

**MEETING of the DOD
TASK FORCE ON THE PREVENTION OF SUICIDE
BY MEMBERS OF THE ARMED FORCES**

1 OCT 09

**Marriott North Bethesda
5701 Marinelli Road
Bethesda, MD 20852**

1. ATTENDEES

PRINCIPAL MEMBERS & REPRESENTATIVES

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
X	Ms.	Embrey	Ellen	Performing Duties of the ASD for HA
X	MG	Volpe	Philip	Joint Task Force National Capital Region Medical, Task Force Co-Chair
X	Ms.	Carroll	Bonnie	Tragedy Assistance Program for Survivors, Task Force Co-Chair
	Dr.	Wilensky	Gail	President, Defense Health Board
X	CDR	Feeks	Edmond	Executive Secretary, Defense Health Board
X	Col	Bader	Christine	Senior Advisor to the Assistant Secretary of Defense Health Affairs
	Dr.	Berman	Alan	American Association of Suicidology
X	COL	Bradley	John	Walter Reed Army Medical Center
X	Dr.	Certain	Robert	St. Peter and St. Paul Episcopal Church
X	SgtMaj	Green	Ronald	United States Marine Corps
X	Dr.	Holloway	Marjan	Uniformed Services University of the Health Sciences
X	Dr.	Jobs	David	The Catholic University of America

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
X	Dr.	Kemp	Janet	Veteran's Administration
X	Dr.	Litts	David	Suicide Prevention Resource Center/Education Development Center, Inc.
	CMSgt	McIntosh	Troy	Air Force Reserve Command
X	Dr.	McKeon	Richard	Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
	MGySgt	Proietto	Peter	United States Marine Corps
X	CDR	Werbel	Aaron	United States Marine Corps

GUESTS & OTHER ATTENDEES

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
X	LTC	Ueoka	Alan	
X	Mr.	Altman	Brian	SPAN USA
X	Ms.	Apple	Sharon	Health Net
X	Mr.	Goldman	Andrew	Health Net
X	Ms.	Green	Farrah	USUHS
X	CDR	Malone	Rosemary	Office of the Armed Forces Medical Examiner
X	Ms.	Schwartz	Sue	Health Net
X	Ms.	Oetjen-Gerdes	Lynne	Armed Forces Medical Examiner System, AFIP
X	Mr.	Cox	Dan	USUHS
X	Mr.	Michael	Charles	Congressman Mike Quigley
X		Blallement		
X	COL	Ritchie	Elsbeth	
X	Mr.	Meagher	Edward	

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
X	Mr.	Hoge	Charles	OTSG WRAMC
X	Ms.	Anderson	Sharon	Public Affairs, Chief of Naval Personnel
X	Mr.	Richard	Fogelson	
X	Mr.	David	Forgosh	
X	Ms.	Schlachter	Terese	Member of the Press
X	Ms.	Quigley	Samantha	Member of the Press

2. ADMINISTRATIVE SESSION (closed)

3. OPENING REMARKS AND INTRODUCTIONS

MG Volpe welcomed attendees to the meeting of the Task Force on the Prevention of Suicide by Members of the Armed Forces and then explained the role of the Task Force under the Defense Health Board. He introduced Ms. Ellen Embrey, as the Designated Federal Official for the meeting and asked her to officially open the meeting.

Ms. Embrey welcomed the Task Force members and the public to the meeting and officially called the meeting to order (rapped the gavel).

MG Volpe asked the attendees to stand for a moment of silence in honor of military service members.

MG Volpe asked the Task Force members and Ms. Embrey to introduce themselves to the audience. Members of the Task Force and Ms. Embrey introduced themselves.

MG Volpe asked CDR Feeks to make administrative remarks.

CDR Feeks welcomed everyone to the meeting and provided administrative announcements. He stated that the next meeting of the Task Force will be held on Thursday, October 8th in the San Diego area at the Hilton San Diego Resort & Spa, and suggested that attendees visit the DHB web site to obtain more information.

4. SERVICE DATA REVIEW: ARMY

CDR Feeks introduced Mr. Walter Morales and Mr. Bruce Shabaz providing service review from the Army. (Biographies attached)

Mr. Walter Morales and Mr. Bruce Shabaz presented, "Army Health Promotion and Risk Reduction Campaign: DoD Suicide Prevention Task Force". (Briefing attached)

SUMMARY OF PRESENTATION:

- The statistics on suicides in the Army were presented. The numbers of suicides per year have increased since 2004. This year, as of 28 Sep 2009, 117 suicides for 2009 (includes Active Duty (AD), pending AD, Army Reserve National Guard (ARNG), pending ARNG, confirmed Army Reserve (USAR) Active, and pending USAR Active). The Army suicide rate has historically been lower than the suicide rate in the U.S. population, however, from 2001 to 2006, the “adjusted” U.S. population suicide rate was steady at 19.5:100,000 while the Army rate doubled from 10:100,000 to 20:100,000.
- Presented which Military Occupational Specialty (MOS) have the highest rates of suicide. Currently, infantrymen have the highest rate of suicide in the Army.
- Reviewed the Army Health Promotion and Risk Reduction Campaign and how the Army is integrating Suicide Prevention into their program. Additionally, the Army established a Suicide Prevention Task Force 23 Mar 09. As part of their Task Force initiative, the Army is performing a gap analysis on suicide prevention to include evaluation of: policy, doctrine, organizations, training, materiel, leadership, people, facilities, and resources.
- Army is taking a two-pronged approach to soldier and family health transformation:
 - increasing resilience of soldiers and families by training specific mental and physical resiliency techniques, increasing physical, emotional, social, spiritual and family strengths
 - implementing immediate and enduring policy to improve and where necessary immediately affect Army health promotion, risk reduction, and other prevention/treatment related programs
- Discussed the Army Way Ahead and desired End State.
- Requested Task Force support to adjust the reporting parameters of the DoD Suicide Event Report (DoDSER) and increase visibility of DoD research efforts.

SUMMARY OF QUESTIONS AND DISCUSSION:

- Ms. Carroll thanked Mr. Morales and Mr. Shabaz for their presentation. She asked questions regarding tracking of reserve and guard suicides and whether suicides that occur while reservists are at their civilian jobs are tracked. Mr. Morales stated that reservists and guardsmen suicides are tracked regardless of their status; however, if the reservist/guardsman is working a civilian job and commits suicide, it is challenging to collect that data. Ms. Carroll also asked if the Army is tracking suicides that occur post 120 days of ETS. Mr. Morales responded that this is also one of the challenges in tracking suicides. Mr. Shabaz added that it is especially challenging because while in civilian status, the soldier does not belong to a unit and there is no chain of command that reports the suicide, the Army has difficulty tracking these suicides. He added that the Army realizes this is a shortfall in the program and has started a research study with the Medical and Materiel Command to examine this issue. Ms. Carroll then asked how the MOS suicide rates track with the MOS distribution throughout the Army. Mr. Morales replied that further analysis has to be conducted to examine those statistics.
- MG Volpe asked whether or not the 240 tasks that the Army is tracking in regard to the gap analysis are tracked by outcomes or impact. Mr. Shabaz answered that the Army is learning lessons on this subject and is tracking metrics on the tasks. Mr. Morales added that the Army has used policy changes to create a “Suicide Prevention checklist” for commanders and leaders to use in order to ensure they are complying with the changes in policy.
- Dr. Certain asked if the Army tracks at the point of suicide, how many combat tours the person had, the time between tours and the type of action seen. He also asked if the Army has a comparison between the suicides among those who have seen combat and those who have been deployed in other ways. Mr. Morales responded that the Army has conducted analysis since 2003 which indicates that the vast majority of suicides are in the population of first-time or never

deployed personnel, with never deployed personnel leading in number. He added that the data indicates the rate of suicide is lower in the soldiers with a higher number of deployments. The data also shows an increase in the number of suicides among soldiers one year post deployment. Dr. Certain asked for clarification and Mr. Shabaz responded that the analysis indicates that the deployment profile of suicides tracks closely to the Army population profile and that the Army is not seeing an increased number of suicides in those members who have deployed multiple times; their rate is not higher than the rate for the rest of the Army.

CDR Feeks thanked Mr. Morales and Mr. Shabaz for their presentation.

5. SERVICE DATA REVIEW: MARINE CORPS

CDR Feeks introduced CDR Aaron Werbel. (biography attached)

CDR Werbel presented, "Marine Corps Suicide Prevention Program (MCSPP). (briefing attached)

SUMMARY OF PRESENTATION:

- Presented summary of manner of death among USMC, USN, and Department of the Navy, and suicide statistics in the USMC, including attempted suicides.
- Discussed suicide and deployment history statistics; 73% of Marine suicides in CY2009 have a history of deployment; 69% of currently AD Marines have been deployed in support of OEF/OIF.
- Mean suicide rate in the USMC from 2001-2007 was 14.9/100,000.
- Demographic risk factors of suicide discussed; most Marines who die by suicide are between 18-25 yrs of age in the infantry; suicides are not over represented among Marines with history of deployment.
- Reviewed current USMC Program initiatives which include:
 - Enlisted training, officer training, provider training, other training, leadership training
 - Regional Coordinators
 - Marketing and Education
 - Research
 - Installation Support Services, National Support Services and Deployed Support Services
- Discussed the Non-Commissioned Officer (NCO) Suicide Prevention Course.
- Presented historic trends and program efficacy; after a required 1 hour suicide awareness training program was implemented in 1997, the average suicide rate dropped 26% (pre- and post-implementation rates compared).

QUESTIONS/DISCUSSION:

- Dr. McKeon stated that the Task Force would need access to all the reports cited in the briefings from the services today and then asked what is guiding the Marine Corps in deciding what programs to implement for suicide prevention, what is helping the most. CDR Werbel responded that the Marines are always trying to target the appropriate populations and that the Marine Corps developed the NCO Suicide Prevention Course in response to NCO input to the Marine Corps Executive Safety Board. NCO's developed the course to fit the audience and the requirement. CDR Feeks said the Marine Corps is trying to go right to the source and find out what is needed and how we should provide services to prevent suicides.
- Another TF member asked if the increase in suicides in the Marine Corps over the last two years is statistically significant. CDR Werbel stated that the increase in 2008 is statistically significant and since 2009 year is not completed, he cannot predict whether the increase will be statistically significant, though he does expect the number of suicides in 2009 will be higher than in 2008.

- Follow on question from the TF: What qualifies an attempt to get included into the database? CDR Werbel responded that all attempts are recorded regardless of what the intervention was following the attempt, however, that suicide attempts are only recorded if the person sought or received medical attention.

CDR Feeks thanked CDR Werbel for his presentation and announced a break. He asked that if any other questions were necessary, they be asked during the discussion later in the afternoon.

BREAK (20 minutes)

6. SERVICE DATA REVIEW: NAVY

CDR Feeks introduced LCDR Bonnie Chavez. (biography attached)

LCDR Chavez presented, “Navy Suicide Prevention Program”. (briefing attached)

SUMMARY OF PRESENTATION:

- Statistics of suicides in the Navy presented; most who died by suicide did not seek care prior to their suicide. Statistics do not indicate increase in suicide among sailors who deployed vs. sailors who did not deploy, although those who have deployed are at greatest risk for suicide within 6 months of returning from deployment.
- Suicide statistics reflect statistics of the Navy population. Rate of suicide per 100K is 10.7; enlisted males 17-34 yrs are at highest risk, majority are Caucasian, die of gunshot wound. In review of Department of the Navy Suicide Incident Reporting database, historically 30% of suicides had a psychiatric history and the majority of that was substance abuse, though the majority of victims did not receive any formal support (medical, chaplain, family support services) in the month prior to their suicide.
- Navy suicide prevention program formally initiated in 1998 and the Navy did see a reduction in suicides after the program began, but rates have increased since 2005.
- Discussed Navy Suicide Prevention Approach: Fostering resilience, vigilance and early intervention, crisis response and post crisis response; includes annual training for members, command written crisis response plans (facility/base specific), DoDSER reporting, and response team including chaplains, counselors, suicide prevention coordinators (SPC). The Navy also has Special Psychiatric Rapid Intervention Teams (SPRINT) to provide member and family support and resources immediately upon identification of risk.
- Barriers to help include: fear of negative impact to career for seeking treatment, loss of security clearance.
- CNO called together a task force this past February to analyze and provide recommendations regarding suicide in the Navy. The CNO tasking includes: conducting a penetrating analysis of suicides, assessing all factors and influences, including policy, and determining if prevention efforts are aligned.
- Navy has mandatory DoDSER reporting requirement, Command Suicide Prevention Coordinator (SPC), established family outreach working group, Navy wide training including 15 conferences at 13 locations with over 51,000 trained.
- Navy suicide prevention includes operational stress control—a line led medically supported program aimed at moving toward mitigating and navigating stress into Navy operations. The goal of the program is to build resilience, recognize effects of stress early and take actions before any negative results occur.

- Encouraged the Task Force to look not only at what went wrong when a suicide occurred, but what went right, what helped prevent a suicide from occurring when an attempt or ideation was averted.

MG Volpe thanked LCDR Chavez for her presentation and asked the audience for questions.

QUESTIONS/DISCUSSION:

- Dr. McKeon asked LCDR Chavez to explain the Navy crisis response system, and also to explain more about the role of the Special Psychiatric Response Intervention Teams (SPRINT). LCDR Chavez responded that the crisis response system is specific to each command, and a plan on what to do in order to respond to a crisis is required. The plan and responses are based on where the command is located, a submarine, ship or shore location. LCDR stated that there are two formal SPRINT teams, one in San Diego and one in Norfolk. She cited the Cole crisis as an example of a crisis that involved SPRINT team response. She added that the Navy is moving toward a more individualized type of crisis response, but these teams are still in place.
- Dr. Litts asked if LCDR Chavez had any data on career impact of seeking mental health care, including loss of clearance. LCDR Chavez stated she did not have that data but it would be very useful to have. She stated that less than 2% of the clearances lost were due to mental health issues, 80% were due to financial issues. Dr. Litts commented that the information on the clearance losses would be good to provide to service members. LCDR explained the “zero tolerance” regarding mental health issues environment of the nuclear submarine community.

CDR Feeks thanked LCDR Chavez for her presentation.

7. SERVICE DATA REVIEW: AIR FORCE

CDR Feeks introduced Lt Col Michael Kindt.

Lt Col Kindt presented, “AF Suicide Prevention Program”. (briefing attached)

SUMMARY OF PRESENTATION:

- AF looks at suicide as an individual and community issue. Discussed the history of the Suicide Prevention Program in the AF: suicide is clearly a community responsibility, leadership involvement is essential for success, atmosphere of accountability and responsibility, integrated network of policy and education.
- Functional components of the program: leadership, policy, education, surveillance. Emphasized that active leadership is a critical component of the program and that recognizing help seeking behavior as a sign of strength is also critical.
- AF Suicide Prevention Program 11 Elements (started in 1996-97): 1) leadership involvement, 2) suicide prevention in professional military education, 3) commander’s guide for managing personnel in distress, 4) community preventive services 5) community education and training 6) investigative interview policy 7) critical incident stress management 8) integrated delivery system (IDS) 9) limited privilege suicide prevention program 10) IDS consultation assessment tool 11) suicide event surveillance system. Discussed various aspects of how the AF Suicide Prevention Program was developed.
- Study of the Suicides in the AF from 1990-2002 indicated that implementation of AF Suicide Prevention Program correlated with: 33% reduction in suicides, 18% decrease in mild family violence, 30% reduction in moderate family violence, 54% reduction in severe family violence, 51% reduction in homicides, 18% reduction in accidental deaths.

- Discussed suicide risk factors. Between 2003 and 2008, only 25% of people committing suicide in the AF had sought mental health care prior to their deaths—Lt Col Kindt pointed out that this indicates that we have to find a way to get people to seek help, and it takes community intervention to make this happen.
- Discussed relationship between deployment and suicide: no correlation between the two for the AF; very few suicides in the AF where PTSD/deployment mental health concerns were cited; 3 confirmed suicides in theater: 1 in 2007, 2 in 2009.
- Highest levels of AF are briefed regularly on suicide statistics so that leadership has visibility on this issue. An annual Lessons Learned report that summarizes statistics and risk factors goes out to all commanders on an annual basis.
- AF program is one of 10 suicide prevention programs listed on Substance Abuse and Mental Health Administration's (SAMHSA) National Registry of Evidenced Based programs and practices.
- Chaplains' role in AF program reviewed; includes several types of training for chaplains, chaplain assistants, and community members.
- Discussed the "Wingman" Culture of the AF: AF mission requires Airmen to take care of themselves and their wingmen; seeking help is seen as a virtue, not as a failure; hinges on the buddy system; annual Wingman Day to reinforce focus on the value of the wingman.
- AF has a Suicide Prevention Working Group; recommendations made in following areas: leadership, policy, training, data collection, professional military education.
- In the future: want to increase "line" involvement in the Suicide Prevention Program, improve flow of information/lessons learned to AF line leadership, develop a public awareness program
- AF program proven effective over time in reducing number of suicides.
- Above average suicide rates are concerning, but are still below pre-program levels despite years of high ops tempo.
- Ongoing program enhancements and action on Suicide Prevention Working Group provide way ahead to address concerns—including return to squadron-based suicide prevention training (vs. computer-based training), beginning family member suicide prevention training, and improving data collection methods to include reserve and guard who are not in active federal status.
- Lt Col Kindt asked the audience for questions.

QUESTIONS/DISCUSSION:

- COL Bradley asked what the most efficacious part of the program is. Lt Col Kindt responded that this is difficult to assess, but personal impression is 1) attention on annual training and 2) impromptu consults/questions from service members after suicide prevention training seminar.
- Dr. Holloway stated that she was impressed with the AF emphasis on leadership involvement and asked how the AF promoted the idea or reinforced the idea to leaders to communicate the message about suicide prevention. Lt Col Kindt responded that commanders are told to tell their people it's okay to ask for help, very senior leaders down to lower leaders share their own experiences and share that seeking help did not affect their careers, many leaders find that after doing this the phone was ringing off the hook for help afterwards. It is communicated to leaders at all levels of their professional military education that they are expected to be communicating downward that it is okay to get help, that it is expected they might need help.
- Dr. Jobes stated he was struck by the data that 25% of the suicide deaths in the AF had a mental health contact. He stated that he is interested in the tension between de-stigmatization and data. Dr. Jobes discussed his interaction with members of the Marine Corps and related that in all his discussions regarding suicide as a problem, Marines stated no problem existed with suicide; basically they told him, "You don't ask a Marine in front of his unit to step out and say I need help"; asking Marines to do that is just unrealistic. Dr. Jobes stated that perhaps this is not as much a mental health issue as it is a systemic cultural issue. He suggested that the Task Force

consider whether their efforts are best targeted toward bolstering mental health care and destigmatization, or if it is best to push into the force a sensibility that if their buddy is in trouble, not go out and get them drunk, but to take them to the chaplain or use the wingman model of the AF. He stated that all the services study the statistics and the completed suicides, but he believes the task force needs to pay attention to the data that puts their biases as mental health care providers aside because many people who commit suicide don't come into contact with providers.

- Dr. Litts stated that he believes that 12 years ago when the AF program started, the answer was to involve leadership and that this is still the answer, that the themes are the same, that stressing it is a sign of strength to get help is a critical factor of success. He noted that the loss of clearance is more correlated with financial problems than with seeking mental health care, and that those numbers remain the same as they were 12 years ago when he began working in the AF program. He posed the question: is this a mental health problem, a community problem, a public health problem?
- MG Volpe stated that he will ask for more details on the data presented by the services today for future meetings. He noted common themes: all services have identified suicide as a major challenge, all show data of increases, and all show they each have different strategies and programs.

MG Volpe posed theoretical questions to the task force for later discussion: Is the fact that we tell each service that they are responsible helpful or inhibitory to cross talk between the services? He asked the Task Force to think about the exact data they need and what common data elements are necessary moving forward.

BREAK FOR LUNCH (1 hour)

8. SUICIDE PREVENTION: VALUABLE INFORMATION LEARNED FROM ARMY SURVEILLANCE AND RESEARCH

MG Volpe introduced COL Elspeth Ritchie. (biography attached)

COL Ritchie presented, "Suicide Prevention: Valuable Information Learned from Army Surveillance and Research". Briefing attached.

SUMMARY OF PRESENTATION:

- Discussed the history of combat related stressors, suicide, and statistics. Mentioned the funding for studying these factors as well as the RAND study on suicide in the military.
- Stated that PTSD is not always a factor in suicide; about 5% of suicides have a diagnosis of PTSD, but the rate is rising over time.
- Mentioned surveillance of critical factors in the Army surrounding mental health including the problems with access to care, stigma, fractured relationships, getting into trouble.
- Mentioned a myriad of Army programs, both completed studies and programs currently underway (MHAT III, IV, & V, CSF, Child and Adolescent Center of Excellence, CHPPM) Cited a variety of data and surveillance sources regarding mental health and suicide. Pointed out that most sources of data regarding suicide don't look at index cases and analysis, but look at overall suicide rates.
- Brought out the "healthy worker effect" that may dilute or escalate statistics: people who are having mental health problems may get out of the military or be boarded out for their problems, therefore not be able to deploy multiple times, so this is one reason the statistics for suicide among members with multiple deployments may be lower than expected or anticipated.
- Reported that MHAT findings demonstrate that theater suicide rates track very closely with other mental health symptoms.

- Discussed the PDHA and PDHRA and the evolution of these tools. Stated that there is no quick and simple tool that is going to pick up people who are going to complete suicide.
- Mentioned EPICON findings that guns, alcohol, and infidelity are a toxic mixture.
- Discussed integrating the variety of reports into meaningful analysis, including the psychological autopsy which provides the details of the suicide.
- Pointed out that stigma is different for ranks in the military: junior ranks are interested in what their buddies would think if they sought help and senior ranks are concerned about the effect the help seeking behavior would have on their careers. This information is hard data that is the result of hundreds of focus groups.
- Discussed “Battlemind” and EPICON findings which indicate that soldiers who are on the battlefield one day and then home the next have greater risk for developing problems; sleep deprivation, irritability and the gun in the night stand can result in homicide/suicide behavior. So Battlemind programs focuses on the critical reintegration period.
- Reviewed statistics of suicides:
 - Almost half of all suicides were seen by mental health in the year before they died.
 - About 5% have PTSD and about 5% have schizophrenia
 - Consistently 2/3 to 3/4 have legal and occupational problems
 - 16% of cases are intoxicated at the time of the suicide, which is lower than civilian world
 - About 25-30% have a substance abuse problem
 - In theater, nearly all suicides are committed with the member’s service weapon and about 50% committed stateside are with their personal firearm
- Discussed that suicide numbers are rising among older soldiers, higher ranking soldiers and in groups not previously considered high risk.
- Mentioned in summary the variety of programs and screening tools, and her belief that suicide is a public health issue and how critical leadership is in prevention. Included gun control, substance abuse prevention, and pain control as areas to include when evaluating suicide.
- Throughout the presentation stated she can share data of all studies mentioned in her briefing with the Task Force.
- Closed presentation and asked for questions.

QUESTIONS/DISCUSSION:

- Task Force Member requested review of what type of mental health contact took place for those who died of suicide. COL Ritchie responded that 25% of the total have seen mental health in the month prior to their death, but stated she does not have the percentage of suicide victims who were seen for medical care prior to their suicide.
- Dr. Holloway asked about the EPICON data on slide 22. She asked if the suicides referred to in the slide were individual cases or if the slide refers to more than one suicide within each group. COL Ritchie responded that the suicides are in clusters, that is why an EPICON is done.
- Dr. Holloway asked what percentage of suicides had previous suicidal behavior. COL Ritchie stated she has that information but will have to get it to Dr. Holloway at a later time. Dr. Holloway stated she wants to see the numbers on the slide broken down into suicidal behavior and those seen by mental health. Mr. Shabaz gave the information to COL Ritchie who responded that 13% of those who committed suicide had had a prior suicidal gesture or behavior while they were in the military. Mr. Shabaz pointed out that we do not have data about any gestures prior to a service member’s military time. COL Ritchie added that occasionally service members have suicidal behavior while on leave and that if the member is not seen in the Tricare system, the behavior may go undocumented and unreported to the military.

MG Volpe thanked COL Ritchie for her presentation.

9. ARMED FORCES INSTITUTE OF PATHOLOGY & ARMED FORCES MEDICAL EXAMINER

MG Volpe introduced CAPT Joyce Cantrell, CDR Rosemary Malone and Ms. Lynne Oetjen-Gerdes. (biographies attached)

CAPT Joyce Cantrell, CDR Rosemary Malone and Ms. Lynne Oetjen-Gerden presented, “AFMES-MSD DSPTF Brief 1 Oct 09”.

SUMMARY OF PRESENTATION:

- CAPT Cantrell presented suicide statistics, autopsies on active duty suicides and the investigations into suicide cases, standardization of classification, CDR Malone discussed psychological autopsies, and Ms. Oetjen-Gerden discussed epidemiology.
- CAPT Cantrell:
- Provided a brief self-biography
- Medical Examiner cases (cases done by a military medical examiner) include all CONUS cases that occur in a federal jurisdiction and all OCONUS cases with a few exceptions, and cases in which an authorized official allows an AFMES or AFMES affiliated Medical Examiner to conduct an autopsy. Federal law 1471, implemented by DoD.
- Non-Medical Examiner cases (cases not done by a military medical examiner) are those which occur in jurisdictions which are not exclusively Federal in which authorized official (i.e. civilian ME) elects to conduct the autopsy.
- If a suicide occurs in a jurisdiction that is not Federal, the civilian ME or other authorized official can release the case for the military ME to conduct the autopsy, or it can occur in a civilian facility by a civilian ME—could take place in a mortician’s office or in a hospital or civilian ME office.
- Because the autopsies are conducted according to jurisdiction, the cause of death ruling may be affected. Occasionally, the civilian ME will rule that the death was accidental, for example if the victim was playing with a hand gun they thought was not loaded that went off mistakenly, where the military ME would rule that case a suicide since the victim had knowledge that he was handling a deadly weapon. Military MEs rule based on the premise that the intent was in the action.
- If a civilian ME does the case, usually the report is shared with the military ME.
- For clarification, an ME investigation/case is conducted much like a criminal case with the ME gathering evidence of the death.
- Occasionally, when a civilian ME has jurisdiction but permits the military ME to conduct the autopsy and investigation, the civilian ME may accompany the military ME during the case and local police department personnel may be involved—so the civilian ME maintains jurisdiction of the case but allows the military ME to do the autopsy. In a case like this the military may do a collateral investigation along with the civilian investigation.
- Pointed out that because the investigations and autopsies are varied in nature the results are also of varied detail and quality.
- Discussed the classification of suicides, especially in regard to self injury behaviors that would indicate a suicide (i.e. previously mentioned case of individual pointing a weapon at their head thinking it was unloaded when it was loaded). Overt indicators are not necessary to indicate a suicide.
- Discussed the issue of classification of suicide if the person was under the influence of alcohol or drugs—classification is based on other factors, not the fact that the person was intoxicated and did not mean to harm themselves.

- Suicide cases are “scrubbed” weekly with the Service Suicide Prevention Managers to ensure accurate reporting. Recently instituted a weekly suicide report for J1. Also participate in quarterly/bi-annual/annual report generation from DCoE to the Secretary of Defense. AFMES also does ad hoc reports for the SPARRC.
- LCDR Malone:
- Provided a brief self-biography
- Psychological autopsies are done to assist the ME to determine the manner of death, not necessarily on all suicides if the manner of death was clearly suicide. Requests come to LCDR Malone via the ME or the investigating agency. Also do behavioral analysis reviews on cases to assist the commander to identify psycho-social factors that may have contributed to that member committing suicide. This analysis and review is done for the purpose of intervention and prevention.
- Psychological autopsies can take over 30 hours of work and the work may be done over several months. No stone can be left unturned; family, friends, co-workers, commanders all have to be interviewed. All records, civilian, military, and medical have to be reviewed. Requests for the psychological autopsy can come weeks or even years after the death. Typically 20-25 different categories on the psych autopsy report from past psychiatric history, family psychiatric history, relationship issues, financial issues, work performance. A chronology of events surrounding the death is done. Finally, a suicide risk assessment is done retrospectively and then the investigating psychiatrist provides a medical opinion regarding the manner of death. Psych autopsy manners of death and physical autopsy reports are separate from the death certificate. All three may not state the same cause of death; final arbiter is the AFME, CAPT Mallak. Each service is responsible for conducting psychological autopsies.
- Working to standardize format and terminology for the reports by the various services.
- MG Volpe asked if every suicide gets a psychological autopsy. LCDR Malone stated that not every suicide gets an autopsy.
- MG Volpe asked what percentage get psychological autopsies and LCDR Malone stated she will have to get that information to him later since she doesn't have it with her today. She stated that the psychological autopsies are done when the manner of death is equivocal and suicide may be a possibility. She stated that the better evaluation to do on a known suicide is the behavioral analysis review which looks into what we could have done differently and how we could have intervened to prevent the suicide.
- MG Volpe asked if there is a standard approach to which cases get psychological autopsies. COL Ritchie replied that the DoD Suicide Event Report is the standardized approach that is done on all suicides. The advantage of the DoDSER is that it is data that can be rolled up whereas the psych autopsy is all text. MG Volpe stated that he is trying to figure out examples of information that is gathered directly that can affect prevention, education and policy; the Task Force is to determine what is the best type of investigation to be done for an autopsy, what kind of information should be collected, who should be qualified to conduct the investigations or review boards; and how is that information used to update education and prevention programs; and how do we maintain patient confidentiality.
- Ms. Oetjen-Gerdes:
- Described the mortality surveillance division mission and workflow; all reported deaths are investigated to determine jurisdiction and reportability and maintain the DoD Mortality Registry.
- The division captures information regarding the cause and manner of death and maintains copies of relevant documentation such as death certificates, autopsy reports, toxicology reports whenever possible.
- Division maintains the SPARRC data and has subject matter focus on high visibility and high urgency topics including suicides, drug and alcohol, infectious diseases and combat deaths.

- Deaths in the regular component are counted, as are deaths in the guard and reserve during their weekend drills including if the death occurs during their travel to and from drill, additionally, deaths that occur during two week training periods, activated and mobilized periods are counted. Mobilized IRR are also counted, and they are the group primarily deployed to Iraq and Afghanistan. Guard and Reserve personnel who are on temporary disability retirement leave or permanent disability retirement leave within 120 days of retirement are counted. After 120 days, they are not reportable to the casualty system. Cadets are also counted.
- Reviewed that suicide rates are increasing since 2003. Stated it is important to recognize that suicides have been standardized among the SPARRC committee only back to 2001, so suicide rates and trends in the system will only go back as far as 2001. Stated that if rates prior to 1998 are needed, the process is extremely labor intensive.
- Reviewed civilian suicide rates. Stated that deaths involving alcohol or drugs are sometimes not designated as suicides, and also if there is no suicide note the death may not be ruled a suicide in the civilian sector.
- Reviewed methods for calculating suicide rates and variances in quarterly projections.
- Reviewed suicide demographics, preferred means of suicide (firearms), and issues affecting suicide policy including the issue of Guard and Reserve rates and the poor visibility on what occurs after these personnel move into civilian status.
- Discussed the complications of calculating suicide rates based on full time equivalents and how the Reserve and Guard numbers are not adequately reflected in the denominator of the equation.
- Stated that changes in policy that impacts the factors surrounding suicide and mental health have been limited, and the waiverable problems for remaining on active duty are increasing. Reflected that it is important to understand how the pool of people remaining in the military may be changing and how that may affect suicide rates.
- Stated that many suicide prevention programs are not evaluated based on metrics and were not designed with metrics in mind. Stated that she sees a problem with this issue--she has a 15 page document of all the suicide prevention programs in the DoD and cannot determine the target population for the program, when the program started, or what outcomes are measured to determine success of the program.
- Mentioned understanding suicide risk factors and stressed the importance of tracking the factors. Cited a study of whether taking mefloquine was a suicide risk factor, but couldn't find data to determine who had taken mefloquine and who had not taken it. Compliance was not tracked, prescriptions were not tracked; geographical location regarding who was given mefloquin was not tracked.
- Stated she is concerned about the limitations of databases in use and cited general examples of how data entry and quality are limiting factors. Stated the division has tons of data and she wants to share it with the Task Force.
- Discussed the limitations of policy and wonders how much can we legislate and mandate.
- Asked the audience for questions.

QUESTIONS/DISCUSSION:

- Question from Task Force member regarding cadets—are ROTC cadets counted? Ms. Oetjen-Gerden replied that ROTC cadets are only reported if they are in a training cycle. If they are in military school or program when they take their lives they are counted. If they are in the course of their studies on a civilian campus when they commit suicide, they are not reportable. Stated that counting Guard and Reserve while in civilian status would require a large increase in staffing and funding, and mandate from each state would be necessary to obtain all the data if deaths were counted while in civilian status.

BREAK (20 minutes)

10. STATEMENTS FROM THE PUBLIC

MG Volpe called the room to order and asked anyone wishing to make a public statement to come to the microphone.

- Mr. Brian Altman introduced himself and stated he is the Director of Public Policy and Program Development for the Suicide Prevention Action Network, USA which is a division of the American Foundation for Suicide Prevention. He discussed the mission of his organization and thanked the Task Force for the opportunity to speak. Thanked MG Mark Graham and his wife for their support and work to bring suicide in the military to the attention of the public. Described the ways in which SPAN USA works with military families and TriWest Healthcare Alliance. Mentioned that SPAN USA is the host of the Military Suicide Prevention Cause Facebook page. Discussed the need for a unified DoD campaign against suicide aimed at military members and their families. Encouraged outreach and education for Reservist and Guard personnel and their families.
- MG Volpe asked for any other public statements. None identified.

10. PANEL DISCUSSION WITH SERVICE REPRESENTATIVES

MG Volpe asked the panel of speakers to introduce themselves again. LCDR Chavez, CDR Malone, Lt Col Kindt, CAPT Cantrell, Mr. Morales, Mr. Shabaz, CDR Werbel, and Ms. Oetjen-Gerdes introduced themselves to the Task Force again.

- Dr. Kemp asked each service branch Suicide Prevention Program Manager what sort of crisis intervention strategies their programs use. She additionally asked if clinical guidelines or standard interventions were used for high risk individuals.
 - CDR Werbel answered that crisis intervention means different things to different people, but that in general all units have their own standard operating procedures for how to respond within the unit specifically. He described the elements of suicide crisis response that are used within the Marines. CDR Werbel stated that all providers are trained in assessing suicide risk.
 - LCDR Chavez answered that Navy program is similar; each command is directed to develop their own crisis intervention plan; each plan differs based on the type of command and where it is located; some things apply uniformly to all commands. Described the common elements of all crisis intervention plans for the Navy.
 - Mr. Morales described the Army process for crisis management, including calling Military OneSource and the DCoE crisis number. Also mentioned the ACE model used by the Army.
 - Lt Col Kindt replied that the Air Force uses a crisis intervention plan that includes the Command Post on each base, chaplains, and on-call mental health providers. Stated that location influences the type of response that occurs. Mentioned that the AF also uses the National Suicide Prevention Hotline as the primary point if someone needs help and has no one else to call. Responded that in terms of clinical guidelines, the Air Force has developed an extensive Guide for Managing Suicidal Behavior that outlines a number of procedures in terms of both assessment and management of suicide risk that the Air Force trains its staff on. He stated that he feels the Air Force is providing a good standard of care to anyone who comes into their mental health care facilities in the Air Force.
 - LCDR Chavez added that during a crisis situation it is important that the varieties of law enforcement at the installation or civilian area along with EMS have a coordinated crisis response system.

- Dr. McKeon asked if the Army promotes the use of Military OneSource in terms of awareness campaigns, pamphlets, brochures and other forms of communication.
 - Mr. Morales responded that Military OneSource is used as a resource for all types of crisis intervention, not just suicide—that is how it is promoted within the Army.
 - Mr. Shabaz stated that all Army stories related to suicide that are released by public affairs will identify Military OneSource for crisis response
 - CDR Werbel added that the Marine Corps provides several different numbers depending on the target audience. The three primary numbers used by the Marine Corps are: Military OneSource, DCoE Outreach call center number and the Lifeline number.
 - Mr. Morales added that the Army also uses the DCoE number and the National Suicide Prevention Lifeline number. He stated that members and their families can call the number they are most comfortable using.
- Dr. Holloway shared that she noticed during the day that a significant portion of time was spent talking about suicide deaths but not as much time on the tracking of suicide attempts or ideation. She expressed that she wanted to emphasize that suicide prevention is not just about individuals who die by suicide, it's also about individuals who think about dying by suicide—who demonstrate some level of self-injurious behavior. She asked for comments on tracking or specific surveillance of suicidal ideation.
 - LCDR Chavez answered that Navy requires official message traffic regarding suicide related behaviors; it is reported to the DoDSER and compliance with reporting this activity is improving. She stated that compliance with this is in a way a reflection of the effectiveness of suicide prevention training, adding that if shipmates or families report this behavior, then it reflects that they have received some sort of suicide prevention training or messaging.
 - Mr. Morales from the Army responded that the Army tracks attempts and ideation separately. Attempts end up in the DoDSER and ideation primarily through AHLTA when soldiers go to clinic and report suicidal ideation or attempting suicide.
 - Lt Col Kindt responded that this is an important point—that suicidal ideation and suicide attempts are difficult to track. The Air Force did collect suicide attempt data in the Air Force Suicide Event Surveillance System, and initially the data was robust but over time became deficient and it appeared attempts were decreasing. He expressed concern that the attempts weren't decreasing, but reporting of them was. He stated he hopes that transitioning to the DoDSER will set a more measureable threshold due to better visibility through the casualty reporting system. He mentioned that all personnel entering the Air Force are now given a survey to assess for prior suicide attempts and other dangerous behaviors. Lt Col Kindt stated that some of that initial data suggests that the questionnaire is predictive of future problems in the Air Force and the Air Force is beginning to look at how they might use the questionnaire as a screening tool for filtering some people out of the Air Force or identifying them for additional training needs much earlier in the Air Force career. He stated that ideation is a much more difficult thing to track. The only way to review that information would be to review all the AHLTA notes and/or mental health notes on individuals identified to have had suicidal ideation.
 - CDR Werbel added that almost all of the training efforts are focused on individuals who have ideations and some who have attempts and all of our tracking is done on individuals who died by suicide. He stated there is a real disconnect in many ways between where training is focused and what is tracked. He added that the Marines, like the Navy do track attempts through official messaging, but the data has not been analyzed to the degree that the suicide data is analyzed.
- Dr. Holloway asked if a person receiving care was having suicidal ideation, how likely the provider would be able to access the medical record information that is available to identify the individual as high risk.

- LCDR Chavez responded that in some cases the provider can look in AHLTA and see the information, in some cases the information is in the paper record, and in some cases the information is in a separate mental health care record or system. She added that the Navy has to switch back and forth between paper and electronic records and that there is opportunity for things to get lost.
- CDR Werbel added that it might be helpful for the Task Force to see a demonstration from the Center of Telehealth and Technology at the Defense Center of Excellence.
- Lt Col Kindt agreed. He stated that he believes there is room for improvement in recordkeeping systems. He stated that in the Air Force, detailed behavioral health records are kept separately from the outpatient medical records, and that brief entries are made in the outpatient record regarding the care including significant indicators that primary care providers may need to know about. He mentioned that the pressure to see many patients in primary care and may not have the time to review all of the information; he believes that with the automated behavioral health record, these issues might be more easily flagged and apparent to providers.
- Mr. Shabaz concurred with the discussion and commented that the Army Suicide Prevention Task Force is working on standardizing documentation and methods to increase access to the electronic medical record AHLTA.
- MG Volpe made statements regarding the aviation accident investigation process and how a similar design process of reviewing suicides and performing suicide investigations might be helpful to identify causal factors and prevention opportunities for cases. He added that he wonders if we can get real data from doing uniform standardized investigations to examine relational aspects of suicides. MG Volpe additionally discussed his thoughts on how data translates to policy, procedure and outcomes to meaningfully prevent suicide.
 - COL Bradley added that this type of procedure in the medical field is called a root cause analysis, factors of a case are examined and lined up; he added that with aviation accident investigations, system failures and procedure failures are examined. He stated he does believe that investigations need to be standardized so that the DoD has a comprehensive way of reviewing suicides.
 - MG Volpe clarified that accident investigations he mentioned would not be admissible in a criminal investigation—the information would remain non-attributable. If information is found regarding criminal activity, this information cannot be turned over to the command to take action for something that was punishable; a separate case would be conducted to discover that information. The process is designed so people will reveal information.
 - CAPT Cantrell discussed the difference between accident investigations and suicide investigations, particularly in civilian jurisdictions. Time is lost between the incident investigation and the ruling of suicide. MG Volpe stated that if legislation change is what is necessary, this Task Force has the independent ability to make that recommendation.
 - Dr. Jobes stated that historically the services all had separate methods for reporting, investigating and counting suicides. He mentioned that three or four years ago a task force was created and a move was made to consolidate under one medical examiner's office. He stated that if this example is used as a metaphor for the current task force, the task force could unify to form a central data collection process in order to shape policy.
 - MG Volpe mentioned resources and that the investigation team might be multidisciplinary and multiservice and that the team would do a comprehensive investigation including family, military record, training to find out all circumstances around that suicide so that lessons learned would be in a repository. MG Volpe also mentioned he heard that 60-65% of the suicides had experienced relationship problems and he wonders if that is the same for suicides in the civilian population.

- Dr. Litts stated that he believes data is not the weak link, he wonders how much of what the services are doing is helpful. He stated that the services are doing so many different and similar things in programs that we don't know individually which interventions are effective and which are not or are less effective than others. He added that it isn't known how effective the services are at implementing the interventions. He wonders how good the fidelity of the training is across the system. He added that suicides are a human event and to evaluate each one for similarities in order to tease out details to change our programs and systems may be difficult.
- MG Volpe briefly discussed his general thoughts on training and how it is and is not standardized across the services.
 - Dr. Litts stated that all providers get refresher CPR training and all service members get their suicide training, but perhaps what is needed is training that teaches how to recognize if a person they are working with is in distress, teach them how to ask if someone is thinking of killing themselves, and train them how to get help for the person. He added that perhaps training should be focused on those skills and when annual training is done, the trainee demonstrates that skill—do they know the questions to ask, do they know the number to Military OneSource, do they know how to get someone help?
 - COL Bradley stated that he believes this is one of the strengths of “Beyond the Front” training—which is distinctly different from other suicide prevention training—“Beyond the Front” training is a skills based situational training. He stated the trainee goes through different situations and gives responses to the situation and he believes this is a wiser approach. He added that he doesn't know if it is more effective but it seems better informed.
- LCDR Chavez stated that we can devote more and more resources toward surveillance, and we can improve on using the data that has been collected and have a more systematic approach, but at the same time what we see are people dying who are the exception to the rule. She stated that civilian data shows that at any given time, at least 3% of the population has serious thoughts of suicide, maybe even making a plan or an action. If this is extrapolated to the military population, then by and large, the training we are doing lets people know what to do and get help. She stated that sometimes it is only after the fact when all the pieces and signs are put together by all sources that it becomes obvious that the person was experiencing problems, and that digging into those tragic cases isn't necessarily revealing how to be effective in the vast majority of situations.
- Dr. McKeon requested each service representative answer whether or not the simulation training “Beyond the Front” is effective; is the training evaluated, and do the services know the impact the training is having on building skills? He stated that he believes conceptually that this type of simulation training has a lot of potential.
 - Mr. Morales answered that the Army has not developed a questionnaire to evaluate training outcomes from “Beyond the Front” training. He stated that “Beyond the Front” has been a great tool for soldiers and focuses on hands-on training which makes the soldiers think about what to do in specific situations. He announced that a new contract has been awarded and “Beyond the Front” training is now called “Homefront”. “Homefront” training will concentrate on the issues surrounding what happens back home, rather than issues directly related to deployment, which was the focus of “Beyond the Front” training. He stated this training will be sent out to the trainers with an evaluation tool included in the packet. Dr. McKeon asked if “Homefront” training would be using the same technology as “Beyond the Front” and Mr. Morales responded positively.
- CDR Werbel stated that now the discussion has shifted to program evaluation, and to the best of his knowledge, the only program that has been studied was the Air Force program, but it wasn't done in a way that could tease out the elements of the program, rather it was found that the overall program was effective. He stated that the NCO course in the Marine Corps is being

studied right now. He added that the services are good at developing training that they think will make a difference. He also expressed that he hopes the Task Force will be able to identify programmatic gaps since the suicide numbers are increasing. He stated that a focus on how we change both the inter-service structure and the process to ensure that we are testing and knowing whether or not interventions work is necessary. He added that the service programs have failed to reach out to family members and that public-private partnership to figure out ways to leverage other organizations doing like activities would help.

- Dr. Holloway stated that perhaps every DoD program needs to have a program evaluation component. She stated that would be her recommendation. Dr. Litts agreed that this is an important element that should be looked at, though it may be complex. Dr. Holloway agreed and stated that it will be complex but making sure that gaps are noticed and resolved.
- Ms. Oentjen-Gerden stated that she believes the intent of the DoDSER is the equivalent of the aviation accident report. She added that her interpretation of this issue is that the data is in one area and the programs are in another and they don't really talk to each other. She went on to explain that for every case that has a DoDSER, a matrix of programs could be done for evaluation purposes to evaluate what could have been done or should have been done, was it done. This could also identify if there was or was not program to meet that need, then the DoDSER data would be connected to programs. This process would not be real time, but a committee or board could do the evaluation, lessons learned and make policy recommendations. She stated that she believes program evaluation is a worthwhile goal but it is difficult to measure success because sometimes successes are indirect. She stated that the group has to keep an objective perspective on how much program evaluation can achieve. She stated she believes developing a matrix will show where gaps in the programs exist and that perhaps the matrix would demonstrate some programs do the same thing and then in other areas no programs exist. Ms. Oentjen-Gerden used "Ask, Care, Escort" as an example, stating that it is a fine program, but does it really address relationship problems and financial and legal problems? She asked how to get to the appropriate level of granularity in interventions and in evaluations?
- Dr. McKeon stated that he wanted to discuss the issue that MG Volpe brought up regarding the connection between surveillance and interventions or programmatic efforts. He stated he agrees that the problem is not that we don't have enough data; and that he believes it is common in suicide prevention nationally that surveillance data is not used to inform suicide prevention efforts. He added that it is most important to translate the information that we have into action and that there may be a number of different ways of doing that. He discussed several examples of programs that have comprehensive community suicide prevention programs and mentioned a variety of studies of suicide related to prevention. Dr. McKeon cited that the most critical point in preventing a suicide is in the 3-6 months following an attempted suicide. He asked if the services prevention programs have any active outreach efforts for those who have made a suicide attempt.
- CDR Werbel responded that in review of Marine Corps suicides over the last 10 years, only two suicides had a history of prior suicide attempt.
- Dr. Litts asked to hear from the other services on this issue and asked if this indicates that people are getting follow-up care or enough support from their units, or perhaps they are getting discharged before they commit suicide.
- CDR Werbel responded that this is a good question and that the Marine Corps is looking into what happens to an individual after a suicide attempt—are the individuals getting the help they need or are they getting medically boarded out of the military? He asked what percentage of suicide attempts actually end up dying by suicide in the national statistics.

- The panel answered that 45% of people who die by suicide have made a previous attempt.
- CDR Werbel clarified that most suicide completers die on their first attempt, so this is a universal screen, but could be a universal approach to a specific population. He added that it seems most people are not boarded out of the military after a suicide attempt, but the data is still being collected on this issue.
- LCDR Chavez stated that follow-up care is integrated into leadership and stress control training curriculums but is not a formal system of follow-up.
- Lt Col Kindt stated that the Air Force has done a number of things related to this issue of managing suicidal behavior. He stated that the Air Force highlights for providers the significance of increased risk in members with previous suicide attempts, the necessary monitoring involved, and the importance of maintaining supportive care for those individuals. He added that the Air Force has taken steps to educate providers in this regard and made policy changes in general, for example, the Air Force now requires all attempts to be reported to the chief medical officer of the installation. The chief medical officer then evaluates the case to determine what level of care is needed and if it is appropriate for the individual to continue on active duty. The review is not a medical board but does provide an initial assessment regarding the risks for that individual. Lt Col Kindt also mentioned that the Air Force now has procedures which establish high risk logs within each mental health clinic so that if a patient in the log misses an appointment procedures exist to reach out and check on that person and ensure adequate follow-up occurs.
- Dr. McKeon asked for data from the Army, Navy and Air Force regarding the number of suicides that had previous attempts.
- LCDR Chavez replied that the Navy has been collecting this type of data but that most of the time; at the time of the incident it is not always apparent that the situation was a suicide attempt. For example, a person drives their car into a tree, or someone comes in for stab wounds that appear to be self-inflicted. Eventually it ends up that these were attempts, but it was not noted at the time the incident occurred. She stated she believes the numbers of previous attempts would be small, but she can get that data for the Task Force.
- Lt Col Kindt stated that he does not have the data with him but can get the data back to the Task Force.
- MG Volpe asked for input from each service regarding what they think the Task Force can do to reduce stigma, either via recommended legislative change or recommended policy change in DoD.
 - Mr. Shabaz stated he thinks the stigma that the Task Force should address is the stigma associated with help-seeking behavior. He mentioned that all stigma is not necessarily bad, for example, the stigma associated with harming yourself should be maintained or increased. He added that the military mantra “leave nobody behind” needs to be reinforced in two ways: take care of your buddy and take care of yourself. He stated he believes stigma should be addressed in a specific manner and that the stigma associated with help-seeking behavior requires a cultural change which is very difficult to achieve. He discussed the difficulty of cultural change using smoking cessation and seat belt use campaigns as examples. Mr. Shabaz stated he believes the military is doing a good job talking about suicide, making the issue public, and creating programs like the Real Warrior Campaign to help combat the stigma. He stated he does not know of literature sources which validate a method for creating culture shift.
 - MG Volpe asked if Mr. Shabaz is saying that he has no recommendation for legislative or policy change to reduce stigma.
 - Mr. Shabaz replied that he has no recommendations.

- LCDR Chavez stated that some behaviors that may appear to be influenced by stigma are actually real barriers to care, not imaginary or attitudinal. She added that reinforcing successful reintegration after an attempt is probably the most influential tactic to reduce the stigma.
- Lt Col Kindt stated that he had a couple of ideas regarding stigma. He continued that there are avenues of seeking help that do not create a permanent record of the interaction; therefore the interaction is not reportable to commanders. He mentioned Military OneSource, talking to a chaplain, and the Air Force Military Family Life Counselors that are helping manage life skills for members and their families. He believes these are great programs on the surface but that they do reinforce the concept that seeing a mental health provider for help is reportable to their commander and therefore is viewed negatively by most military members since that can affect your career or clearance. He stated that in spite of the fact that the majority of individuals who seek mental health care do not experience negative career impact or loss of clearance, the fact that non-reportable methods of help seeking may reinforce the negative view of seeking help from a mental health clinic. Lt Col Kindt added that the Air Force Suicide Prevention Program has influenced a change in policy regarding reporting of privileged communications. If a person is undergoing a court martial or Article 15 proceeding, policy allows the person to have privileged communication with a mental health provider that cannot be used in the characterization of their discharge or against them in court. He added that this could be expanded to include anyone who received Miranda Rights since all the services have discussed legal problems and administrative problems as increasing risk for suicide.
- MG Volpe summarized that in the military suicide prevention programs, too many disparate entities exist that don't communicate with each other and asked for confirmation of his summary.
 - Lt Col Kindt replied that the problem is not just that information is not being shared, but it's the sense that members don't want to go to the psychologist on base because that information is going to follow them when they are screened for deployment or undergo a security clearance evaluation, but if they go to Military OneSource the information would be confidential, and that this thereby reinforces and increases the stigma of going to the mental health clinic for care.
 - MG Volpe stated that perhaps the issue is how we incentivize help-seeking behavior without having people take advantage of it.
 - Lt Col Kindt agreed and stated that as LCDR Chavez had alluded to, we need to recast what we are doing not as correcting a deficiency but as enhancing performance. He stated this is what the Air Force is trying to integrate into their suicide prevention program.
 - CDR Werbel stated another policy recommendation. He described a mandatory mental health exam much like the mandatory dental exam and classification that is needed for deployment. He stated that since no one would be singled out for getting the exam perhaps more people with risks would be identified.
 - MG Volpe stated that this is being done at Ft. Lewis.
 - COL Bradley stated that it must be recognized that we are struggling with a paradox of risk management and transparency and reducing stigma. He stated that as long as we cater to the commander's "need to know" mental health, substance abuse counseling, legal counseling information on their soldiers, we are creating an obstacle to reducing stigma. This is an institutional obstacle to help-seeking behavior. He believes the Task Force has to reconcile this and look for solutions to the paradox.
 - Dr. Kemp thanked the four service Suicide Prevention Program Managers for their input and transparency.

- Dr. McKeon also thanked the group and stated that the systematic evaluation is extraordinary and that the Task Force will do all they can to help and not hinder the service efforts in suicide prevention.
- MG Volpe thanked everyone and requested that the meeting conclude.
- CDR Feeks made administrative announcements.
- Col Bader thanked everyone for participating and as the Acting Designated Official for Ms. Embry officially adjourned the meeting at 5:20 p.m.