DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE SENATE ARMED SERVICES

SUBJECT: PROGRESS IN PREVENTING MILITARY SUICIDE AND CHALLENGES IN DETECTION AND CARE FOR THE INVISIBLE WOUNDS OF WAR

STATEMENT OF: GENERAL CARROL H. CHANDLER
VICE CHIEF OF STAFF, UNITED STATES AIR FORCE

22 JUNE 2010

NOT FOR PUBLICATION UNTIL RELEASED
BY THE SENATE ARMED SERVICES COMMITTEE

Introduction

The Air Force is strongly committed to the physical, emotional, and mental health of our Airmen, and appreciates the linkage between health of the force and mission readiness. The number of Airmen taking their own lives has been rising, despite our commitment to prevention. Similarly, Post Traumatic Stress Disorder (PTSD) is an area of increasing concern. Finally, detection and treatment of Traumatic Brain Injury continues to challenge us. All three are similar in that they are difficult to detect, and may have significant impact on health and mission readiness. We are taking action to reduce risk through measures to prevent, identify, and treat each. Efforts to bolster every Airman's resilience must involve the entire chain of command, commanders, supervisors, co-workers, base support agencies, and especially our Air Force families throughout the Total Force.

Suicide in the U.S. Air Force

In 2010, 45 Airmen—27 Active Duty, 8 Guard, 3 Reserve, and 7 Civilians—have taken their own lives, compared to 33 during the same period last year. Currently, the Air Force suicide rate exceeds 14 suicides per 100,000 Total Force Airmen. If these levels persist, the Air Force suicide rate by year's end will be a significant deviation from the 11.6 per 100,000 the Air Force averaged during the last six years.

Among our Airmen who took their own lives, nearly two-thirds were not receiving assistance from a mental health professional. Despite concerted efforts to reverse a long-held

bias against seeking mental health assistance, many Airmen continue to resist seeking help when they most need it. Even among those who seek counseling, there is a marked bias against involving their chain of command in their treatment. Based on an anonymous review of more than 1,000 mental health records in 2006, approximately 89 percent did not inform their chain of command. Additionally, in the 2008 Health Related Behaviors Survey one out of every eight Airmen responded that they believe that a mental health appointment will "definitely" hurt their career.

While no segment of the Air Force is immune to suicide, there are known high-risk populations. The most common risk factors associated with Air Force suicides are relationship problems, legal issues, financial troubles, and history of mental health diagnosis. The Air Force seeks to identify these factors prior to enlistment and throughout an Airman's service. While not directly linked to deployments or work-place stress, these factors can be exacerbated by demanding military lifestyles. Notably, only approximately 20 percent of Air Force suicide victims have deployment experience within the last year. Over the past two years, the Air Force has had four suicides in the U.S Central Command area of responsibility—three in 2009 and one in 2010. In 2009, approximately 60 percent of all Air Force suicides were committed by Airmen in age groups 17-24 and 25-34, accounting for 29 percent and 31 percent of total Air Force suicides respectively. Thus far in 2010, these age groups continue to be at the highest risk for suicide, combining for more than 61 percent of Air Force suicides. The Security Forces and Intelligence career fields have the highest suicide rates; both averaged approximately 24 per 100,000 during the last several years. The Air Force recognizes suicide as a public health

concern that requires active and persistent involvement from commanders, supervisors, and wingmen at all levels of the organization.

Total Force Resiliency

In February of this year, the Air Force initiated Total Force Resiliency to holistically address the root causes of suicide. Because there is significant commonality between the Services, we have studied the Army and Navy resiliency programs and shared best practices to provide our Airmen the skills they require to succeed during potential physical and psychological challenges. The Air Force program reflects a broad-based approach to supporting Airmen and their families. It recognizes that physical, mental, and emotional health are critical to readiness and optimal performance, and is a comprehensive approach to enhance well-being, not merely a safety net. Our resiliency program focuses on the ability to withstand, recover and/or grow in the face of stressors and changing demands. Airman resiliency and the Air Force Suicide Prevention Program are complementary efforts. The key components of our suicide prevention program are leadership engagement and immediate family involvement. Both are helped by base support activities which deliver relevant programs and services.

To emphasize the imperative of leader and peer participation, the Chief of Staff directed a Service-wide “WINGMAN DAY.” During the month of May, every unit took time out to discuss suicide prevention, Total Force Resiliency, and reinforce the significance and role of every Airman as supportive wingmen in prevention and resilience. This effort generated positive momentum and challenged every member of the Air Force to recognize his or her role in suicide prevention. There is no substitute for Airmen knowing their subordinates and coworkers well

enough to recognize changes in attitude, behavior, and personality – and then intervening when something is not right.

Availability of Services

The Air Force Surgeon General, in collaboration with the Military Health System Strategic Communication Group, is working to ensure suicide prevention programs and messages receive sufficient breadth and depth of exposure. At Headquarters Air Force, Major Commands, and base level, the Community Action Information Board (CAIB) provides a forum for cross-organizational review and resolution of individual, family, installation, and community issues that impact the readiness of the force and the quality of life for Air Force members and their families. In a recent change, based on our concerns about the increased suicide rate, the Air Force Vice Chief of Staff now chairs the HQ USAF CAIB.

In addition, the Air Force has significantly expanded counseling services beyond those traditionally available through chaplains or the mental health clinic. Mental health providers are now based in primary care clinics across the Air Force. Airman and Family Readiness Centers sponsor Military Family Life Counselors that offer counseling to individuals or couples without generating documentation. Military OneSource, a Department of Defense program that provides resources and support to service members and their families, provides free access to off-base counselors for as many as six sessions.

Targeted Training Programs

Resiliency training is delivered based on a tiered model. The few career fields with the highest risk factors, including those departing or returning from deployments, receive the greatest and most structured exposure to resiliency training and suicide prevention programs in the Tier 1 category. Tier 1 training also ensures that members with acute risk of suicide receive clinical care by mental health professionals. Tier 2 training tailors and intensifies resiliency and suicide prevention messages based on risk factors. Tier 3 training provides basic education and training to the widest possible audience via unit briefings, chaplain services, financial classes, and computer-based training. Additionally, the Air Force is identifying strategies to ensure all accessions, beginning with Basic Military Training at Lackland AFB, Texas, will incorporate resiliency training into their curriculum to provide initial exposure. Shortly thereafter, this training will be expanded to include commissioning programs and technical training. In order to improve the effectiveness of healthcare provider interventions, we are also focusing on advanced provider training.

Deployment Transition Center

A Deployment Transition Center (DTC) will begin initial operations in July 2010 at Ramstein AB, Germany. This organization will provide two days of training to assist in the transition from deployment to home station for Airmen regularly exposed to significant risk of combat-related death, and will be initially focused on convoy operators, explosive ordinance disposal personnel, and security forces personnel, although these services may be extended to other at-risk Air Force members as the DTC matures. This overseas center will provide these

Airmen centralized training and facilitate a graduated transition home with positive family reintegration. The goals of the center include providing reconstitution, utilizing the support of fellow Airmen returning from deployment, and fostering individual resiliency skills and coping mechanisms. The center is part of the overarching resiliency education and training program being developed with the goal of supporting broader Air Force populations, not merely those Airmen considered most vulnerable due to high potential of exposure to traumatic situations.

Invisible Wounds of War: Post Traumatic Stress Disorder and Traumatic Brain Injury

In 2003, more than 600 USAF personnel were diagnosed with Post Traumatic Stress Disorder (PTSD), and in 2008 that number increased to over 1,500, with over 78 percent of the diagnoses stemming from deployment related events. Over the same period, there has been an increase in the number of medical visits for PTSD, from more than 3,800 in 2003, to more than 14,300 in 2008. The increase in medical care can be attributed not only to the increase in PTSD cases, but also our increased awareness and treatment efforts. The Air Force has taken numerous steps to address this threat to our Airmen, beyond the standup of the DTC already discussed.

Efforts to prevent, identify and treat PTSD begin at home, during pre-deployment preparation. Prescreening and education at home bases now enhance resilience through education on risk factors, symptom recognition, benefits, and de-stigmatization of mental health care, and promotion of the wingman culture. Also, the Integrated Delivery System (IDS) and the CAIB provide forums at each installation for cross-organizational review and resolution of individual, family, installation, and community issues associated with PTSD and other issues that

impact mission readiness. Additionally, mental health providers are receiving training focused on prevention, identification, and treatment of PTSD. Finally, Traumatic Stress Response teams at each installation now foster resiliency through focused preparatory education and psychological first-aid for those exposed to potentially traumatic events.

Similarly, Combat Operational Stress Control teams seek to prevent or minimize adverse effects of combat on our Airmen in theater. In addition to Airmen deployed to the combat zone, non-deployed Airmen, like our remotely piloted aircraft crews and intelligence personnel, must be monitored for post-traumatic stress symptoms—they too are actively engaged in combat operations. Although challenges remain for the Air Force to prevent, identify, and treat PTSD, we, along with our Joint partners, are actively engaged to improve our capability and capacity institutionally, for what is often a very individualized need. Recognizing PTSD is a challenge—as it often is for Traumatic Brain Injury (TBI).

TBI is recognized in the Air Force as a physical condition that can cause life-long symptoms. From 2001 to 2009, 1,008 Airmen were diagnosed with TBI, accounting for 4 percent of all Department of Defense TBI cases reported. Effective early TBI detection is the cornerstone of TBI care, and baseline Automated Neuropsychological Assessment Metric is now collected on 56% of Airmen deploying into theater. Also, the Air Force will begin educating commanders and medical personnel by the end of this calendar year, applying best Joint practices in prevention, identification, and treatment of TBI. Through education that is focused on early detection and prevention, our goal is to identify TBI cases and ensure our Airmen receive the best possible treatment, minimizing the impact on long-term health and maximizing rehabilitation, recovery, and reintegration.

Conclusion

Airmen are our Air Force's greatest asset—the key component to our ability to partner with the Joint and coalition team to win today's fight. We ask for an extraordinary amount of selflessness and sacrifice from them and their families. In return, our obligation is to assist each of them according to their particular needs. There is commonality among suicide, PTSD, and TBI beyond their obvious impact on individuals and mission; they all require heightened awareness and understanding if we are to prevent, identify, and treat them effectively. Also, although it is possible to focus efforts on high-risk categories of people, every individual remains vulnerable, valuable, and must be considered. The needless loss of an Airman and the resultant impact on their families and the Air Force is not acceptable.