CONGRESSIONAL TESTIMONY

Understanding and Preventing Veteran Suicide

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Madame Chairwoman Buerkle, Ranking Member Michaud, and members of the Subcommittee: Thank you for the privilege of testifying today. It is an honor to be here. Military suicide, that of both service members and veterans, is a tragedy that affects more than the individual. Each suicide devastates a family, a unit, and a community. There are also implications beyond the local.

Military suicide is a national security issue. George Washington said, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the Veterans of earlier wars were treated and appreciated by their nation." If Washington was correct, suicide among service members and veterans threatens the health of the all-volunteer force. Mentors and role models, including parents, teachers and, importantly, veterans, play a critical role in the enlistment decisions of young men and women. We should realize that these mentors and role models will not steer youth toward the military if they perceive damage to service members or a failure to address the mental health care needs of those who have served their country.

While the topic at hand is suicide prevention among veterans, I urge the committee to recognize the importance of considering both veteran and service member suicide. This recommendation is based upon more than the recognition of suicide as a tragic outcome; it is based upon the pragmatic recognition that we can only be sure that improvements have been made when the frequency of suicide decreases amongst both of these populations. There is, for example, a possibility that a decrease in the frequency and number of suicides among service members could represent only expeditious out-processing of service members struggling with mental health wounds of war. Likewise, a decrease in veteran suicide, once we have greater visibility of these outcomes, could reflect the shifting of suicides to the time prior to military discharge. Only the joint consideration of both service member and veteran outcomes will highlight reasons for increased concern or will identify success.

There does not currently exist a systematic combined analysis of service member and veteran suicide. Neither the Department of Defense (DOD) nor the Department of Veterans Affairs (VA) fully consider or analyze suicide in one another's population. Given the potential implications of veteran suicide for the all-volunteer force, both the VA and the DOD should seek to understand which veterans, and how many veterans, are dying by suicide. In particular, we should recognize that veterans who left the service only shortly before they killed themselves may have suffered from unaddressed mental health wounds incurred while in service to their nation.

This testimony derives from a CNAS policy brief, *Losing the Battle: The Challenge of Military Suicide*, which discussed the stark numbers of the veterans and service members who die by suicide every day. The policy brief also identified obstacles to improvement and made recommendations to address these obstacles. This testimony focuses upon the recommendations most applicable to the veteran community.

It is important to note that the U.S. military and veteran population cannot avoid the stark reality of suicide entirely. Service members and veterans reflect the broader American public, which not only suffers from suicide, but also stigmatizes mental health care. Further, some service members enter military service with mental health challenges and we should not conclude that serving in the military caused these suicides.

This testimony also notes that leaders in the services and the VA deserve recognition for their actions to reduce the rate of suicide among service members and veterans. Senior military leaders have exerted considerable effort in recent years to acknowledge and confront the challenge of suicide. The VA and each of the military services have emphasized the development of suicide prevention programs, education about the risk of suicide and the most effective ways to prevent it. The DOD suicide prevention programs, with slogans such as "Never Leave a Marine Behind" and "Never Let Your Buddy Fight Alone," resonate with service members by being service-specific and embedded in their service cultures. The services ensure that the necessary tools, such as hotlines, are readily available. The VA's Veterans Crisis Line is especially important in this regard. In its first three years, the hotline received more than 144,000 calls involving veterans and saved more than 7,000 actively suicidal veterans.[1] Challenges remain nonetheless.

Service Member and Veteran Suicide

From 2005 to 2010, service members took their own lives at a rate of approximately one every 36 hours.[2] While suicides in the Air Force, Navy and Coast Guard have been relatively stable and lower than those of the ground forces, U.S. Army suicides have climbed steadily since 2004. The Army reported a record-high number of suicides in July 2011 with the deaths of 33 active and reserve component service members reported as suicides. Suicides in the Marine Corps increased steadily from 2006 to 2009, dipping slightly in 2010.

The VA estimates that a veteran dies by suicide every 80 minutes,[3] but is impossible, given the paucity of current data, to determine the suicide rate among veterans with any accuracy or to understand which veterans are dying.

The Relationship Between Military Service and Suicide

Although the number of military suicides has increased since the start of the wars in Afghanistan and Iraq, the prevailing wisdom has been that suicides are not linked directly to deployment.[4] However, recent analysis of Army data demonstrates that soldiers who deploy are more likely to die by suicide.[5] Data have long indicated definitive links between suicide and injuries suffered during deployment. Individuals with traumatic brain injury (TBI), for instance, are 1.5 times more likely than healthy individuals to die from

[1] Text refers to period from July 2007 to March 2010. Department of Veterans Affairs, Fact Sheet: VHA Suicide Prevention Program, Facts About Veteran Suicide.
[2] Department of Defense, "The Challenge and the Promise: Strengthening the Force, Preventing Suicide, and Saving Lives," Final Report of the DOD Task Force on Prevention of Suicide by Members of the Armed Forces (August 2010), provides data through 2009. The 2010 data are from the Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2010 Annual Report (September 2011).
[3] Department of Veterans Affairs, Fact Sheet: VHA Suicide Prevention Program, Facts About Veteran Suicide (March 2010).
[4] This relationship has not been evident in prior analyses and is not evident in suicide data from the Navy, Air Force, Marine Corps or Coast Guard.
[5] Sandra A. Black et al., "Prevalence and Risk Factors Associated with Suicides of Army Soldiers 2001-2009," *Military Psychology* 23 no. 4 (July 2011), 433-451.

suicide.[6] Additional factors that heighten risk include chronic pain and post-traumatic stress disorder (PTSD) symptoms such as depression, anxiety, sleep deprivation, substance abuse and difficulties with anger management.[7] These factors are also widely associated with deployment experience in Afghanistan and Iraq.

Some psychiatric experts argue that there is an indirect relationship between suicide and military service during wartime. In the psychiatric field, one school of thought, known as the interpersonal psychological theory of suicide, suggests that the following three "protective" factors preclude an individual from killing oneself: belongingness, usefulness and an aversion to pain or death.[8] Any one of these protective factors normally is sufficient to prevent suicide. Traditionally, military service has had a protective quality: Military service members have been less likely to die by suicide than civilians. It appears now, however, that the nature of military service – especially during wartime – may weaken all three protective factors.[9] The cohesion and camaraderie of a military unit can induce intense feelings of belonging for many service members. Time away from the unit, however, may result in a reduced or thwarted sense of belonging, as individuals no longer have the daily support of their units and feel separate and different from civilians. This is especially true for Guardsmen, Reservists, and for veterans.

The responsibility inherent in military service, the importance of tasks assigned to relatively junior personnel and the high level of interaction among unit members establish the importance and usefulness of each unit member, particularly in an operational environment. In contrast, the experience of living in a garrison environment (for active component personnel) or returning to a civilian job (for Guardsmen, Reservists and veterans) or, worse, unemployment, can introduce feelings of uselessness. Individual accounts of military suicide both in the media and in interviews with us echo this sentiment. Over and over, these accounts show that individuals withdrew, felt disconnected from their units and their families, and perceived themselves as a burden.

The third protective factor – an aversion to pain or death – is especially important in considering military suicide, because military service is one of the few experiences that can override this factor. Repeated exposure to military training as well as to violence, aggression and death dulls one's fear of death and increases tolerance for pain.[10] Thus, the very experience of being in the military erodes this protective factor, even for service members who have not deployed or experienced combat, in part because service members experience pain and discomfort from the beginning of their training.[11] By removing some of the

[6] Department of Veterans Affairs, Memorandum from Deputy Under Secretary for Health for Operations and Management, "Recent VHA Findings Regarding TBI History and Suicide Risk" (October 29, 2009) Department of Veterans Affairs, Memorandum from Deputy Under Secretary for Health for Operations and Management, "Recent VHA Findings Regarding TBI History and Suicide Risk" (October 29, 2009).

[7] Sandra A. Black et al., "Prevalence and Risk Factors Associated with Suicides of Army Soldiers 2001-2009," 442; and E. C. Harris and B. Barraclough, "Suicide as an Outcome for Mental Disorders: A Meta-analysis," *British Journal of Psychiatry* 170 no. 3 (March 1997), 205-228.

[8] Thomas Joiner, *Why People Die by Suicide* (Cambridge, MA: Harvard University Press, 2007).

[9] See the discussion of these effects in Edward A. Selby et al., "Overcoming the Fear of Lethal Injury: Evaluating Suicidal Behavior in the Military through the Lens of the Interpersonal-Psychological Theory of Suicide," *Clinical Psychology Review* 30 no. 3 (April 2010), 298-307.

[10] Craig J. Bryan et al., "Challenges and Considerations for Managing Suicide Risk in Combat Zones," *Military Medicine* 175 no. 10 (October 2010), 713-718; and Edward A. Selby et al., "Overcoming the Fear of Lethal Injury."

[11] C. J. Bryan et al., "A Preliminary Test of the Interpersonal-Psychological Theory of Suicide Behavior in a Military Sample," *Personality and Individual Differences* 48 no. 3 (February 2010), 347-350.

protective factors of suicide, therefore, military service, especially during wartime, may predispose an individual toward suicide.

Challenges and Recommendations

There are obstacles to addressing suicide that should be resolved. Some of these obstacles are especially difficult to eliminate. Many of the recommendations we have made pertain specifically to service member suicide, for two reasons. First, we know more about service member suicide than about suicide amongst veterans. The lack of understanding about suicide among veterans reduces the likelihood of actionable recommendations. Second, reducing the challenges to mental health among service members should also improve the mental health of recently discharged veterans.

Challenge I: Americans lack a complete accounting of veteran suicide. The estimation of veteran suicides is extrapolated from extremely limited data. Specifically, states provide death data to the Centers for Disease Control (CDC) for inclusion in the National Death Index, but only 16 U.S. states indicate veteran status in their data.[12] The number of veteran suicides from the remaining 34 states is extrapolated to estimate the overall number of veteran suicides.[13] Further, the current numbers are extrapolated from three year-old data.

An effort is underway to match the Social Security numbers in the national death data with DOD files to identify veterans included in the data. This effort provides the capability to analyze the data and characterize the veteran victims of suicide. It will thus be possible to quantify veteran suicide and contribute an understanding of the number of suicides among post-9/11 veterans, as compared with veterans of earlier generations. This analysis could also permit an understanding of whether veterans kill themselves soon after leaving the military.

Recommendation: Given the potential implications of veteran suicide for the all-volunteer force, the DOD should seek to understand which veterans, and how many veterans, are dying by suicide. In particular, the DOD, as well as the VA and the country at-large, should recognize that many veterans who left the service only shortly before they killed themselves may have suffered from unaddressed mental health wounds incurred while in service to their nation. Congress should establish reasonable time requirements for states to provide death data to the CDC, and the Department of Health and Human Services (HHS) should ensure that the CDC is resourced sufficiently to expedite compilation of national death data. The DOD, the VA and HHS should coordinate efforts to analyze veteran suicide data and should conduct these analyses annually.

Challenge II: As service members return home from deployment, they complete a post-deployment health assessment (PDHA). As part of this assessment, they are asked questions about their physical and mental health, such as, "Did you encounter dead bodies or see people killed or wounded during this deployment?" and "During this deployment, did you ever feel that you were in great danger of being killed?" There are also self-evaluative questions, such as, "Are you currently interested in receiving

[12] The states are Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia and Wisconsin.

[13] Even if all states indicate veteran status, suicides will still be underreported because of the vulnerability of civilian death data to the social stigma of suicide.

information or assistance for a stress, emotional or alcohol concern?" While we do not question the contents of the assessment, its administration has been problematic.

A 2008 study found that when Army soldiers completed an anonymous survey, reported rates of depression, PTSD, suicidal thoughts and interest in receiving care were two to four times higher as compared to the PDHA. Likewise, our interviews with veterans uncovered numerous accounts of returning service members whose unit leaders advised them to fabricate answers. Individuals across all services have been told, "If you answer yes to any of those questions, you are not going home to your family tomorrow." This may be factually correct, but it neglects to inform service members of the implications of answering untruthfully – namely, that they will have difficulty receiving treatment or compensation for mental health problems that appear after their service. As an improvement, the 2010 National Defense Authorization Act requires trained medical or behavioral health professionals to conduct the PDHA evaluations individually and face-to-face, in the hope that service members will respond honestly to a trained health professional. [14]

Recommendation: Unit leaders should encourage members to complete the PDHA truthfully and should underscore that an honest answer will allow them to link any future mental health problems requiring treatment to their military service. This is especially important for veterans, as the PDHA informs decisions regarding their eligibility for mental health care after they separate from service.

Challenge III*:* There is a national shortage of mental health care and behavioral health care professionals, a factor linked to higher rates of suicide. According to the VA, suicide rates decreased by 3.6 deaths per 100,000 in seven regions[15] where staff numbers increased to levels recommended in the 2008 Veterans Health Administration Handbook.[16] Sixteen regions are still not manned to these levels, however. Additionally, for the Army, only 80 percent of the psychiatrist and 88 percent of the social worker and behavioral health nurse positions are filled. With respect to psychologists, 93 percent of positions are filled.[17] Military hospital commanders have temporary authority to hire psychologists and social workers and behavioral health nurses on an as-needed basis, but a shortage of care providers precludes them from easily filling that gap. This shortage is a national issue, which affects the availability of care providers for the DOD and the VA. It also affects veterans' families, who seek treatment from the civilian health care system to cope with the strain of reintegration.

Recommendation: Congress should permanently establish expedited or direct hire authority allowing military hospitals to hire behavioral health care providers. Congress should require the VA to establish deadlines by which all twenty-three VHA regions will be manned to the recommended levels of behavioral health care providers. Additionally, and especially in the meantime, the VA should increase their use of existing public-private partnerships to provide mental health care, to the extent that such partnerships would expedite evidence-based care to veterans.

[14] The National Defense Authorization Act for FY 2010, Public Law 111-84, sec. 70.
[15] The Veteran Health Administration (VHA) is a subordinate organization to the Department of Veterans Affairs. The VHA is divided into 23 regions called Veterans Integrated Service Networks.
[16] Department of Veterans Affairs, Veterans Health Administration Handbook 1160.01 (September 11, 2008)
[17] Army personnel numbers are as of July 2011, from communication with Army Medical Command representative (September 29, 2011).

Challenge IV: Permanent change of station (PCS) moves are a feature of military life. Individuals also often relocate their families as they leave the military. However, because professional organizations license mental health care providers on a state-by-state basis, a geographical move across state lines can preclude continued care from the same provider. When a care provider and a veteran, service member or family member invest in developing a care relationship, and that relationship is severed by a move, patients are often reluctant to begin treatment anew.

Recommendation: Congress should establish a federal pre-emption of state licensing such that mental health care can be provided across state lines for those instances in which military service members or family members have an established pre-existing care relationship.

Challenge V: The programs and services designed to understand and reduce service member and veteran suicide should complement one another and gain both efficiency and effectiveness from interacting synergistically. Obtaining veteran suicide data and understanding the circumstances surrounding individuals who die by suicide depends on the states and the HHS, as well as on the participation of the VA and the DOD.[18] Within DOD, the military services and components do not regularly and consistently share information. Information should also be shared between the House Armed Services Committee (HASC) and the Senate Armed Services Committee (SASC),who interact primarily with DOD and the Senate Committee on Veteran Affairs and the House Veterans Affairs Committee, who interact primarily with the VA..

Recommendation: The DOD, the VA and HHS should share data and information pertaining to suicide. The military services' leaders should meet regularly to discuss issues and approaches pertaining to suicide, and to share lessons learned. The Senate Committee on Veterans Affairs and the House Veterans Affairs Committee should embrace the opportunity to work with the SASC and HASC, with the intent of developing provisions for the NDAA to address the problem of veteran suicide.

Challenge VI: The health and survival of service members hinges on the removal of the stigma associated with mental health care. This stigma exists in both military and civilian culture. In the military, it prevents many service members from seeking help to address mental health care issues; 43 percent of soldiers, sailors, airmen and Marines who took their own lives in 2010 did not seek help from military treatment facilities in the month before their deaths.[19] The percentage of service members seeking help has improved – from 40 percent in 2008 and 36 percent in 2009 to 57 percent in 2010 – but the stigmatization of mental health care remains an issue.[20] Military leaders recognize the importance of removing this stigma. Indeed, recently retired Chairman of the Joint Chiefs of Staff Admiral Mike Mullen identified the stigma of PTSD as the greatest challenge confronting troops returning from war in Iraq and Afghanistan,[21] and other

[18] The CDC is subordinate to the HHS.

[19] Fifty-seven percent of DOD suicides were seen at a military treatment facility in the month prior to their deaths. Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2010 Annual Report (September 2011), 23.

[20] Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2009 Annual Report (2010), 29; and Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2008 Annual Report (2010), 26.

[21] Stephanie Gaskell, "Stigma of Posttraumatic Stress Disorder Is Greatest Challenge of Returning Troops: Mullen," *Daily News* (April 19, 2010).

DOD leaders at the highest levels have urged service members to seek mental health care as needed. Nevertheless, the stigma persists.

This culture is unlikely to change quickly. Leaders have not provided sufficient guidance about how to remove the stigma associated with depression and suicidal thoughts, and they have not consistently disciplined service members who belittle or ridicule members with mental health issues.[22] Removing the stigma for PTSD, an invisible injury, will be especially difficult, given that some service members do not even consider TBI, which is physically evident and recognizable, a "real injury."[23] Yet the stigma must be removed to address and treat PTSD and TBI, both of which are linked to suicide. The effect of military culture will also inform and bear upon the perspectives and behavior of veterans even after they leave the military service.

Recommendation: Military leaders must eliminate the stigma associated with mental health care and hold unit leaders accountable for instances in which individuals are ridiculed for seeking treatment.

Challenge VII*:* Misuse of prescription medication is another obstacle to addressing the problem of military suicide. Approximately 14 percent of the Army population is currently prescribed an opiate.[24] Forty-five percent of accidental or undetermined Army deaths from 2006 to 2009 were caused by drug or alcohol toxicity,[25] and 29 percent of Army suicides between 2005 and 2010 included drug or alcohol use.[26]

Data collected from civilian populations indicate that adults aged 18-34 are the most likely to have attempted drug-related suicides,[27] and that 58.9 percent of drug-related suicide attempts resulting in visits to an emergency room involve psychotherapeutic drugs.[28] Another 36 percent of emergency room visits for suicide attempts involve pain medications.[29] If we anticipate similar rates among military service members, it is important to address the excess prescription medicine among military service members. Yet, there is no opportunity to do so. When military doctors prescribe an alternative medication or dosage from what a service member was previously prescribed, there is no request made for the service member to return the remainder of his or her prior medication. Instead, military doctors dispense additional medications, because only law enforcement personnel can conduct "take-back" programs for medications. On January 26, 2011, the Army Vice Chief of Staff requested that the Drug Enforcement Administration

[22] See, for example, the following news article for a publicized account of such ridicule: http://www.q13fox.com/news/kcpq-suicide-rate-spiking-at-joint-baselewismcchord-20110817,0,1023250.story.
[23] The authors interviewed veterans who did not mention their own TBI in response to the question, "Were you physically wounded during deployment?" When interviewees mentioned TBI in subsequent conversations, they would typically explain that their initial answer only included "real injuries.
[24] U.S. Army, *Health Promotion Risk Reduction Suicide Prevention Report* (August 2010), 45. Also, the Army estimates that 30,401 soldiers would test positive for a medical review officer–reviewable drug, with 3,925 representing illicit use. Ibid., 44.
[25] Ibid., 4.
[26] Ibid., 43.
[27] 2004 data, as reported by Substance Abuse and Mental Health Services Administration, *The OAS Report: Suicidal Thoughts, Suicide Attempts, Major Depressive Episode & Substance Use among Adults* 34 (2006), 5, http://www.oas.samhsa.gov/2k6/suicide/suicide.pdf, as of September 9, 2011.
[28] Substance Abuse and Mental Health Services Administration, *The OAS Report: Suicidal Thoughts, Suicide Attempts, Major Depressive Episode & Substance Use among Adults*, 6.
[29] Substance Abuse and Mental Health Services Administration, *The OAS Report: Suicidal Thoughts, Suicide Attempts, Major Depressive Episode & Substance Use among Adults*, 6.

(DEA) permit the Army's military treatment facilities and pharmacies to accept excess prescription medicine for disposal.[30] The request was denied.

Recommendation: The DEA should grant the DOD authority to accept and destroy excess prescription medication from military service members. Given this authority, the Office of the Army Surgeon General should initiate an effort with the Navy, Air Force and Coast Guard surgeon generals to develop policies and practices regarding how best to account for, and regain possession of, excess prescription medications. Such a drug take-back program will be targeted to the military services, but could also help ensure that service members do not transition out of the military with surplus prescription medications.

Challenge VIII: The DOD approach to suicide prevention depends heavily on what experts refer to as "gatekeeper strategies." The Army, for example, asserts that "[t]here is no other aspect of [its suicide prevention] that is more important for preventing negative outcomes than the vigilance of the individual commander, supervisor, Soldier, law enforcement agent or program/service provider. Leaders, supervisors, and 'Buddies' represent the first level for surveillance of high risk behavior."[31] Although medical and academic experts identify gatekeeper approaches as one of the most promising strategies,[32] the limitations of this approach are notable for the Guard and Reserve, where there are long monthly gaps between drill periods when leaders and peers do not have the opportunity to watch for warning signs. Yet studies indicate that even the smallest amount of contact can reduce the risk of suicide.[33] These findings suggest that even postcards or text messages from unit leaders between drill weekends can help prevent suicides.

Recommendation: The DOD should address weaknesses in gatekeeper-based programs for drilling Guard and Reserve units. Specifically, Guard and Reserve units should develop a leadership communication plan that addresses the stresses on units and details the frequency and method (written, electronic or telephone) by which small unit leaders should remain in contact with their subordinates. Leaders should pay closer attention to this communication following a deployment. Such communication could especially help save the lives of our country's "affiliated veterans," those who periodically return to uniform, either for drill or mobilization and deployment.

Challenge IX: Assessing which suicide prevention strategies are effective requires systematic efforts to understand military suicide. Yet these efforts are thwarted by the existence of too many programs. Suicide prevention programs in the National Guard are a decentralized multitude that the Adjutant General (TAG) of each state and U.S. territory initiates and manages. This grassroots solution is inefficient given that, while some states had more suicides than others, overall the Army National Guard averages slightly more than one suicide per state annually. Although the individual programs may use evidence-based approaches, it will be difficult to demonstrate which suicide prevention programs are effective with the

[30] Peter W. Chiarelli, Vice Chief of Staff, U.S. Army, letter to Joseph T. Rannazzisi, Deputy Assistant Administrator, Drug Enforcement Administration, Office of Diversion Control (January 26, 2011).
[31] U.S. Army, *Health Promotion Risk Reduction Suicide Prevention Report*, 46.
[32] Mann et al., "Suicide Prevention Strategies: A Systematic Review."
[33] Alexandra Fleischmann et al., "Effectiveness of Brief Intervention and Contact for Suicide Attempters: A Randomized Controlled Trial in Five Countries," *Bulletin of the World Health Organization* 86 no. 9 (September 2008), 703-709.

military community or efficacious in reducing suicide, because the small numbers do not support rigorous analysis. Even more important, these programs risk reduction or elimination due to dwindling state resources. This is the case of Minnesota, where there exists both the highest number of National Guard suicides, and also dwindling resources to address their problem.[34]

Recommendation: The National Guard should reduce the number of unique suicide prevention programs, and consider adoption of a systemwide, centrally funded, prevention approach.

Conclusion

Addressing suicide among service members and veterans is integral to the fitness and sustainability of the all-volunteer force. It will take a collaborative effort by DOD, VA, federal and state legislatures, and communities to curb suicide among those who have served the United States. The military must take better care of its own. Although a goal of no suicides is unachievable, the increasing number of suicides is unacceptable. Additionally, although the benefits and services available from the VHA will likely remain the best system of care for veterans, the DOD has moral responsibility to acknowledge and understand former service members.

The CNAS policy brief, from which my comments are extracted, is entitled *Losing the Battle: The Challenge of Military Suicide*. America is currently losing its battle against suicide by veterans and service members. As more troops return from deployment, the risk will only grow. To honor those who have served and to protect the future health of the all-volunteer force, America must renew its commitment to its service members and veterans. The time has come to fight this threat more effectively and with greater urgency. Thank you for addressing your attention to this critically important battle.

[34] Mark Brunswick, "Anti-Suicide Program for Military Runs Low: Shortfall Comes as Minnesota Guard Fights High Suicide Rates," *Star Tribune*, October 2, 2011.

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Prior to joining CNAS, Dr. Harrell was a Senior Social Scientist at the RAND Corporation. At the RAND Corporation, Dr. Harrell's research addressed military manpower and personnel, military families and quality of life. She led or co-led projects addressing the resiliency of military families; how best to support reserve component families; the promotion and management of military generals and admirals; assignment policies for military women; and how best to promote, develop and assign military officers. Dr. Harrell also conducted research for the country of Qatar, assessing how best to manage Qatari institutions providing social services to families.

Dr. Harrell has published over fifty monographs, journal articles and book chapters. Notable works she has authored or coauthored about military families include *Deployment Experiences of Guard and Reserve Families: Implications for Support and Retention* (RAND 2008); "Understanding the Deployment Experiences of Reserve Component Families," in Winkler and Bicksler (eds.), *The New Guard and Reserve* (Falcon Books, 2009); *Working Around the Military: Challenges to Military Spouse Employment and Education* (RAND 2004); *Invisible Women: Junior Enlisted Army Wives* (RAND 2000); "Army Officers' Spouses: Have the White Gloves Been Mothballed?" (*Armed Forces and Society*, Fall 2001); and "Gender and Class-Based Role Expectations for Army Wives" in Frese and Harrell (eds.), *Anthropology and the United States Military: Coming of Age in the Twenty-first Century* (Palgrave Macmillan, 2003).

Dr. Harrell has presented her research findings to audiences including senior leaders from the Army, Navy, Air Force, and Marine Corps as well as senior officials from the Office of the Secretary of Defense and Congressional members and staff. She has also briefed international audiences, spoken extensively at conferences and lectured at the United States Military Academy. Dr. Harrell's research has been reported by the *New York Times, Washington Post*, *Washington Times*, *National Journal*, *Time Magazine*, *Army Times*, *USA Today*, *Miami Herald*, *New York Daily News*, *Chicago Tribune*, *Chicago Sun-Times*, *Government Executive,* NPR, BBC, AP, and Reuters.

She holds a B.A. with Distinction from the University of Virginia, a M.S. in Systems Analysis and Management from the George Washington University, and a Ph.D. in Cultural Anthropology from the University of Virginia, where her dissertation was entitled, "Brass Rank and Gold Rings: Class, Race, Gender and Kinship with the Army Community."