8 You don't show emotion. You just suck it up and  
9 be strong for everybody. Once I got stationed at  
10 Sheppard, that started becoming a little bit of an  
11 issue for me due to the fact prior to me coming  
12 into basic training, I had a friend who was  
13 murdered. I had a friend commit suicide. And I  
14 never was given the opportunity to emotionally  
15 deal with those situations, so I put them on the  
16 back burner as I'd been taught to do.

17 And once I finally had gotten to a  
18 comfortable position on base, I decided to reach  
19 out and get a little bit of help to deal with some  
20 anxiety issues and a bit of stress management  
21 problems. I was immediately transferred over to a  
22 psychiatrist, a major. And I sat down with him

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1 for about 10 minutes for the first session, and he  
2 said, "I think I'm going to prescribe you some  
3 Paxil." And he said, "I think that this will get  
4 rid of your sleeping issues, your anxiety issues,  
5 and your stress issues." And then shortly after  
6 that, he made a comment to me, "You know, if I  
7 could prescribe myself some Paxil, I would  
8 probably do the same thing." And so here I am  
9 thinking, that doesn't sound right, but you know  
10 what? He has a degree. I'm going to trust him.  
11 So I trust him. I start taking the Paxil. Not  
12 only did my sleeping patterns get worse, my  
13 anxiety went through the roof, and I started  
14 feeling depressed which I'd never felt before. So  
15 I go back to my doctor. "Something's wrong, sir.  
16 My anxiety's through the roof. I think I'm  
17 getting a little bit worse." "Okay, Airman Yager.  
18 Well, what we're going to do is since you're not  
19 showing any signs of, you know, throwing up or  
20 nausea or dizziness or anything like that, we're  
21 going to up the dosage and hopefully your body  
22 will be able to adjust to that." "Okay, sir."

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1           So this went on from the end of August  
2 of last year until the beginning of this year.  
3 And my parents had started noticing a severe,  
4 severe, increase in my depression. I felt like I  
5 was going crazy. I knew something was wrong, but  
6 I started thinking that maybe it was just me, it  
7 was just in my head -- Readers Digest version I  
8 guess.

9           The end of February, beginning of March,  
10 after reaching my hand out for help several times  
11 and getting nowhere, absolutely nowhere, I  
12 snapped. I called my dad -- and I'm a "daddy's  
13 girl" -- and I called him and I told him that I  
14 was going home. And I drank a bottle of liquor,  
15 took a couple of bottles of pills -- along with  
16 the Ambien that I was also being prescribed from  
17 the same doctor on top of the Paxil -- took them,  
18 and I don't remember anything aside of the phone  
19 conversation I had with my father.

20           I woke up the next morning with a tube  
21 down my throat and down my nose. I'd been on life  
22 support all night. I had friends in the room with

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1 me when I had attempted. Nobody had tried to stop  
2 me. When they took my blood alcohol content for  
3 that night -- probably approximately two or three  
4 hours after I had stopped drinking -- I was like  
5 around a.23. I shouldn't have made it that night.  
6 By the Grace of God I did. When I first woke up,  
7 I was livid, absolutely livid at the fact that I  
8 was still alive, I was still hurting, nothing had  
9 been solved. I felt that the people who'd been in  
10 my room, whoever called the ambulance, whoever it  
11 was, was being selfish. I felt that the only way  
12 for me to end my pain and to end the pain I was  
13 imposing on other people or the burden or what  
14 have you was for me to ultimately end my life.

15 I was sent to a mental institution for  
16 two weeks. And while I was there they had cut me  
17 off, cold turkey, from Paxil. I started having  
18 severe withdrawal symptoms -- shaking, nausea,  
19 cold sweats, getting sick -- so then they  
20 prescribed me Xanax and Klonopin and Effexor. And  
21 one night, after seeing my doctor -- this is  
22 probably about three days after seeing my doctor

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1 and being put on Effexor -- I'd gone up to the  
2 nurse to get my medication for the evening. And  
3 instead of one pill of Effexor that she handed me,  
4 she handed me two. And I said, "Why are you  
5 handing me two pills of Effexor?" She said,  
6 "Well, the doctor, based off of the notes, thinks  
7 that you should be okay if we up the dosage." I  
8 said, "I haven't seen him in three days and I've  
9 only been on this medication for three days." I  
10 threw them in the trash, and I said I'd much  
11 rather deal with the withdrawal symptoms than  
12 having to be thrown into different medications  
13 just so these people can, you know, try to  
14 pinpoint what works.

15 I got out and I went back to the same  
16 doctor who had prescribed me Paxil. And I had  
17 tried reiterating to him, "Sir, I stressed the  
18 concern to you. Look where it put me?" I was --  
19 at that point I was having the withdrawal symptoms  
20 from the Paxil and the Effexor because I had quit  
21 everything cold turkey. I was refusing to take  
22 medication at that point because of what it had

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1 done to me already. And he put me back on Effexor  
2 to get rid of the withdrawal symptoms -- a low  
3 dosage though.

4 Well, the second I get put back on that  
5 stuff, I'm having all the same thoughts again, the  
6 same issues that I had reiterated over and over  
7 and over again to everybody that I was having  
8 prior. So I wanted to ultimately just get off the  
9 medication, the antidepressants, everything. So  
10 about a month after taking the Effexor and me back  
11 on station, I called my doctor again to get an  
12 appointment with him to see if there was any way  
13 we could switch medications. And my friend and  
14 fellow airman -- she works up at mental health --  
15 and she said, "Well, your doctor's been  
16 temporarily relieved of duty for a month." And I  
17 said, "Why's that?" "He's under investigation  
18 right now for the same thing you went through."  
19 Okay.

20 In the midst of this, I had to go ahead  
21 and get a new doctor and at this point I didn't  
22 trust anybody with my own mental health other than

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1 myself. So in the midst of this, I was dealing  
2 with issues with my chain of command. Being that  
3 I was 20 years old at the time of the incident and  
4 I'd consumed alcohol, I received an LOR and a UIF  
5 for consuming alcohol while underage the night I  
6 tried to commit suicide. They'd asked me to do a  
7 response for that LOR and UIF, so I did a  
8 response. The way I was brought up is that if I  
9 do something wrong, if I intentionally break a  
10 law, to own up to it and to accept accountability.  
11 If I do something to deliberately disobey  
12 somebody, I will gladly receive a punishment for  
13 it. So when they asked me to do a response and  
14 apologize for underage drinking the night that I  
15 tried to take my own life, there's no way I was  
16 going to do it. So I did all the research I could  
17 on Paxil and what it does to the mind and the body  
18 and the statistics on the medication. And I wrote  
19 a three-page response, pleading my side of the  
20 story. And my chain comes up and says, "Airman  
21 Yager, this response wasn't what we were looking  
22 for. We were looking for more of an apology. So

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1 the LOR and the UIF are going to stick." If I  
2 wasn't already down -- as it was, I think that  
3 really pushed me down a little bit more.  
4       So dealing with issues with that -- like  
5 both these women up here said -- the stigma as  
6 well; being called crazy, incompatible with  
7 military standards, unfit for service, just  
8 labeling. My take on that, ladies and gentlemen,  
9 if each one of us in this room were to be screened  
10 for some sort of mental disorder, we'd all have  
11 something. We all would. And the treatment that  
12 the majority of the military members who I've seen  
13 go through the same thing is unfair. I've seen  
14 quite a few outstanding military members with  
15 great potential get kicked out of Service because  
16 of depression. So I was afraid of that. I was  
17 threatened with discharge for failure to comply.  
18 I was threatened with that. Ever since I've been  
19 in, I've been spied on. I love my job. I love my  
20 career field. I joined the world's greatest Air  
21 Force, and I wouldn't want to be any place else  
22 but here. This whole thing's discouraged me a

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1 little bit, though, to be honest with everything.  
2 A side of that, when I got to my new  
3 doctor, I sat down with him and told him  
4 everything that had happened. And his first words  
5 were, "I cannot believe you went through all those  
6 types of medication. You reached out this many  
7 times. You showed people something was wrong.  
8 You told people something was wrong. And nobody  
9 did anything about it." He said, "First off, I  
10 never would have even prescribed you half of what  
11 this gentleman prescribed you." So there I knew  
12 there was an issue and I'm assuming it's --  
13 hopefully it was just a rare case and it just so  
14 happen, you know, to fall into my lap.  
15 So I was seeing a new doctor when I got  
16 out. For the military to even consider me being a  
17 fit member of Service, I had to prove myself that  
18 I deserved to be in the military. I had to show  
19 them that I was willing to go above and beyond  
20 anything imaginable. I was willing to bend over  
21 backwards and do everything they asked of me, just  
22 so long as I could keep my spot in the military

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1 for the rest of my enlistment. I was seeing a  
2 Chaplain once a week, a therapist twice a week, a  
3 psychiatrist once a week. I had AA meetings that  
4 I had to go to because they thought now I have a  
5 drinking problem because I abused alcohol the  
6 night I tried killing myself, so I was labeled an  
7 alcoholic -- AA meetings, ADAPT meetings, ADAPT  
8 groups, outpatient groups at the hospital. I was  
9 going to probably seven plus meetings and  
10 appointments a week. I was thrown right back into  
11 work completely stressed out.

12 So finally I -- with the ADAPT and the  
13 things I felt weren't necessary -- luckily I felt  
14 comfortable enough to stand up and tell them that  
15 it wasn't working for me instead of being pushed  
16 around and just trusting the system to work for  
17 me. It failed. I'm not going to lie. It failed.  
18 So doing what I knew would be the best things in  
19 my interest to take care of me and my mental  
20 health, I did just the groups that I felt were  
21 helpful. I cut out ADAPT. I told them that I  
22 wasn't going anymore. I wasn't an alcoholic. I

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1 wasn't crazy. I didn't need to go to all these  
2 outpatient groups. I didn't need to go see a  
3 therapist twice a week. I just needed somebody  
4 every once in a while just to sit there and just  
5 listen. That's it.

6       Like Corporal over here said, when she  
7 was talking about the solution to everything, my  
8 personal opinion is that you can throw stats and  
9 demographics at people all day long. I think that  
10 military -- NCOs, supervisors, higher ups -- I  
11 think there's a tendency of the human element  
12 being bred out of us. In a deployed situation, I  
13 think it is necessary to have that robotic  
14 mentality, absolutely. There isn't any time to  
15 ask questions in a deployed location. However,  
16 here, when we're on our own soil, we need to be  
17 able to balance that human element. In order for  
18 the mission to be fulfilled, you've got to take  
19 care of your people. If the people aren't taken  
20 care of, the mission's never ever going to  
21 succeed, ever. And if does, I have no idea how  
22 it's gotten there.

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1           That's pretty much it as far as my  
2 story. And as far as talking about my opinions  
3 for a solution, I just think that the solution's  
4 rather simple. And I think it's -- everything's  
5 being a little over analyzed to be honest. People  
6 just need to show that they care more, and just  
7 show that they need to be open to listening and to  
8 offering people help. Like she even said, if  
9 someone were to come up to me -- even if it was  
10 someone who outranked myself -- and said, "Do you  
11 have any suggestions? I'm feeling this way." I  
12 couldn't completely despise the person. It's my  
13 duty to take care of these people. They're my  
14 family. I'm going to do anything I can to help  
15 them, and I would expect the same in return.  
16 That's all I have.

17           COL MCPHERSON: Ladies, thank you very  
18 much. If you have some time, we could take a few  
19 questions?

20           MG VOLPE: We have time. We'll make  
21 time. Thank you all very, very much. Appreciate  
22 sharing your personal stories and how that related

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1 to your job-work environment and the help-seeking  
2 environment and mental health. Appreciate it.  
3 Can any -- and this is for any of you,  
4 if you could talk -- Phil Volpe, by the way -- if  
5 you can comment on -- each of you have experienced  
6 getting awareness education and training in  
7 suicide prevention in your units or at your  
8 installations everywhere. And now, based on your  
9 experience that you all encountered, this very  
10 personal experience, can you comment on your  
11 thoughts on the effectiveness or lack of  
12 effectiveness of those suicide awareness education  
13 and prevention programs? And your thoughts on how  
14 they could be made better to include some of the  
15 comments you made about getting the human aspects  
16 back into caring, compassionate, people around you  
17 to listen and intervene?

18 CPL SCARBOR-VINKLAREK: Yes, sir. When  
19 I first attempted to kill myself, the Marine Corps  
20 started doing suicide prevention very feverishly.  
21 There was immediately -- I would say about a week  
22 after I got out of the hospital -- there was a

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1 PowerPoint presentation sent to all commands. No  
2 talking points. Nobody had any idea what this  
3 presentation was supposed to be about. We were  
4 all called into the presentation room, and I sat  
5 amongst very senior Marines to me and watched a  
6 presentation about suicide prevention that not a  
7 soul in the room understood, even the presenter.  
8 And he openly said, "I don't really know what this  
9 presentation is about, but I'm just going to talk  
10 to you about suicide prevention." And from the  
11 get-go I was little offended. I looked at this  
12 presentation, and I thought, "You know, I could  
13 have died. My husband had absolutely no idea what  
14 to do and no one took it seriously enough to try  
15 to educate anybody."

16 Since then, however, the Marine Corps  
17 has established the suicide prevention training  
18 for NCOs. I was a part of -- I took part in the  
19 training. I got to sit through and see exactly  
20 what the Marine Corps was expecting. The Marine  
21 Corps has established, in my eyes, a very  
22 appropriate stance on suicide prevention by

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1 putting the responsibility on the younger troops,  
2 on the younger leaders. We tend to be a little  
3 less robotic -- no offense -- we still have the  
4 personality instilled in us. We still have our  
5 childlike ways that kind of make us naïve and a  
6 little more understanding of each other. And to  
7 have NCOs take responsibility for not only their  
8 junior troops, but the senior troops, seems very  
9 fitting, especially for the Marine Corps. I know  
10 that as an NCO myself, when I expressed to by  
11 gunny that I was going to kill myself, he turned  
12 his back on me and did nothing. When I got out of  
13 the hospital, I noticed some very similar signs in  
14 him, that he was obviously depressed. He was  
15 starting to lose focus at work, and he to me  
16 seemed like he was going down the same path that I  
17 did. But as an NCO, it was my responsibility to  
18 take care of my fellow Marine regardless of  
19 seniority, and I stepped up and I told others that  
20 I thought that he was going to have a problem and  
21 that I didn't see that he was working the way he  
22 had before and that he wasn't functioning the way

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1 he had before. And subsequently he was  
2 hospitalized, but fortunately it was before he  
3 tried to take his life. It was my responsibility  
4 and I think that all NCOs and junior leaders feel  
5 responsible to not only their peers, but their  
6 seniors as well. And I do think that the Marine  
7 Corps has instilled a great policy and procedure  
8 as far as suicide prevention goes.

9 CPT STEHR: Emily Stehr. I've got to  
10 give it to the Marines. I do think that they're  
11 doing a better job than the U.S. Army at this  
12 point. That's just my own professional opinion --  
13 go Marines! -- but I love the Army.

14 The training I sat through, the standup  
15 or stand- down training or whatever you want, the  
16 scenario-based training, the PowerPoint slides,  
17 the AFN commercials. I'm an educated healthcare  
18 provider. I know not to kill myself. I know all  
19 that stuff. If you don't -- it just doesn't hit  
20 you. It doesn't penetrate, I think. I don't know  
21 about you, but the people I've talked to, it's  
22 like you're speaking a different language, and you

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1 have no idea how I feel, and your societal rules  
2 don't apply to my situation. You know, really,  
3 the only way I, you know -- how do you reach our  
4 population? You know, it sounds like the Marine  
5 Corps' doing a pretty good job. Think the Army  
6 has some room to grow.

7 So I decided to start doing testimonial  
8 pieces. You know, I did AFN stuff. I did press  
9 for DA. You know, you can Google me, for God's  
10 sake. And I don't enjoy it. It's not fun for me,  
11 but I did it because it needed to be done. There  
12 was a void. And my hope is that the void will  
13 close, but there is a void, you know, between what  
14 the research says, what the PowerPoint says, what  
15 the leadership, you know, "Well, everyone take  
16 suicide prevention training." "Okay, yeah, we'll  
17 do that. Great." We all did that. But to get to  
18 the human element, which I think a lot of the time  
19 you can't get with PowerPoints -- and frankly, if  
20 you -- you know -- and people who have been in  
21 combat or any situation, if you haven't been  
22 there, you don't know what you're talking about.

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1 And you can talk all that you want, but I won't  
2 really want to talk to somebody who knows what I'm  
3 going through, you know. So for me, testimonial  
4 pieces are the way to go, meaning that people tell  
5 their stories. And I was really hoping that there  
6 would be a male here, but I guess we're not --  
7 maybe next time. So, that's all I have to say  
8 about that.

9 COL MCPHERSON: Do you have anything?

10 A1C YAGER: Airman Yager. My take is  
11 the same as these women up here as well. We get  
12 briefed for about 20 minutes, and the typical  
13 attitude is like, "All right, guys, we got  
14 briefing. Sorry, suck it up." You know, and we  
15 sit there and everyone's falling asleep and  
16 they're reading us statistics and what to look  
17 for. And it's very impersonal, very impersonal.  
18 Their attitude is that they're briefing simply  
19 because they have to. Nobody's going to learn  
20 from that nor care what they have to say. So --  
21 and like we've all talked about, too, just if we  
22 could somehow incorporate the human element back

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1 into things -- I wrote to our JAG newsletter my  
2 story. That's my way of trying to get out there  
3 and reach people. And I found out it was very  
4 successful. I had a lot of responses back from  
5 it. From this as well -- things like this. I  
6 think that testimonials are definitely the way to  
7 go. The more that we talk about it and show  
8 people that just because we're military members  
9 and we're supposed to be a cut above the rest, it  
10 does not exempt us from being normal human beings.  
11 We're just like each and every one of you in this  
12 room. And I think that if people can get face  
13 time with people who have been through situations  
14 such as ourselves, then maybe they'll have a  
15 little bit more understanding and they'll be more  
16 receptive of it.

17 CPT STEHR: And just to back to the  
18 whole trauma or combat related part, you know,  
19 it's -- as a healthcare provider and as a human,  
20 it's so frustrating for me to see -- because I'm a  
21 regimental physical therapist, you know. I  
22 followed my guys to Sadr City, DLI, went where

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1 they went. You know, they go take out the  
2 objective and, you know, people die. And -- but  
3 the culture that we have says you can't, you know,  
4 you can't share those feelings because you'll be  
5 weak and the mission will be less effective.  
6 You're not allowed to be human. You know, that's  
7 the culture and it's a toxic culture. And that's  
8 why I started talking, you know, is because  
9 whether we talk about it or not, people are still  
10 dealing with this stuff. And by us not talking  
11 about it, we're I think enabling the toxic culture  
12 and we're losing people, you know. And not even  
13 just to suicide, but it's marriages and poor  
14 choices, you know, just because it's the "s" word.  
15 Nobody wants to talk about suicide. Nobody wants  
16 to talk about mental health, you know, but when  
17 you have war and people die, you're going have  
18 emotional repercussions. We need to recognize  
19 that and validate it and say it's okay to be sad.  
20 It's okay to be angry. This doesn't make you a  
21 horrible person. This doesn't make you a bad  
22 robot or a really bad infantry person. This makes

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1 you a human being and you're allowed to feel pain.  
2 But you can handle it, and you can still go on  
3 and, you know, achieve the objective. I think the  
4 whole -- for me I think the whole stigma is just  
5 -- it's rampant, it's everywhere, it's everywhere.  
6 And I think, you know, that's what needs to be  
7 attacked is the stigma, you know, in that we are  
8 human beings even if we are in the Marines or the  
9 Air Force or the Army or the Special Forces or the  
10 SEALS. You know, everybody -- I've been doing  
11 physical therapy for eight years. A knee is a  
12 knee is a knee, you know. A heart is a heart is a  
13 heart. I don't care what your background is. I  
14 don't care how many people you've killed, you  
15 know, we're all humans. And I think the answer is  
16 -- like these ladies said -- you know, recognize  
17 the human connection, allow people to be human,  
18 you know. I think by allowing people to be human  
19 and talking about our experiences corporately or  
20 however, you know, write a book or -- but take the  
21 shame away, you know, take the shame away. That's  
22 where we need to start, you know. I mean, same

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1 thing, I was forbidden to talk because, you know,  
2 fear of vocational retribution, absolutely  
3 forbidden. I can't -- you can't share your story.  
4 The stigma, you know. You can't -- officers don't  
5 have those kinds of issues. You know, and I was  
6 like, okay, and I waited for him to, you know, not  
7 be my commander anymore. And then I decided to  
8 talk because he made me angry.

9       So, I mean, that's where we need to  
10 start, I think, is removing the shame. So however  
11 you do that I don't have the answer, but I think  
12 what we've said is, you know, start -- that people  
13 like us need to start speaking up. And people  
14 like us need to be given the ability and the okay  
15 to speak up, you know, because we can talk about  
16 stats all day and it's all really good stuff. But  
17 it's staying in the academic world. It's not  
18 touching the trenches, you know. How do you get  
19 to the trenches? I think you get there through  
20 people like us. Group therapy, you know, just be  
21 human. I think that's right.

22       MG VOLPE: Thank you.

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1 DR. MCKEON: Richard McKeon. Each of  
2 you has described being through a suicidal crisis.  
3 Do you have any recommendations for us about  
4 anything that you think can be done better or  
5 differently to help others in the military going  
6 through -- who are in the midst of -- a suicidal  
7 crisis as you were?

8 CPL SCARBORO-VINKLAREK: BG McGuire this  
9 morning expressed that there's a way -- if there  
10 was a way to combine programs so that everybody  
11 could effectively have maybe, you know, four or  
12 five programs to answer all their questions, that  
13 that would most likely be the best route to take  
14 as far as getting the education out there, getting  
15 the answers out there. I think for anybody that  
16 is feeling suicidal, number one the stigma is what  
17 prevents them from getting help. But secondarily,  
18 the education is lacking. They don't know where  
19 to turn. They don't know who to ask. And a lot  
20 of the times when someone is feeling suicidal,  
21 they're not going to look for answers, they're  
22 just going to ask anybody that's within earshot

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1 for help. The -- in my opinion, the most  
2 important thing is to get the education out to the  
3 person that's getting asked for help. They need  
4 to know how to respond in a very quick and simple  
5 manner. Just listen. All you have to do for  
6 someone who's feeling suicidal is listen to them.  
7 Answer their questions. Listen to them. And  
8 don't give up on them. Don't dismiss them. Don't  
9 ignore them. Just listen to them. If they're  
10 having financial problems, if they are having  
11 marital problems, if they're having personal  
12 problems, listen to them and help them find their  
13 solution. But keeping the human element is really  
14 the most beneficial thing for anyone who's feeling  
15 suicidal.

16 And it's very difficult. When you are  
17 feeling suicidal, you don't want to talk to  
18 anybody. You don't -- either you're openly asking  
19 for help or you're turning inward and you feel  
20 you're not worthy of anybody's assistance. You  
21 don't want to burden anybody. You don't want to  
22 impose your concerns on anybody else. But keeping

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1 that human element, making sure that we know  
2 something about the person sitting next to us,  
3 knowing, "Hey, he's just not acting right today.  
4 He hasn't been there all week." That's what's  
5 going to stop someone from acting on those ideas.  
6 Being able to put your foot in front of them and  
7 say, "Hey, I know that you have a problem. Why  
8 don't you talk to me about it. I don't know what  
9 it is, but I'm your buddy. I'm your friend. I'm  
10 your family. I'm wearing the same outfit you are.  
11 Let's talk." That's the answer. That's what's  
12 going to get some resolution. That's what's going  
13 to help someone the most. And unfortunately,  
14 through all of the therapy that I've been through,  
15 one of the things that has been expressed most  
16 frequently is, "If you're not a therapist, don't  
17 act like a therapist. Don't take on other  
18 people's problems when you're got your own to deal  
19 with." But in the military there's got to be a  
20 common ground. No, I'm not a therapist, but I  
21 know you. As a human being, I know you. As my  
22 friend, I know you. As my comrade in arms, I know

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1 something's not right. Talk to me and we'll find  
2 a solution together. And I think that that is the  
3 most impactful way to prevent suicides and suicide  
4 attempts.

5 COL BRADLEY: John Bradley. Suicide is  
6 by its very nature a very isolating event. And  
7 each of you have described how isolated you felt  
8 in the midst of your crisis, and I applaud you for  
9 coming out and telling us that story.

10 Knowing that you feel isolated at the  
11 time of your crisis, what outreach would be  
12 effective or what should leaders look for in their  
13 fellow troops, in their subordinates, to be  
14 effective in bridging that communication gap,  
15 providing that emotional support, and getting the  
16 help that's needed?

17 A1C YAGER: Sir, in my personal opinion,  
18 everybody has bad days. I don't think that you  
19 can walk in an office and just pinpoint, "Oh, that  
20 person's suicidal." You know, I think what needs  
21 to be done at a supervisory level first off is --  
22 if I were an NCO and I had troops underneath me,

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1 this is what I would do to bridge that  
2 communication gap. Once a week, if even, pull  
3 your troops in your office, take your blouse off,  
4 get rid of your rank, talk to me as a human being  
5 and say, "Look, every Friday or whatever time I  
6 have an open-door policy here. If something's  
7 going on -- because I can't read your mind -- if  
8 something's going on, I want you to feel  
9 comfortable with talking to me about it." You  
10 have to open that door to allow people to come to  
11 you. You have to show people that you're  
12 approachable. Because like I said, you won't be  
13 able to read everybody's minds. And, you know, in  
14 my case when I was going through my issues, I made  
15 a very, very genuine effort to make sure that  
16 people didn't see I was depressed. I put that  
17 smile on my face no matter how bad it hurt. And  
18 the ones who smile the most are the ones that you  
19 have to worry about most often.

20 CPL SCARBORO-VINKLAREK: Exactly. That's  
21 so true.

22 CPT STEHR: That's true, very true.

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1           A1C YAGER: And like I -- there's -- you  
2 can't just look at somebody and assume they're  
3 depressed or suicidal. I think that you just need  
4 to treat your troops or your office in a general  
5 way, show each one of them individually that you  
6 care. There's only so much you can do. We're  
7 never going to be able to get rid of suicide.  
8 Never. But if you open that door and allow people  
9 -- even if it's 10 to 15 minutes and just show  
10 them, "I am putting this 10 to 15 minutes aside of  
11 my time to show you that I care about you as a  
12 human being. Let me know what's going on." I  
13 think that that might be a good place to start.

14           CPT STEHR: I have to agree. You know,  
15 never make an assumption. People would go to me,  
16 "You don't seem suicidal." And I'd be like,  
17 "Well, I'm sorry I don't fulfill your expectation  
18 of what a suicidal person should be." Same thing,  
19 I was fully functional. No problems at work. No  
20 problems at home. I could, you know, I'm a great  
21 orthopedic physical therapist, but that was the  
22 veneer. But what was going on inside is that, "I

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1 don't want to be here anymore. I want to die."  
2 You know, and eventually my energy level got so  
3 low that I couldn't maintain the veneer anymore.  
4 And, you know -- but I have to say, I think  
5 chain-of-command support is so important. And I  
6 know it sounds like they're -- you know, everybody  
7 struggles with that. I am in a situation where I  
8 have a really great support network,  
9 professionally, personally. And I think that  
10 definitely made a difference. I mean I did an  
11 article for Armed Forces Network and I know the  
12 things I'm supposed to say, and I know the things  
13 -- you know, I know not to buy into the stigma,  
14 you know, I know that. I'm a smart person. I'm  
15 not a less-quality individual. I'm not crazy.  
16 I'm not a bad Christian, or whatever. But still  
17 that stigma, you know, it's there and it just eats  
18 at you and demoralizes you. And if this is how I  
19 feel, you know, I can only imagine it's worse for  
20 the -- what we call -- grunts, you know. And I  
21 know the stigma demoralizes me, so I can only  
22 imagine what it feels for them. But I think one

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1 of the best things that happened to me was I did  
2 an article and my regimental commander, who's a  
3 full bird, came out and he said, "You know, we're  
4 all human. We all make mistakes. We all have to  
5 get taken care of." And his -- you know, I didn't  
6 even talk to him about it. I knew I did my piece  
7 to the article. I knew, you know, the reporter  
8 said, "Who should I talk to?" I said, "Talk to my  
9 regimental commander. You know, that'd be awesome  
10 if he would say something." And he said something  
11 like that. And it just like -- I felt validated,  
12 you know, like it was okay. You know, it was okay  
13 that I was human, and you know. I mean I think --  
14 I mean generals have talked about it and stuff,  
15 but I would really like to see more line people  
16 who are regimental commanders and squad, you know  
17 -- whatever commanders, brigade commanders,  
18 actively engaged in combat or going, that people  
19 who haven't been out for 20 years, you know,  
20 people who are actually doing the stuff in the  
21 trenches -- come out and say like what my  
22 regimental commander did. "It's okay." You know,

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1 I think that would be really empowering to the  
2 people who are -- the suffering who aren't  
3 talking, you know, and there's a lot of them.

4 MG VOLPE: Well, all three of you on  
5 behalf of all the members here on the board -- Ms.  
6 Bonnie Carroll, myself, as the co-chairs, really  
7 greatly appreciate not only your service to our  
8 nation in uniform, but your service to this board  
9 in giving us an understanding and a perspective  
10 from your individual personalized experiences and  
11 having the courage to speak about those. I know  
12 it takes a lot of courage, even with all the  
13 stigmas that are out there that we've discussed  
14 here and everything. So greatly appreciate it.  
15 It's been invaluable to the board. We will take  
16 everything into consideration in our  
17 deliberations. Again, this board exists for the  
18 purpose of helping future soldiers by saving  
19 lives, preventing or eliminating suicide by  
20 members of the Armed Forces. And we're committed  
21 to that effort in our report. And that's why  
22 we're getting briefing on the statistics as well

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1 as having panels of family members and troops and  
2 attempted suicides and sensing sessions. We're  
3 going to go visit installations and all of those  
4 kinds of things to pick up all of the vibes and  
5 how things are working and what people's feelings  
6 are about programs and effects, some of these  
7 human dimension things that you're mentioning.  
8 Our job is to translate that into coherent  
9 recommendations for the Department of Defense, to  
10 be helpful to the Services rather than interfere  
11 with what they're doing. So we greatly appreciate  
12 everything you're doing. I'd like to thank you on  
13 behalf of all of the members.

14 This concludes the public portion of our  
15 meeting. And COL McPherson, if you can please  
16 adjourn the meeting.

17 COL MCPHERSON: Actually, sir, I believe  
18 CDR Feeks has to do that until I get my  
19 designation.

20 MG VOLPE: Oh, excuse me. CDR Feeks.  
21 Oh, he's got the hammer.

22 COL MCPHERSON: He's got the gavel.

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1 There you go.

2 MG VOLPE: Well, CDR Feeks, can you  
3 please adjourn the official portion of this  
4 meeting, the public portion of this meeting?

5 CDR FEEKS: This is CDR Ed Feeks. Thank  
6 you, MG Volpe. I'd like to join my thanks to the  
7 General's to CPT Stehr, Cpl. Scarboro-Vinklarek,  
8 and A1C Yager. Thank you very much for what you  
9 did for us today. I want to thank everyone else  
10 for attending, especially those who worked so hard  
11 to prepare the presentations that were so good.

12 And with that, this meeting of the DoD  
13 Task Force on the Prevention of Suicide by Members  
14 of the Armed Forces, a subcommittee of the Defense  
15 Health Board is adjourned.

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